

REPORT TO CONGRESS
STUDY AND REPORT RELATED TO MEDICAID MANAGED
CARE REGULATION

As required by section 12002 of the 21st Century Cures Act (P. L. 114-255)

January 25, 2022

ACRONYMS AND ABBREVIATIONS

BHO	Behavioral health organization
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
FAQ	Frequently asked questions
FFP	Federal financial participation
HHS	U.S. Department of Health and Human Services
ILOS	In lieu of services
IMD	Institution for mental diseases
MCO	Managed care organization
MMCP	Medicaid managed care program
MMIS	Medicaid management information systems
PIHP	Prepaid inpatient health plan
P. L.	Public law
SUD	Substance use disorder
UM	Utilization management

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EXECUTIVE SUMMARY

In the “Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability Final Rule” (81 FR 27497) published in Federal Register on May 6, 2016 (hereafter referred to as the 2016 final rule), the Centers for Medicare & Medicaid Services (CMS) adopted a regulation (42 C.F.R. § 438.6(e)) to permit states to use federal Medicaid matching funds to make capitation payments to managed care organizations or prepaid inpatient health plans on behalf of beneficiaries aged 21 to 64 receiving treatment in IMDs¹ in lieu of² covered Medicaid services if certain conditions are met.³ Section 12002 of the 21st Century Cures Act (P.L. 114-255) directed the U.S. Department of Health and Human Services (HHS), acting through the CMS Administrator, to conduct a study and submit to Congress a report on its findings on coverage by Medicaid managed care plans of services to individuals between the ages of 21 and 64 for the treatment of a mental health disorder in institutions for mental diseases (as defined in section 1905(i) of the Social Security Act. This report draws on findings from a 2019 survey of states and territories with risk-based managed care arrangements, supplemented with findings from a targeted environmental scan and consultation with subject matter experts conducted in 2018 and 2019, to address five study topics outlined in the statute.

Background

Since Medicaid was enacted in 1965, federal statute has prohibited the use of federal Medicaid matching funds, known as federal financial participation (FFP), for services provided to people enrolled in Medicaid ages 21 to 65 who are patients in IMDs.⁴ Known as the Medicaid “IMD exclusion,” this policy has remained in place since it was first enacted in 1965 with a few modifications over time. The Medicaid program has historically offered risk-based Medicaid managed care plans the flexibility to provide alternative services in lieu of covered Medicaid services or settings as long as the alternative services are medically appropriate and cost-effective. But the interaction of the IMD exclusion and the use of IMDs as alternative services or settings presented legal issues prior to the adoption of 42 CFR § 438.6(e). Although some states allowed plans to cover IMDs in lieu of covered services before May 2016, there was some uncertainty as to whether this use contravened the IMD exclusion.⁵ To address this uncertainty and ensure compliance with the exclusion, the 2016 final rule adopted clear parameters

¹ The term “IMD” is defined in section 1905(i) of the Social Security Act as “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”

² In lieu of services (ILOS) are alternative services or settings that are “in lieu of” services or settings covered under the Medicaid State Plan in accordance with 42 CFR § 438.3(e)(2). CMS clarified its policy about and adopted parameters for use of ILOS in the 2016 final rule.

³ 42 CFR § 438.6(e) was initially adopted in the 2016 managed care final rule (81 FR 27497). A subsequent proposed rule in 2018 Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care solicited comment on the regulation and the final rule, released in November 2020 Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care, discussed those comments but did not amend the regulation (85 FR 72789-72790). See <https://www.medicare.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rules/index.html>.

⁴ This policy (known as the “IMD exclusion”), is currently reflected in a provision under subdivision (B) following section 1905(a)(30) of the Social Security Act.

⁵ In the preamble to the 2016 final rule, CMS estimated that at least 17 states were already paying for services in IMDs for managed care enrollees and accounting for an estimated \$6.0 million in expenditures in 2010.

(continued)

for the use of IMDs in lieu of covered services (hereafter referred to as the “IMD in lieu of services [ILOS] authority under § 438.6(e)”) while permitting FFP for the capitation payments for coverage of the periods while the enrollee is a patient in the IMD. Section 1013 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the “SUPPORT for Patients and Communities Act”) amended section 1903(m)(7) of the Social Security Act to provide that payment of FFP is permissible for state expenditures for capitation payments described in 42 CFR § 438.6(e)

The 2016 final rule adopted conditions under which FFP is available to states for certain Medicaid managed care capitation payments on behalf of people receiving inpatient treatment in an IMD in lieu of Medicaid-covered services. Under this regulation, FFP is available for full monthly capitation payments to risk-based managed care plans for Medicaid enrollees aged 21 to 64 who are in an IMD if the following criteria are met: (1) the facility must be a hospital providing psychiatric or substance use disorder (SUD) inpatient care or a sub-acute facility providing psychiatric or SUD crisis residential services, (2) the length of stay cannot exceed 15 days in a given calendar month, (3) certain requirements for in lieu of services are met, and (4) certain requirements for rate setting are met.^{6, 7} The provision of services in the IMD must meet the following requirements that in lieu of services are: (1) medically appropriate and cost-effective substitutes for the Medicaid-covered services and settings, (2) selected voluntarily by the beneficiary, and (3) authorized and identified in the managed care contract and optional for the managed care entity to offer.⁸ Finally, for the purposes of rate setting, the regulation at 42 CFR § 438.6(e) states can “use the utilization of [IMD] services provided to an enrollee under this [regulation] when developing the inpatient psychiatric or substance use disorder component of the capitation rate, but must price utilization at the cost of the same services through providers included under the State plan.” For example, states could use the price of inpatient psychiatric services provided in psychiatric units of general hospitals instead of the IMD costs.

In the preamble to the 2016 final rule, CMS explained the conditions and limits on the availability of FFP for capitation payments when an enrollee is a patient in an IMD in light of the risk-based nature of Medicaid managed care contracts and the need to ensure compliance with how the Medicaid statute excludes Medicaid coverage for services for certain beneficiaries while they are patients in an IMD⁹. In addition, the rule makes clear that states can continue to cover long-term stays in IMDs with other funds without FFP, such as state general funds, through separate arrangements. Further, in August 2017, CMS released a frequently-asked-questions document (FAQ) addressing common questions related to the IMD ILOS authority under 42 CFR § 438.6(e) (CMS 2017)¹⁰. The FAQ clarified that FFP is available for prorated (that is, partial) capitation payment to managed care plans to cover only the days in the

⁶ 42 CFR § 438.6(e). Qualifying Medicaid managed care plans are comprehensive managed care organizations or prepaid inpatient health plans with risk contracts, as defined in 42 CFR 438.2.

⁷ The regulation does not prohibit IMD stays of more than 15 days; rather, it prohibits states from receiving FFP for full capitation payments to plans on behalf of beneficiaries with IMD stays exceeding 15 days.

⁸ 42 CFR § 438.3(e)(2)(i) through (iii). In addition, the utilization and actual cost of in lieu of services that are not IMD services must be taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise. 42 CFR § 438.3(e)(2)(iv).

⁹ 81 FR 27555-27556

¹⁰ <https://www.medicare.gov/federal-policy-guidance/downloads/faq08172017.pdf>

month when the enrollee is not a patient in the IMD when the stay in the IMD exceeds the 15 day maximum specified in the regulation.

Study requirements and design

Section 12002 of the 21st Century Cures Act requires the secretary of HHS, acting through the administrator of CMS, to conduct a study on coverage under the Medicaid program of services provided through an MCO or PIHP for people older than age 21 and younger than 65 for the treatment of a mental health disorder in IMDs. The report must include: (1) the extent to which states (including the District of Columbia) and territories provide capitated payments to MCOs or PIHPs for enrollees who receive services in IMDs; (2) the number of Medicaid beneficiaries who receive services in IMDs through MCOs or PIHPs; (3) the range of and average number of months and the length of stay during such months that such individuals receive such services in IMDs; (4) how MCOs or PIHPs determine when to furnish services through an IMD in lieu of other benefits (including the full range of community-based services) under their contract with the state Medicaid agency to address psychiatric or SUD treatment; and (5) the extent to which the provision of services within such institutions has affected the capitated payments for MCO and PIHPs.

To address the five study topics, the study team conducted a targeted environmental scan and consulted with subject matter experts in late 2018 and early 2019, and developed and fielded a 16-question semi-structured survey of the 45 states and territories with risk-based Medicaid managed care arrangements in 2019.^{11,12} The survey included questions that directly address the study topics, as well as questions to provide context to and help the study team better understand state responses regarding study topics. Ultimately, 42 (93 percent) of states and territories responded to some or all survey questions. The study team then supplemented state survey responses with additional information gathered through the environmental scan and a second round of expert consultations.

Study results, by 21st Century Cures Act study topic

1. Extent to which states and territories provide capitated payments to managed care plans for enrollees who receive treatment in IMDs in lieu of covered services

Of the 42 states that responded to the survey, 37 reported including inpatient psychiatric or SUD treatment in risk-based MCO or PIHP-covered benefits. ***The majority of states that cover inpatient psychiatric or SUD treatment through risk-based Medicaid managed care use the IMD ILOS authority under § 438.6(e) to provide capitated payments to plans for enrollees ages 21 to 64 receiving***

¹¹ The environmental scan and consultations were conducted in the fall of 2018 and spring of 2019. The survey was conducted in the spring of 2019. To account for variability in the in lieu of services authority implementation dates and data lags across states, for most quantitative survey questions the study team asked states that were using the authority as of July 1, 2018 to report data for the most recent 12-month contract period during which the authority was used and for which data were available. Therefore, the data reported cover various time periods since enactment of the 2016 final rule. The sums and denominators for survey results also vary based on the number of states and territories that responded to each survey question. See Chapter II for additional information on the study timeline and methods.

¹² To identify states and territories eligible to participate in the survey, the study team used data from CMS's Medicaid Managed Care Enrollment Reports to identify states and territories with qualifying Medicaid managed care programs. States and territories eligible to participate in the survey were required to have risk-based managed care arrangements.

treatment in IMDs in lieu of covered services. In total, 32 of 37 states that include inpatient psychiatric or SUD treatment in MCO- or PIHP-covered benefits reported allowing plans to receive capitation payments on behalf of beneficiaries receiving treatment in IMDs using the ILOS authority under § 438.6(e). Most states indicated an intention to continue using the authority in the future. Three of the four states with risk-based managed care programs *not* permitting plans to cover IMD services under the authority (as of July 1, 2018) mentioned expecting to use the authority in the future, and the fourth might change its plans after completing a review of behavioral health treatment needs. The types of inpatient behavioral health services that states reported permitting MCOs or PIHPs to provide in IMDs in lieu of covered services generally mirrored the services included in Medicaid managed care arrangements in those states.

States reported that their primary rationale for using the IMD ILOS authority under § 438.6(e), either now or in the future, is to increase access to inpatient behavioral health services. States also described the need for more access because of increased demand for psychiatric and SUD treatment, and they believe IMD services to be a critical part of a full continuum of appropriate levels of care. A few states also mentioned the ability to allow plans to cover services in IMDs, or pay for services in IMDs with state or local funds before the 2016 final rule, and cited a desire to draw down federal funds for services that might previously have been entirely funded by the state. States also noted offering IMDs as a way to divert Medicaid beneficiaries from more-costly and less-appropriate settings, offer more specialized services, or ensure greater continuity of care.

2. Number of Medicaid beneficiaries who receive services in IMDs in lieu of covered services through managed care plans

The number of beneficiaries with one or more IMD stay in lieu of covered services in the last 12-month period for which data were available varied widely by state, ranging from fewer than 100 to nearly 50,000. The percentage of Medicaid beneficiaries enrolled in managed care programs permitted to use the IMD ILOS authority under § 438.6(e) who had at least one IMD stay in the 12-month reporting period also varied considerably, ***from less than 0.1 percent to 3.8 percent.***

3. Range and average number of stays and length of stay in IMDs for Medicaid beneficiaries receiving treatment in IMDs in lieu of covered services

The average number of stays per year among Medicaid managed care beneficiaries receiving treatment in IMDs across states using the IMD ILOS authority under § 438.6(e) ranged from 1.0 to 2.8 stays. The average number of stays in most states ranged from 1.0 to 1.7 per beneficiary per year. ***Average lengths of stay per stay across states ranged from 4.2 to 23.2 days, with average lengths of fewer than 10 days in about 80 percent of states that provided data on lengths of stay.*** However, the full distribution and range of stay lengths is not known, so the extent to which states must forgo FFP for capitated payments because enrollees are receiving treatment in IMDs for more than 15 days in a month is unknown.

4. How managed care plans determine when to furnish treatment for psychiatric or substance use disorders in IMDs in lieu of other benefits covered by the contract with the state Medicaid agency

In general, state and plan protocols and guidance are focused on ensuring plans and providers establish medical necessity before beneficiaries' admission to an IMD rather than providing clear guidance on when to choose IMDs over other covered services for specific beneficiaries. A few states and plans have established clear requirements for prior authorizations, utilization reviews, and discharge planning, and a few states and plans mentioned that determinations about when to use IMDs are based on the availability of beds in alternative settings. Managed care plans use a variety of criteria to guide their medical necessity and utilization review processes, including guidance developed by the American Psychiatric Association, the American Society of Addiction Medicine, and others.

States' contracts with managed care plans generally list the core requirements for offering the IMD ILOS option, or, at a minimum, cite 42 CFR 438.6(e). Most state contracts reiterate the limit of full capitation payments for beneficiaries with IMD stays of up to 15 days in any given month, note the age range for which the authority applies (ages 21 to 64), and indicate that the IMD ILOS must be voluntary for enrollees, medically appropriate, and cost-effective. Most states describe their approaches for ensuring that FFP is not claimed on behalf of people with stays of more than 15-days in their contracts. States often note their oversight and tracking processes and convey payment adjustment approaches such as prorating, full recoupment, or use of state general funds. A few contracts also explicitly describe the rate-setting requirements of the 2016 final rule or note additional state-specific requirements related to IMD ILOS and the interaction with other state policies.

Some states reported providing formal and informal guidance to managed care plans in addition to the required contract provisions to clarify use of the IMD ILOS authority under § 438.6(e). In general, the purpose of formal guidance was to explain the contract language to plans and sometimes to provide further operational details. States also noted that they provided informal guidance to plans in presentations, monthly MCO meetings and conference calls, emails, phone calls, and office hours.

States have developed a range of monitoring and oversight processes to ensure FFP is not used for full capitation payments to plans for enrollees with IMD stays of greater than 15 days. These processes include requiring plans to submit periodic reports, generating reports themselves, requiring immediate reporting, and using encounter data to track IMD stays.

5. The extent to which permitting plans to cover services for enrollees receiving treatment in IMDs in lieu of covered services affected capitated payments to managed care plans

About half of states using this authority (n = 15 of 27 states) reported that permitting plans to use the IMD ILOS authority under § 438.6(e) changed the inpatient psychiatric or SUD component of their capitation rate. In total, 12 states indicated that including or changing IMD utilization in rate setting affected rates, and 9 states noted that pricing utilization of IMDs at the cost of equivalent services delivered by providers included under the state plan affected rates.

States are not permitted to use FFP for full monthly capitation payments to managed care plans for an enrollee who receives services in an IMD for more than 15 days in a month. CMS has clarified, however

that prorating is allowed—that is, states can adjust the monthly capitated payment amount so that it is proportional to the number of days in the month when the enrollee is not in an IMD and the enrollee is eligible to receive all other Medicaid-covered services. To better understand how states ensure FFP is not used for capitation payments for enrollees with long stays, the survey asked states to report what they do when they become aware that an enrollee has an IMD length of stay of more than 15 days in a given month. ***States most commonly reported prorating capitation payments, followed by paying for stays with state general funds, and then full recoupment of the capitation rate.*** But states can also use other strategies, such as suspending a beneficiary’s enrollment in managed care or disenrolling them entirely, to ensure compliance with the 2016 final rule.

Limitations and opportunity for future research

As with any study, it is critical to keep in mind its limitations when interpreting the results. This study did not use rigorous quantitative methods to independently assess the extent to which states are using the IMD ILOS authority under § 438.6(e) to serve Medicaid beneficiaries, nor did it permit an assessment of the effects of the authority on access to or quality of care. The study relied on data voluntarily reported by states that were not independently validated and which might be incomplete or of marginal quality. Findings from the environmental scan, consultations, and survey represent a snapshot of the point when the information was gathered. For that reason, readers should interpret and apply the findings with significant caution. Future research using more robust qualitative and quantitative methods could address such limitations.

I. INTRODUCTION

In the “Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability Final Rule” (81 FR 27497) released in May 2016 (hereafter referred to as the 2016 final rule) the Centers for Medicare & Medicaid Services (CMS) adopted conditions under which states are permitted to receive federal Medicaid matching funds for full monthly capitation payments to managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) on behalf of beneficiaries aged 21 to 64 receiving treatment in institutions for mental diseases (IMDs) in lieu of covered Medicaid services if certain conditions are met.¹³ Section 12002 of the 21st Century Cures Act (P.L. 114-255) directed the Secretary of Health and Human Services (HHS), acting through the CMS Administrator, to conduct a study and submit to Congress a report on its findings related to five topics (described in Chapter II of this report). This report addresses five study topics outlined in the statute by drawing on (1) findings from a 2019 survey of states and territories with risk-based managed care arrangements, and (2) findings from a targeted environmental scan and consultation with subject matter experts conducted in 2018 and 2019.¹⁴ ¹⁵ Chapter I provides background information on federal Medicaid policy rules regarding coverage of IMD services and options for state coverage of services for people receiving IMD treatment as permitted by the 2016 final rule. Chapter II describes the topics specified in the study’s legislative mandate and the study’s design and methods. Chapter III reports results and findings for each of the study topics required by the statute. Finally, Chapter IV discusses conclusions.

A. Background on IMDs in Medicaid

Since Medicaid was enacted in 1965, federal statute has prohibited the use of federal Medicaid matching funds, known as federal financial participation (FFP), for services provided to Medicaid-enrolled individuals under the age of 65 who are patients in IMDs.¹⁶ Federal Medicaid statute defines an IMD as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.¹⁷ Known as the Medicaid “IMD exclusion,” this policy has generally remained in place since it was first enacted in 1965, with a few modifications over time. For example, in 1972, states were given the option to cover IMD services for people younger than age 21, and in 1988,

¹³ 42 CFR § 438.6(e) was initially adopted in the 2016 managed care final rule (81 FR 27497). A subsequent proposed rule in 2018 Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care solicited comment on the regulation and the final rule, released in November 2020 Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care, discussed those comments but did not amend the regulation (85 FR 72789-72790). See <https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rules/index.html>.

¹⁴ The environmental scan and consultations were conducted in the fall of 2018 and spring of 2019. The survey was conducted in the spring of 2019. To account for variability in the in lieu of services authority implementation dates and data lags across states, for most quantitative survey questions, the study team asked states that were using the authority as of July 1, 2018 to report data for the most recent 12-month contract period during which the authority was used and for which data were available. Therefore, the data reported cover various time periods since enactment of the 2016 final rule. The sums and denominators for survey results also vary based on the number of states and territories that responded to each survey question. See Chapter II for additional information on the study timeline and methods.

¹⁵ This report refers to states, territories, and the District of Columbia collectively as states for the sake of brevity and to preserve anonymity.

¹⁶ Subdivision (B) following section 1905(a)(30) of the Social Security Act.

¹⁷ Section 1905(i) of the Social Security Act.

(continued)

Congress limited the definition of IMDs to facilities with more than 16 beds (Melecki and Weider 2016).^{18,19} The IMD exclusion does not apply to psychiatric or SUD inpatient or crisis residential treatment facilities not considered to be IMDs, such as those with 16 or fewer beds.

B. Options for state coverage of IMD services for Medicaid managed care enrollees

Historically, the Medicaid program has offered risk-based Medicaid managed care plans the flexibility to provide alternative services in lieu of covered Medicaid services or settings as long as the alternative services were medically appropriate and cost-effective. But the interaction of the IMD exclusion and the use of IMDs as alternative services or settings presented legal issues prior to the adoption of 42 CFR § 438.6(e). Although some states allowed plans to cover IMDs in lieu of covered services or settings before May 2016, there was some uncertainty as to whether this use contravened the IMD exclusion.²⁰ To address this uncertainty and ensure compliance with the exclusion, CMS promulgated regulations in the 2016 final rule that included clear parameters for using IMDs in lieu of covered services (hereafter referred to as the “IMD in lieu of services [ILOS] authority under § 438.6(e)”).

The 2016 final rule clarified the conditions under which FFP is available to states for certain Medicaid managed care capitation payments on behalf of people receiving inpatient treatment in an IMD in lieu of Medicaid-covered services. Under this regulation, FFP is available for full monthly capitation payments to risk-based managed care plans for Medicaid enrollees aged 21 to 64 who are in an IMD in lieu of covered services if the following criteria are met in addition to requirements that apply to in lieu of services generally: (1) the facility must be a hospital providing psychiatric or substance use disorder (SUD) inpatient care or a sub-acute facility providing psychiatric or SUD crisis residential services and (2) the length of stay may not exceed 15 days in a given calendar month.^{21, 22} Requirements that apply to in lieu of services generally include that the in lieu of services must be (1) medically appropriate and cost-effective, (2) selected voluntarily by the beneficiary, and (3) authorized and identified in the managed care contract and optional for the managed care entity to offer.²³ Finally, for the purposes of rate setting, the 2016 final rule indicates states can “use the utilization of [IMD]services provided to an enrollee under this [regulation] when developing the inpatient psychiatric or substance use disorder component of the capitation rate, but must price utilization at the cost of the same services through providers included under the State plan” (for example, states could use the price of inpatient psychiatric services provided in psychiatric units of general hospitals instead of the IMD costs). In the preamble to

¹⁸ Social Security Amendments of 1972 (P.L. 92-603).

¹⁹ The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360).

²⁰ In the preamble to the 2016 final rule (80 FR 27840), CMS estimated that at least 17 states were already paying for services in IMDs for managed care enrollees and accounting for an estimated \$6 million in expenditures in 2010.

²¹ 42 CFR § 438.6(e). Qualifying Medicaid managed care plans are comprehensive managed care organizations or prepaid inpatient health plans with risk contracts, as defined in 42 § CFR 438.2.

²² The regulation does not prohibit IMD stays of more than 15 days; rather, it prohibits states from receiving FFP for full capitation payments to plans on behalf of beneficiaries with IMD stays exceeding 15 days.

²³ 42 CFR § 438.3(e)(2)(i) through (iii). In addition, the utilization and actual cost of in lieu of services that are not IMD services must be taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise. 42 CFR § 438.3(e)(2)(iv).

the 2016 final rule, CMS explained the conditions and limits on the availability of FFP for capitation payments when an enrollee is a patient in an IMD in light of the risk-based nature of Medicaid managed care contracts and the need to ensure compliance with how the Medicaid statute excludes Medicaid coverage for services for certain beneficiaries while they are patients in an IMD. In addition, the rule makes clear that states can continue to cover long-term stays in IMDs with other funds, such as state general funds, through separate arrangements without FFP.

In August 2017, CMS released a frequently-asked-questions document (FAQ) addressing common questions related to the regulation permitting FFP for full monthly capitation payments when the enrollee is a patient in an IMD for part of the month when other requirements are also met (CMS 2017). The FAQ document clarified, for example, that the 15-day length of stay is cumulative across multiple admissions in the same calendar month; the total number of days across admissions cannot exceed 15 days within the month for which the capitation payment is made. It also clarified that states can make two capitation payments to a managed care plan for an enrollee's stay of more than 15 days across two calendar months as long as the stay does not exceed 15 days in each month. States also are permitted to make a prorated (that is, partial) capitation payment to managed care plans to cover only the days in the month when the enrollee is not a patient in the IMD. Section 1013 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271) amended section 1903(m)(7) of the Social Security Act to provide that payment of FFP is permissible for state expenditures for capitation payments described in 42 CFR § 438.6(e).²⁴

As noted, before 2016, many states were already using IMDs as in lieu of services and the 2016 final rule adopted a regulation (42 CFR § 438.6(e)) to set parameters for the availability of FFP for full monthly capitation rates when the enrollee is a patient in an IMD for part of the month. In addition to relying on 42 CFR § 438.6(e), some states have had other pilot or waiver programs in place allowing use of IMDs. For example, from 2012 to 2015, 12 states participated in the Medicaid Emergency Psychiatric Demonstration, which tested the extent to which reimbursing IMDs to stabilize a psychiatric emergency medical condition improved access to and quality of care for beneficiaries and reduced overall Medicaid costs and utilization (Centers for Medicare & Medicaid Services 2019a). States also have the authority to use federal Disproportionate Share Hospital funding to make payments to mental health treatment facilities, including IMDs (U.S. Government Accountability Office 2017).²⁵ Historically, CMS also has permitted states to cover IMD services for adult Medicaid beneficiaries ages 21 to 64 with SUD and serious mental illnesses through 1115 demonstration waivers, including recent opportunities promoted by CMS in 2017 (SUD) and 2018 (serious mental illnesses).²⁶ As of April 16, 2021, 32 states had an 1115 waiver in place to cover IMD stays for SUD treatment, and another 3 states had pending waivers. Seven states had an 1115 waiver permitting coverage of mental health treatment in IMDs, and three states had waiver applications pending (Kaiser Family Foundation 2021). States can also cover certain

²⁴ 42 U.S.C. 1396b(m)(7)

²⁵ 42 U.S.C. § 1396r-4.

²⁶ Information about 1115(a) demonstration projects pertaining to serious mental illness/serious emotional disturbance and substance use disorder, including opioid use disorder, is available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf> and <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>, respectively.

(continued)

IMD stays for beneficiaries age 21 through 64 who have at least one substance use disorder diagnosis through the Medicaid state plan option authorized by section 5052 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271) (Centers for Medicare & Medicaid Services 2019b).²⁷ In addition, most states have traditionally covered IMD stays, particularly in public institutions, without federal financial participation (using state and local funds).

²⁷ Section 5052 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) amended section 1915 of the Social Security Act to add a new subsection (l) that authorizes, for the period beginning October 1, 2019, and ending September 30, 2023, a state to elect, through a State plan amendment, to provide medical assistance for items and services furnished to a beneficiary who is a patient in an eligible IMD, subject to specified requirements. See <https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf>.

II. STUDY DESIGN AND METHODS

A. Study topics required by the 21st Century Cures Act

Section 12002 of the 21st Century Cures Act requires the Secretary of HHS, acting through the administrator of CMS, to conduct a study on coverage under the Medicaid program of services provided through a Medicaid MCO or PIHP with respect to individuals over the age of 21 and under the age of 65 for the treatment of a mental health disorder in IMDs.²⁸ Section 12002(a) requires the report to include information on the following topics:

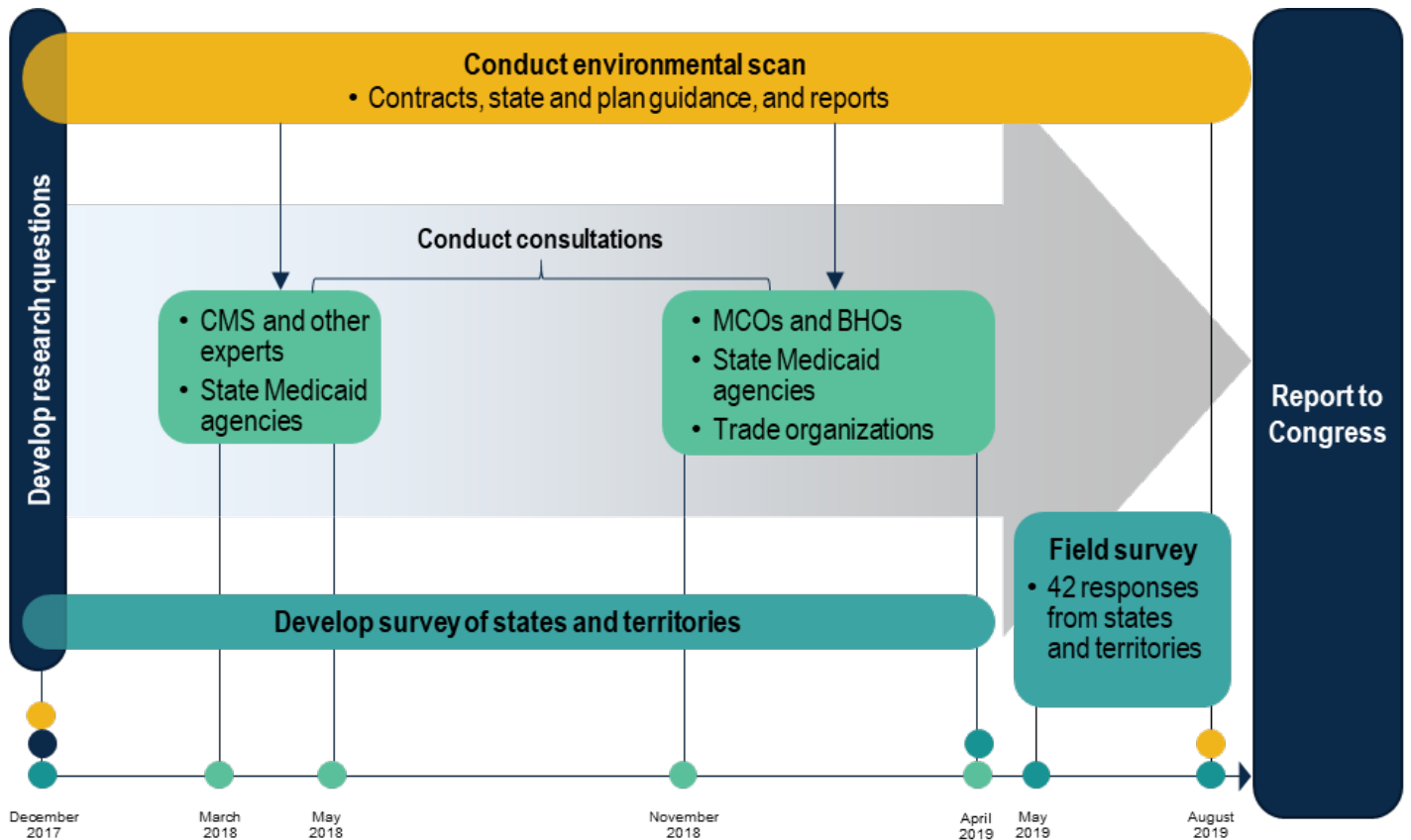
1. The extent to which states (including the District of Columbia) and territories provide capitated payments to Medicaid MCOs or PIHPs for enrollees who receive services in IMDs
2. The number of Medicaid beneficiaries who receive services in IMDs through MCOs and PIHPs
3. The range of and average number of months and the length of stay during such months that such individuals receive such services in IMDs
4. How MCOs and PIHPs determine when to furnish services through an IMD in lieu of other benefits (including the full range of community-based services) under their contract with the state Medicaid agency to address psychiatric or substance use disorder treatment
5. The extent to which the provision of services within such institutions has affected the capitated payments for MCOs and PIHPs

B. Study components and data collection methods

As shown in Figure II.1, to address the five overarching study topics, the study team and CMS developed a set of specific research questions to guide the study design and analyses. After developing an initial list of research questions, the study team conducted a targeted environmental scan and consulted with subject matter experts to explore potential data sources and limitations, refine the research questions, and gather information on Medicaid managed care contract provisions and state efforts related to the IMD ILOS authority under § 438.6(e) and IMD services. Based on initial information from experts and the environmental scan regarding gaps in and limitations of existing data sources, and because of the data collection timeline established by the authorizing legislation, the study team determined that a survey of states and territories would be the most efficient way to address most study topics that must be included in the report. Accordingly, the study team developed and fielded a semi-structured survey of states and territories with risk-based Medicaid managed care arrangements. They then supplemented state survey responses with additional information gathered through the environmental scan and a second round of expert consultations. This chapter describes each data source and related analytic methods in greater detail. Appendix A contains a list of the study's research questions and the survey questions and other data sources used to answer each question.

²⁸ 42 CFR 438.6(e) is not limited to treatment for mental health disorders; rather, IMDs may provide psychiatric or substance use disorder treatment.

Figure II.1. Study methods



BHO = behavioral health organization; CMS = Centers for Medicare & Medicaid Services; MCO = managed care organization.

1. Environmental scan

The study team conducted a targeted environmental scan of managed care contracts and gray literature to inform research questions, explore potential sources of data that might be available to conduct the study, and answer and provide context to study research questions and survey results. Before beginning the scan, the study team developed a search protocol to identify state contracts and other relevant resources, including state and plan guidance documents and key studies and reports. The study team initially gathered a broad set of resources in winter 2018 through Google searches of two sets of search terms: (“IMD” and “in lieu of”) and (“IMD” and “managed care rule 2016”). The scan was restricted to resources published after 2015 to capture early state perceptions and planning for using the authority. The study team also reviewed a convenience sample of 10 state contracts with MCOs or behavioral health organizations (BHOs, which are typically a type of PIHP), extracting information from relevant sources and organizing them into thematic tables. They expanded the contract search by locating earlier and later contracts for states in the sample to examine differences in contract language over time and then to include additional resources and state contracts referenced in initial sources. Similarly, when the team identified informative state or plan guidance on the IMD ILOS authority under § 438.6(e), they attempted to locate the state’s contract as well (and vice versa). The study team also conducted small, targeted scans as necessary to inform consultations with specific states and entities and to contextualize specific findings from the consultations and survey responses. The results of the environmental scan

were summarized by research question and some findings were later integrated into this report to supplement and contextualize survey findings.

2. Expert consultations

During the study period, the study team consulted, by phone, administrators and subject matter experts from CMS, state Medicaid agencies, MCOs, BHOs, and trade organizations representing state Medicaid programs and plans. To select relevant experts, the study team solicited feedback from CMS to identify administrators with expertise relating to Medicaid managed care, behavioral health, and actuarial science. The study team solicited CMS's input to identify state Medicaid agencies, with the goal of gathering the perspective of states with previous experience providing payments for Medicaid beneficiaries receiving services in IMDs and those that adopted the IMD ILOS authority under § 438.6(e) after the 2016 final rule. In addition, the study team identified Medicaid managed care plans and BHOs operating in multiple states and trade organizations representing plans to obtain a broad payer perspective. The study team conducted two rounds of consultations in late 2018 and early 2019. The first was with CMS officials and state Medicaid officials at the beginning of the study to develop and refine research questions, explore data sources, and inform survey development, and the second round was with additional state officials and representatives from plans and trade organizations at the study's midpoint to answer specific research questions and provide context to survey results. In total, the team consulted 20 experts. Upon completing the consultations, the study team analyzed responses and summarized key themes by topic, and some findings were later integrated into this report to supplement and contextualize survey findings.

3. Survey of states and territories with Medicaid managed care

To address most study topics required by the 21st Century Cures Act, the study team designed and fielded a 16-question semi-structured survey of all states and territories with risk-based Medicaid managed care arrangements.

Survey design. Informed by findings from the expert consultations and the environmental scan, the study team designed the survey to collect systematic information on the required study topics. The survey included questions that directly address the study topics, as well as questions to provide context to and help the study team better understand state responses regarding study topics. Because states were not required to respond to the survey, and the data collection timeline was short, the study team sought to balance the need for gathering comprehensive information with maximizing state participation. The study team provided states and territories definitions of terms to facilitate standardized responses, and its online survey tool included complex skip logic and integrated data checks to minimize states' burden and ensure that states only responded to questions relevant to the specific circumstances of individual state Medicaid programs. Before deploying the survey, CMS and the study team received approval for survey data collection efforts from the Office of Management and Budget in accordance with the Paperwork Reduction Act.

State identification, outreach, and response. To identify states and territories with qualifying Medicaid managed care programs to participate in the survey, the study team used data from CMS's

Medicaid Managed Care Enrollment Reports.²⁹ The study team identified 45 states with risk-based managed care programs and sent the survey to them; these 45 states and territories represent the survey sample. The study team communicated extensively via email and phone before and throughout the three-month survey period during which states completed the survey to increase state participation and engagement. The study team also regularly solicited and encouraged state communication with the survey team regarding questions and clarifications about survey content. Ultimately, 42 (93 percent) of the states and territories in the sample responded to some or all survey questions, and 3 states (7 percent) did not respond.

Survey data sources. States reported drawing on a variety of data sources to inform responses to survey questions, including (1) state Medicaid management information systems (MMIS) enrollment and encounter data, (2) state Medicaid managed care plan reporting forms and requests, and (3) state Medicaid managed care contracts and policy guidance documents.

4. Analysis and synthesis

The study team's analysis combined survey results with data collected from other study components. For survey questions that required states to report enrollment, utilization, and length of stay data, and for questions that included multiple choice options, the study team analyzed survey data and computed descriptive statistics (for example, n's, percentages, and averages) using state-submitted data using Excel and SAS software. In addition, the team used Excel and Word to analyze themes of free-text survey responses. After completing and synthesizing analyses of survey data, the study team used findings from expert consultations and the environmental scan to explain and interpret survey results.

5. Study limitations

The results in this report are based on state-reported data. The quality and completeness of state-reported data varied considerably, and the study team and CMS were unable to independently validate state responses. In cases in which state-reported data were outside expected ranges and states were unable to verify their accuracy, the study team excluded such data from the analyses. Similarly, the team's analysis of written survey responses is limited to the information states submitted and thus might not provide a complete picture of a state's policies or efforts. In addition, although the survey tool included extensive definitions and instructions, states could have interpreted and responded to questions slightly differently. The survey was intended to gather standardized data, and thus does not fully account for the variety and complexities of state Medicaid policies and approaches to the IMD ILOS authority under § 438.6(e). Readers should interpret and apply the results with caution.

To account for variability in implementation dates and data lags across states for the IMD ILOS authority under § 438.6(e), for most quantitative survey questions, the study team asked states that were using the authority as of July 1, 2018 to report data for the most recent 12-month contract period during which the IMD ILOS authority under § 438.6(e) was used and for which data were available. Therefore, the data reported in results tables covers various time periods since enactment of the 2016 final rule. The

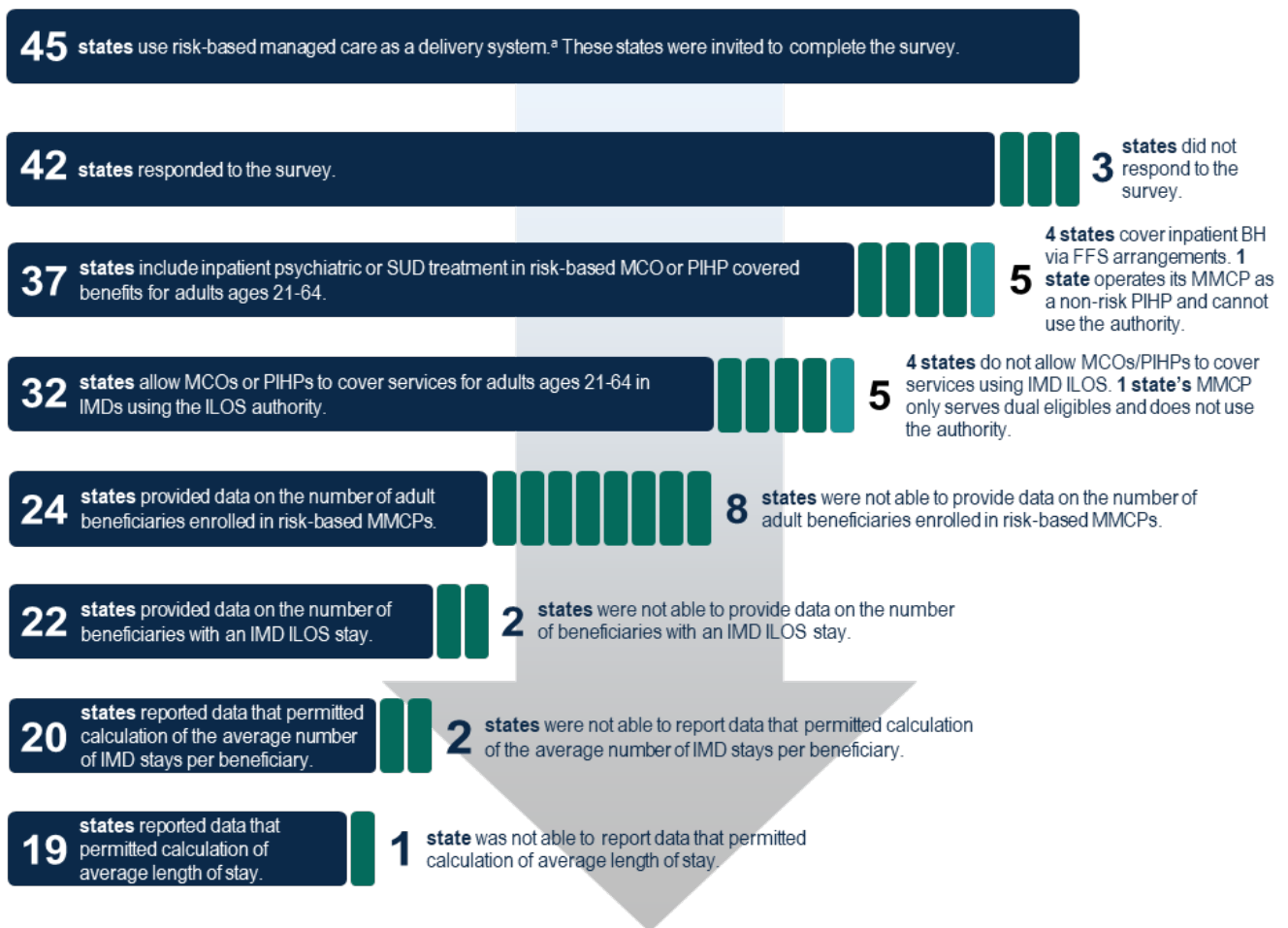
²⁹ States and territories eligible to participate in the survey were required to have risk-based managed care arrangements.

sums and denominators for tables with survey results also vary based on the number of states and territories that responded to each survey question.

III. STUDY RESULTS

This chapter reports study results and findings, organized by study topic required by the 21st Century Cures Act. Figure III.1 describes the number of states that provided data to address study topics 1 to 3 and reported in tables III.1 and III.2-4.

Figure III.1. Survey response roadmap



^a As reflected in CMS's Medicaid Managed Care Enrollment Reports as of July 1, 2017.

Notes: Some states that cover inpatient behavioral health treatment through fee for service allow beneficiaries to use IMD services through an 1115 waiver. This report focuses on states' use of the IMD ILOS authority codified in 42 CFR 438.6(e).

ILOS = in lieu of services; IMD = institution for mental diseases; MCO = managed care organization; MMCP = Medicaid managed care program; PIHP = prepaid inpatient health plan; SUD = substance use disorder.

A. Extent to which states and territories provide capitated payments to managed care plans for enrollees who receive treatment in IMDs in lieu of Medicaid-covered services (Study topic 1)

1. How many and which states permit managed care plans to cover services for enrollees receiving treatment in IMDs in lieu of Medicaid-covered services?

Of the 42 states that responded to the survey, 37 reported covering some or all inpatient psychiatric or inpatient SUD treatment for Medicaid beneficiaries ages 21 to 64 using risk-based managed care programs (Figure III.1). As shown in Table III.1, **32 of the 37 states (86 percent) covering inpatient psychiatric or SUD treatment through managed care indicated permitting MCOs or PIHPs to cover services for enrollees ages 21 to 64 receiving inpatient psychiatric treatment, SUD treatment, or both in IMDs in lieu of covered services as permitted under 42 CFR 438.6(e) as of July 1, 2018.** In all, 27 of the 32 states using the authority reported permitting MCOs or PIHPs to cover services for people receiving inpatient psychiatric *and* inpatient SUD treatment in IMDs in lieu of covered services. Only 4 of the 32 states using the authority reported allowing plans to cover services for people receiving **only inpatient psychiatric treatment** in IMDs, and 1 state allows plans to cover services **only for people receiving inpatient SUD treatment** in IMDs under the ILOS authority under § 438.6(e).

Four of the 37 states with risk-based managed care arrangements reported *not* permitting MCOs or PIHPs to cover services for people receiving inpatient psychiatric or SUD treatment in IMDs under the ILOS authority under § 438.6(e). However, 3 of the 4 states indicated that they plan to permit Medicaid managed care programs, using this authority, to cover such services in the future [MS, NY, WV]. A fourth state reported that although it is not planning to permit its Medicaid managed care programs to use the IMD ILOS authority under § 438.6(e) in the future, this decision could change after it finishes a review of psychiatric and residential treatment needs [ND].

The remaining state with risk-based managed care arrangements reported *not* using the IMD ILOS authority under § 438.6(e) because the only program to which the authority applies serves beneficiaries who are dually-eligible for Medicaid and Medicare.³⁰

Given the requirements regarding in lieu of services, it is not surprising that **in all but two states, the types of inpatient behavioral health treatment that states reported permitting MCOs or PIHPs to provide in IMDs in lieu of covered services mirrored the services included in managed care arrangements in those states.** That is, states that covered inpatient psychiatric and SUD services using managed care arrangements generally allowed plans to use the IMD ILOS authority under § 438.6(e) for psychiatric and SUD treatment; states that covered only inpatient psychiatric services via managed care arrangements generally allowed plans to use the IMD ILOS authority under § 438.6(e) for only psychiatric treatment; and states that only covered inpatient SUD services via managed care generally allowed plans to use the IMD ILOS authority under § 438.6(e) only for inpatient SUD treatment. But two states with managed care programs that cover inpatient psychiatric *and* inpatient SUD services using managed care arrangements permit the MCOs or PIHPs to cover IMD services only in lieu of

³⁰ Medicare pays for up to 190 days of inpatient hospital services in a psychiatric hospital per lifetime.

psychiatric treatment in other settings and from other providers that are covered under Medicaid[OR, TX].

Table III.1. State use of in lieu of services authority

State (N = 32)	For both psychiatric and substance use disorder treatment (N = 27)	For psychiatric treatment only (N = 4)	For substance use disorder treatment only (N = 1)
AR	YES	×	×
AZ	YES	×	×
CO	×	YES	× ^a
DC	YES	×	×
DE	YES	×	×
FL	YES	×	×
GA	YES	×	×
HI	YES	×	×
IA	YES	×	×
IL	YES	×	×
IN	YES	×	×
KY	YES	×	×
LA	YES	×	×
MA	YES	×	×
MN	YES	×	×
MO	YES	×	×
NC	YES	×	×
NE	YES	×	×
NJ	YES	×	×
NM	YES	×	×
NV	YES	×	×
OH	YES	×	×
OR	×	YES	×
PA	YES	×	×
RI	YES	×	×
SC	×	× ^a	YES
TN	YES	×	×
TX	×	YES	×
UT	×	YES	× ^a
VA	YES	×	×
WA	YES	×	×
WI	YES	×	×

Source: Mathematica analysis of state survey data, 2019.

Notes: This table includes only states that selected “yes” when asked to report whether the state/territory permits any of its Medicaid MCOs or PIHPs to cover services for enrollees aged 21-64 who are receiving inpatient psychiatric or SUD treatment in IMDs in lieu of covered services as of July 1, 2018. The information included in this table was reported by state Medicaid officials. Mathematica was not able to independently verify the accuracy or completeness of these data.

^a State reported not covering this service type through risk-based managed care.

The survey also asked respondents to report whether their state or territory planned to continue permitting Medicaid MCOs or PIHPs to cover services for people receiving inpatient treatment in IMDs in lieu of Medicaid-covered services in the future or whether they would begin permitting it if they did not do so now. The survey then asked respondents to share the reasons underpinning those plans. Thirty-seven states reported their plans as follows:

- Twenty-eight of the 37 states responding to this survey question permitted managed care programs to cover services for people receiving IMD treatment using the IMD ILOS authority under § 438.6(e) as of July 1, 2018. All 28 indicated that they plan to continue permitting Medicaid managed care plans to cover services for enrollees receiving care in IMDs under the ILOS authority under § 438.6(e) (data not shown).³¹
- As noted, 3 of the 4 states with risk-based managed care programs *not* permitting plans to cover services for people receiving treatment in IMDs under the authority (as of July 1, 2018) also responded to this survey question and indicated they plan to use the authority in the future [MS, NY, WV]. The fourth state reported that although it is not planning to use the authority in the future, this decision could change after it further reviews treatment needs [ND].³²
- The 4 states not covering services for people receiving IMD treatment through managed care arrangements that responded to the survey reported on their intentions as well. Three of the 4 do not plan to use IMD ILOS authority under § 438.6(e) in the future because they do not plan to cover inpatient behavioral health services through managed care; however, these states do allow beneficiaries to receive SUD treatment in IMDs under the authority of section 1115 waivers [CA, MD, and OK].³³ The fourth state not covering inpatient psychiatric and SUD services through managed care (as of July 1, 2018) indicated it plans to pursue coverage of inpatient SUD treatment in IMDs in the future to enable greater MCO involvement in the continuum of SUD services [KS].

2. Why did states choose to use the IMD in lieu of services authority?

To enable the study team to better understand the extent to which states were using the IMD ILOS authority under § 438.6(e), the survey asked states using the authority to describe their rationale for permitting plans to receive capitation payments for beneficiaries receiving treatment in IMDs using the ILOS authority. Twenty-eight of the 32 states using the IMD ILOS authority under § 438.6(e) responded to this survey question (data not shown). **Most commonly, states reported a desire to maintain or increase access to inpatient behavioral health services as the primary driver of the state's use of the IMD ILOS authority under § 438.6(e).** Fourteen states noted increased demand for services resulting from recent increases in opioid use disorder. Ten states described IMD services as a critical part of a full continuum of care and reported using the authority to ensure that beneficiaries have access to the level of

³¹ Three states permitting managed care plans to use ILOS for IMD treatment did not respond to this question. One state permitting the use of the authority responded in a way that indicated a misunderstanding of the question; as a result, the study team excluded the response from this analysis.

³² One additional state reported *not* using the IMD ILOS authority under § 438.6(e) because the only program to which the authority applies serves beneficiaries who are dually-eligible for Medicaid and Medicare. Medicare pays for up to 190 days of inpatient hospital services in a psychiatric hospital per lifetime.

³³ One of these three states [CA] mentioned its use of IMD services for SUD treatment under a 1115 waiver in its written response to this survey question. The study team obtained information about the other two states' [MD, OK] 1115 waivers from Medicaid.gov.

care appropriate to their needs. Seven states mentioned allowing plans to cover services for people receiving IMD treatment, or paying for services in IMDs, with state or local funds before the 2016 final rule; consequently, the 2016 rule clarifications allowed them to draw down federal funds for services that might previously have been funded, in whole or in part, by the state, thus freeing up state funds. Six states noted offering IMD services as a way to divert Medicaid beneficiaries from more costly and less appropriate settings, such as acute care hospitals and emergency departments.

Several states also described using the authority to expand their Medicaid-reimbursable network of inpatient providers or suggested that the authority will allow them to provide access to IMD services while awaiting approval of 1115 waivers.³⁴ Finally, several states also stated a desire to offer more specialized services or to ensure greater continuity of care. For example, one state noted, “We wanted to ensure continuity of care for enrollees while in an IMD so that they can continue receiving [other] services from MCO network providers while in the IMD. We also want to eliminate any issues in accessing network providers as enrollees transition out of the IMD.” In addition, most states reported permitting all of the MCOs or PIHPs in the state to cover services for enrollees in IMDs out of a desire to ensure comparable coverage and equity across plans, with only a few exceptions. For example, one state described limiting IMD ILOS solely to its PIHPs. Echoing survey results, one state explained during a consultation that the fundamental reason it is using the IMD ILOS authority is to address significant barriers to inpatient treatment, especially in rural or frontier areas of the state; from the state’s perspective, allowing plans to cover services for Medicaid MCO enrollees receiving treatment in IMDs was essential to increasing access to inpatient care.

Mirroring responses regarding state reasons for initially using the IMD ILOS authority under § 438.6(e), states that shared their intention to either begin or continue using the IMD ILOS authority under § 438.6(e) in the future (n = 32) most frequently reported being driven by a desire to increase or maintain access to care (n = 13) and noted the importance of IMDs in providing a full continuum of treatment services (n = 8). For example, one state noted that the authority provides eligible enrollees “access to more timely, medically appropriate, and cost-effective services.” Others explained they intend to continue using the IMD ILOS authority under § 438.6(e) to maintain increased access, improve care coordination, and strengthen overall behavioral health benefits. Another state spoke to the role of IMDs in the states’ continuum of care, noting that “IMDs in [our state] play a pivotal role in the system by providing an alternative to more expensive acute care in the general hospital setting on one hand, and stabilizing individuals for return to community settings on the other.”

3. What are states’ perceptions of the effects of the IMD ILOS authority under § 438.6(e) on access?

To provide supplemental understanding of the extent of states’ use of the IMD ILOS authority under § 438.6(e), the survey asked states to consider how the 2016 final rule’s policy clarifications affected adult Medicaid managed care enrollees’ access to inpatient psychiatric or SUD treatment based on their experience with implementing the IMD ILOS authority under § 438.6(e) so far.

³⁴ At the time of the survey (early 2019), many states were in the early stages of obtaining approval for 1115 waivers to receive FFP for beneficiaries receiving SUD or mental health treatment in IMDs.

Among the 27 states that answered this question, 6 believe the policy has increased access to inpatient psychiatric and SUD treatment (Table III.2). For example, one state reported that the state’s monitoring reports revealed an increase in access, noting that all of its plans offer IMD ILOS under § 438.6(e) and report on IMD ILOS utilization. Another reported a number of early outcomes: the state reported observing that emergency room holds have decreased, acute psychiatric inpatient admissions have increased, and community residential SUD service waitlists have decreased as enrollees used a greater range of the treatment options available.

In contrast, two states believe that the policy had led to a decrease in access, and two others³⁵ expressed concerns about decreasing access in the long-term. For example, one state, that had permitted its Medicaid managed care plans to cover services furnished in an IMD in lieu of other Medicaid-covered services and settings before the 2016 final rule, reported a decrease in access because of the limit on using FFP for capitation payments for people with IMD stays of more than 15 days under the rule. Another state reported decreased access to inpatient psychiatric treatment and shared early plan and IMD-level reactions: “Plans are less willing to pay for treatment if they know there is a risk of not having these costs count in future rating setting. IMDs in the state are reluctant to accept patients if there is a chance they won’t be reimbursed.”^{36,37} Two states that permitted its Medicaid managed care plans to cover services furnished in an IMD in lieu of other Medicaid-covered services and settings before the 2016 final rule expressed their concern that the loss of federal revenue for longer stays could impact sustainability and translate to reduced access over the long term. One of these states noted that the rule was “unnecessarily more restrictive” than the state’s prior practice.

Because states began implementing the IMD ILOS authority under § 438.6(e) adopted by the 2016 final rule relatively recently, most states (n = 19) reported that the effect of the IMD ILOS authority under § 438.6(e) on adult Medicaid managed care enrollees’ access to inpatient psychiatric and SUD treatment is unclear or there is no effect so far. Three of the 11 states reporting being unsure said that it was too early to tell; one of these states had just implemented the policy in March 2019. Other states indicated they had not evaluated access or were still analyzing data. Three states noted the difficulty in assessing effects because of their unique circumstances. For example, one state reported recent reductions in capacity for inpatient psychiatric and SUD treatment, which complicated its ability to assess the 2016 final rule’s effects on access. Three of the 8 states that reported “no effect” explained not perceiving a change in access because they permitted Medicaid managed care plans to cover services furnished in an IMD in lieu of other Medicaid-covered services and settings before the rule or they cover longer stays with state general funds. Finally, one state clarified that although it did not observe a change in IMD admissions with the new rule, continuity of care improved for its managed care enrollees.

³⁵ Regarding perceptions of current effects, these two states were classified as “unsure” and “no effect” respectively.

³⁶ Under 42 CFR § 438.3(e)(2)(i) ILOS must be a “cost-effective” substitute and under 42 CFR § 438.6(e), states may use the utilization of IMD services when developing the inpatient psychiatric or SUD component of the capitation rate, but they must price IMD utilization at the cost of the same services delivered by providers covered under the state plan. As such, using the cost of such treatment and the utilization of the IMD settings seems unlikely to result in capitation rates that are lower than adequate and necessary for coverage of the non-IMD Medicaid-covered services and settings.

³⁷ The state did not clarify the metrics it used to assess access.

Table III.2. State perceptions of the effects of in lieu of services authority on adult Medicaid managed care enrollees’ access to inpatient psychiatric and substance use disorder treatment

Response	Number of states (N = 27)	Percentage of states
Impact unclear/unsure	11	41%
No effect	8	30%
Increased access	6	22%
Decreased access	2	7%

Source: Mathematica analysis of survey responses, 2019.

A few states shared their strategies to address outstanding access issues in response to this survey question; three states specifically cited use of 1115 waivers. For example, one state noted that the 2016 final rule’s allowance for covering services for beneficiaries who receive IMD treatment for up to 15 days was beneficial but not adequate to meet enrollees’ behavioral health needs, so the state uses state general funds to pay for longer IMD stays. It has an 1115 waiver to cover longer SUD IMD stays and plans to apply for an 1115 waiver to cover longer psychiatric IMD stays.

B. Number of Medicaid beneficiaries who receive services in IMDs in lieu of Medicaid-covered services through managed care plans (Study topic 2)

1. In each state, how many people ages 21 to 64 are enrolled in managed care programs that cover services for enrollees receiving treatment in IMDs in lieu of Medicaid-covered services?

Twenty-four states of the 32 states using the IMD ILOS authority under § 438.6(e) responded to a question regarding the number of beneficiaries ages 21 to 64 enrolled in managed care programs that permitted their MCOs or PIHPs to use the IMD ILOS authority as specified by 42 CFR 438.6(e).³⁸ **The number of enrollees in such programs ranged from fewer than 12,000 [AR] to just under 1.5 million (1,486,253) [OH] (Table III.3).** Seven states had more than 1 million enrollees each, and three states had fewer than 100,000 enrollees. The median number of enrollees across the 24 states that reported on their beneficiaries was 574,853. One state with fewer than 100,000 enrollees reported that only managed care programs designed for a specific group of beneficiaries—those with complex behavioral health and/or intellectual or developmental disabilities—were permitted to cover services for people receiving treatment in IMDs in lieu of covered services [AR]. In contrast, many states that reported large numbers of enrollees have large adult Medicaid beneficiary populations and large comprehensive managed care programs, which the state permitted to cover IMD services in lieu of Medicaid-covered services under 42 CFR 438.6(e).

³⁸ Eight states permitting their MCOs and PIHPs to use the IMD ILOS authority under § 438.6(e) did not provide data on the number of beneficiaries enrolled in such managed care programs, nor did they specify the number of beneficiaries in such managed care programs who received services in an IMD during the reporting period. States cited a few reasons for not providing these data, including that they did not have such data available from existing reporting, they did not have necessary fields in their data system to enable accurate production of this information, and other priorities such as legislative requests limited their capacity to provide data.

(continued)

2. In each state, how many people ages 21 to 64 enrolled in managed care programs that cover IMD services in lieu of covered services actually received services in IMDs covered by such plans in the last 12-month contract period?

Twenty-two states responded to a question regarding the number of beneficiaries with an IMD admission among enrollees of Medicaid managed care programs permitted to use the IMD ILOS authority under § 438.6(e) over a 12-month period (Table III.3).³⁹ **The number of beneficiaries with one or more IMD stay varied widely by state, ranging from fewer than 100 [IA, MO, NE, NJ] to nearly 50,000 [PA].** The percentage of Medicaid beneficiaries enrolled in managed care programs permitted to use the IMD ILOS authority under § 438.6(e) who had at least one IMD stay in the 12-month reporting period also varied considerably, from less than 0.1 percent to 3.8 percent. The median percentage of enrollees with one or more IMD stays was 0.62 percent, or about 6 per 100,000 beneficiaries. The mean percentage of enrollees with one or more IMD stay was 0.91 percent, or roughly 9 per 100,000 beneficiaries.

³⁹ Two states (AR, FL) that reported the number of beneficiaries enrolled in Medicaid managed care plans permitted to use the IMD ILOS authority under § 438.6(e) did not have data available to provide the number of beneficiaries who received services in IMDs under the IMD ILOS authority under § 438.6(e).

Table III.3. Number of Medicaid beneficiaries ever enrolled in managed care programs permitted to use the IMD ILOS authority under § 438.6(e) and number who received IMD services under that authority

	Beneficiaries enrolled in managed care programs (N = 24)	Beneficiaries who received services in IMDs (N = 22)	Percentage of beneficiaries who received services in IMDs (N = 22)	Number who received services in IMDs per 1,000 beneficiaries ^a (N = 22)
AR ^b	11,677	---	---	---
AZ	828,938	14,838	1.79%	18
CO	146,357	2,641	1.80%	18
DC	134,592	861	0.64%	6
DE	120,067	2,640	2.20%	22
FL ^c	1,014,535	---	---	---
GA	412,089	1,559	0.38%	4
IA	252,371	59	0.02%	0
IL	1,293,814	139	0.01%	0
IN	1,126,258	5,983	0.53%	5
KY	814,330	12,085	1.48%	15
LA	829,674	14,236	1.72%	17
MA	1,161,695	8,381	0.72%	7
MN	517,218	5,353	1.03%	10
MO	47,315	53	0.11%	1
NE	80,039	97	0.12%	1
NJ ^d	985,708	34	0.00%	0
OH	1,486,253	9,251	0.62%	6
PA ^e	1,244,539	47,515	3.82%	38
RI	282,276	1,582	0.56%	6
TN	632,488	3,626	0.57%	6
VA	290,503	1,349	0.46%	5
WA	1,074,711	2,917	0.27%	3
WI	448,905	3,830	0.85%	9
Total	15,236,352	139,029	0.91% (mean)	9 (mean)

Source: Mathematica analysis of state survey data, 2019.

Notes: The table is limited to the states that answered associated survey questions. Medicaid officials reported the data contained in this table; Mathematica was not able to independently verify the accuracy or completeness of these data. States reported data for the most recent 12-month contract period for which data were available as of the time of the survey (May-August 2019).

^a This is rounded to the nearest whole number.

^b This state's [AR] managed care plans permitted to use the IMD ILOS authority under § 438.6(e) enroll only beneficiaries with "intense levels of treatment or care needs due to mental illness, substance abuse, or intellectual or developmental disability." These plans were not permitted to use the authority until March 1, 2019. Therefore, the state was unable to report data on IMD use.

^c This state [FL] was unable to provide data on the number or percentage of beneficiaries who received services in IMDs.

^d This state [NJ] indicated that during the reporting period, plans were permitted to cover services in IMDs under the IMD ILOS authority under § 438.6(e), but MCOs became solely responsible for inpatient psychiatric and SUD admissions at a more recent date outside of the reporting period.

^e This state [PA] has historically allowed plans to use IMD services in lieu of other covered services, which could explain, in part, the state's comparatively high IMD use under the IMD ILOS authority under § 438.6(e).

ILOS = in lieu of services; IMD = institution for mental diseases; MCO = managed care organization; SUD = substance use disorder.

The factors contributing to variations in the percentage of Medicaid beneficiaries enrolled in managed care programs permitted to use the IMD ILOS authority under § 438.6(e) who received services in an IMD are unclear. Neither differences in the total number of beneficiaries in managed care programs nor states' concurrent use of 1115 waivers for SUD treatment in IMDs appear associated with higher or lower rates of the use of IMD services in lieu of other services. But several states with higher rates of IMD ILOS use allowed plans to cover services in IMDs before the 2016 final rule, suggesting IMDs may have had more time to become incorporated into the Medicaid behavioral health services continuum.

C. Range and average number of stays and length of stay in IMDs for Medicaid beneficiaries receiving treatment in IMDs in lieu of covered services (Study topic 3)

Twenty states of the 32 states using the IMD ILOS under § 438.6(e) authority reported data that permitted calculation of the average number of IMD stays per year among Medicaid managed care program enrollees who received services in an IMD during the most recent 12-month period for which data were available. **The average number of stays per year among these enrollees ranged by state, from 1.0 to 2.8 stays per enrollee per year. Excluding outliers, the average in most states (n = 18) ranged from 1.0 to 1.7 per enrollee per year (Table III.4).** Four states at the lowest end of the range reported either exactly or very close to 1 stay per enrollee [IA, IL, NJ, VA]. Three of these states [IA, IL, NJ] reported low overall IMD use; fewer than 150 enrollees had an IMD stay in each of these states during the 12-month reporting period, representing 0.02 percent of beneficiaries or fewer. Two of these states, however, also reported longer average lengths of stay relative to other states. The fourth state at the lowest end of the range [VA] reported an average of exactly 1 stay, indicating that no enrollees had more than one stay in an IMD during the reporting period. Only two states had average numbers of stays above 1.7 [GA, PA]. The state with the highest average number of stays per beneficiary (2.76) [PA] is also an outlier in its high percentage of beneficiaries with an IMD stay. Pennsylvania reviewed and confirmed the data submitted but did not explain the high average numbers of stays relative to other states.

The average length of stay per stay across states ranged from 4.2 to 23.2 days. Most states, 15 of the 19 reporting this information, indicated an average length of fewer than 10 days (Table III.4).⁴⁰ Five states [CO, DC, GA, KY, MO] had an average length of stay of 6 days or fewer, and four states [IA, NJ, PA, WA] had an average length of stay longer than 10 days. Two of the four states with average lengths of stay longer than 10 days had fewer than 100 beneficiaries with IMD stays under the IMD ILOS authority under § 438.6(e); another of the four had about 3,000 enrollees with IMD stays, but this represented less than 0.3 percent of those enrolled in managed care programs using the IMD ILOS authority under § 438.6(e) in the state. One state reporting an average length of stay longer than 10 days (but fewer than 15 days) also reported both a high percentage of enrollees having an IMD stay under the IMD ILOS authority under § 438.6(e) and the highest average number of stays among eligible managed care enrollees. It is not known whether this is because of higher needs among the eligible enrollees in that state, prevailing standards of treatment that differ from other states, or other reasons.

⁴⁰ One state that provided data required to calculate the average number of stays per beneficiary was unable to provide data on length of stay. In an email, the state said, "this information was n't readily available and known from existing reporting to allow us to respond on a timely basis."

Table III.4. Range and average length of stay in IMDs in lieu of covered services in the last 12-month contract period for which data are available

State	Average number of stays per beneficiary per year (N = 20)	Average length of stay (number of days) per stay (N = 19)	Average number of days per beneficiary per year (N = 19)
AZ	1.70	--	--
CO	1.18	5.5	6.5
DC ^a	1.40	5.7	8.0
DE ^a	1.65	7.5	12.4
GA	1.89	4.2	7.9
IA	1.02	23.2	23.6
IL ^a	1.07	7.8	8.4
KY ^a	1.46	4.4	6.4
LA ^a	1.48	6.8	10.1
MA ^a	1.42	8.9	12.6
MN ^a	1.16	8.0	9.3
MO	1.30	4.2	5.5
NE _a	1.23	6.8	8.4
NJ ^a	1.03	14.1	14.5
OH ^a	1.50	7.4	11.2
PA ^{a,b}	2.76	12.8	35.4
TN	1.33	6.6	8.8
VA ^a	1.00	9.6	9.6
WA ^a	1.17	15.4	18.0
WI ^a	1.55	6.5	10.0
Cumulative average	1.41	8.7	11.9

Source: Mathematica analysis of state survey data, 2019.

Notes: The table is limited to the states that answered associated survey questions. State Medicaid officials reported the data contained in this table. Mathematica was not able to independently verify the accuracy or completeness of these data.

^aThese states had an approved 1115 waiver for SUD or mental health treatment in IMDs approved or pending at the time of the survey (See <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table5>).

^bThis state reviewed and confirmed the data submitted but did not explain the high average numbers of stays relative to other states.

ILOS = in lieu of services; IMD = institution for mental diseases; SUD = substance use disorder.

Our finding of an average length of stay of under 10 days in most states suggests that many stays fall within the 15-day limit that allows the state to receive FFP for full capitation payments to managed care plans for enrollees for the month of an IMD stay. However, the full distribution and range of stay lengths is unknown, so the extent to which states must forego FFP for a portion of or all of the monthly capitated payments because enrollees are patients in IMDs for more than 15 days in a month is unknown.

D. How managed care plans determine when to furnish treatment for psychiatric or substance use disorders in IMDs in lieu of other services covered by the contract with the state Medicaid agency (Study topic 4)

1. Do states provide direction to plans, either in contract provisions or other guidance, regarding provision of treatment in IMDs in lieu of other Medicaid services?

a. Contract provisions

States that use the IMD ILOS authority under § 438.6(e) are required to have contract provisions governing the provision of services in IMDs. The survey asked states to enter the relevant language from their contracts, and twenty-five states submitted contract excerpts.⁴¹ The information states typically include in their contracts related to the IMD ILOS authority under § 438.6(e) follows.

States' contracts with managed care plans generally list the core requirements for offering IMD services in lieu of covered services, or at a minimum, cite 42 CFR 438.6(e). Most state contracts specify the limit on capitation payments for beneficiaries with stays of more than 15 days in any given month; the age range to which the authority applies (ages 21 to 64); and that the IMD ILOS must be voluntary for enrollees, medically appropriate, and cost-effective.⁴² A few contracts also define IMDs or cite 42 CFR 435.1010 (which defines IMDs).

- **Fifteen day limit.** Most states use language similar to that used in 42 CFR 438.6(e) regarding the limit on capitation payments on behalf of enrollees with stays exceeding 15 days in a given month (for example, “the length of stay in the IMD is for a short term stay of no more than 15 calendar days during the period of the monthly capitation payment”). A few states explicitly note that the 15 days are cumulative rather than consecutive. A few states tie the 15-day limit to other requirements in the federal regulations. For example, one state clarifies that while “the [plan] is not prohibited from contracting with an IMD to provide mental health services to members’ ages 21 through 64 ... Medicaid will not compensate the [plan] for the provision of such services beyond 15 days per calendar month either through direct payment or considering any associated costs in Medicaid rate setting.” Contract language from a few states suggests that states may have established additional parameters and requirements for plans regarding lengths of stay beyond those required by the 2016 final rule. For example, one state’s contract indicates that plans shall provide services in IMDs so long as the “length of stay in the IMD is for a short term stay of no more than 15 days.”⁴³
- **Ages.** States commonly note that provisions apply to beneficiaries ages 21 to 64. A few states describe how their payment approach for this age range differs from their approach for other ages.

⁴¹ The completeness of the contract excerpts states provided varied and might not fully reflect all language related to the IMD ILOS authority under § 438.6(e) that states’ contracts include.

⁴² In this section, “most” reflects the majority of states that responded to the particular question or submitted data, whereas “a few” reflects less than the majority of that group of states. Relatedly, “a few” is often used to describe environmental scan findings, as the scan was not systematically conducted and thus the denominator is difficult to approximate.

⁴³ The 2016 final rule, i.e., 42 CFR § 438.6(e), does not prohibit IMD stays of more than 15 days; rather, it prohibits states from receiving FFP for full capitation payments to plans on behalf of beneficiaries with IMD stays exceeding 15 days.

- **General in lieu of service requirements.** Most contracts frame the requirement for services to be voluntary for a beneficiary using a variation of “plans may not require an enrollee to receive IMD services” or “an enrollee is not required to accept an ‘in lieu of’ service instead of a covered service.” In general, states use or refer to the regulatory language, in 42 CFR 438.3(e)(2)(i), requiring ILOS to be medically appropriate and cost-effective without further elaboration, although a few states acknowledged certain regulatory requirements or provided additional guidance. For example, one state specifies that plans should assess in collaboration with the enrollee whether the enrollee’s health status and quality of life is expected to be the same or better using the IMD ILOS as it would be using the customary covered services.

Most states describe in their contracts their approaches for ensuring that FFP is not claimed for full monthly capitation payments on behalf of enrollees with stays of more than 15 days in a calendar month. States often describe their oversight and tracking processes as well as payment adjustment approaches such as prorating, full recoupment, or use of state general funds for stays longer than 15 days (described further in section III.E). The tracking approaches states mentioned vary widely across contracts, including the extent to which they are described. For example, a few states refer to other policy documents or specifications in their contracts, such as requiring plans to submit data “as outlined in the reporting manual” or “as specified by the state,” whereas other states provide more detail on tracking processes directly in their contracts, such as specifying how frequently plans should submit reports to states. The payment approaches states describe vary across contracts as well, including the extent to which they are described, from citing the 2016 final rule regarding the payment limits, to describing the payment adjustments they will use for beneficiaries with stays exceeding 15 days in a calendar month.

A few contracts explicitly describe the rate-setting requirements of the 2016 final rule. That is, contracts specify that the state may use the IMD utilization experience to inform capitation rate setting, but IMD services will be priced at the cost of equivalent services covered under the state plan delivered by other types of providers.⁴⁴ Contract language varies from repeating the federal regulatory language verbatim to adding clarifying details such as specifying that the rates must be actuarially sound and reflective of only the first 15 days of the IMD stay when accounting for utilization.

Contracts sometimes acknowledge interactions with other state policies. For example, a few state contracts note that the 15-day length of stay limit only applies to enrollees’ psychiatric stays, because their section 1115 demonstration waivers cover SUD-related IMD stays of more than 15 days. Others discuss court-ordered stays. One state notes that “the contractor will comply with all court-ordered length of stays.”

b. Formal and informal guidance

The survey also asked states whether they provide formal or informal guidance to plans about providing services in IMDs in lieu of covered services in materials other than contracts. If states responded yes, the survey requested that states describe the format and content of this guidance and that they include a link to the guidance if it is publicly available.

⁴⁴ The 2016 final rule indicates that states **MAY** use the utilization of IMD services when developing the inpatient psychiatric or SUD component of the capitation rate, but they **MUST** price utilization at the cost of the same services delivered by providers covered under the state plan.

Five states reported providing formal guidance to plans about the option to use IMD ILOS in addition to contractual requirements. In general, the purpose of the formal guidance was to explain the contract language to plans and, sometimes, to provide further operational details. States reported issuing guidance to plans in a variety of forms, including written policy updates, bulletins, letters, plan manuals, and FAQ documents. Generally, formal guidance documents explained the federal rule and the requirements for plans regarding IMD ILOS. Formal guidance documents covered a range of other topics:

- **Provider or facility type.** A few states identified the specific provider or facility types that qualify as IMDs in their states.
- **Reporting requirements.** One state focused its formal guidance on reporting requirements for plans related to IMD utilization.

CLOSER LOOK: Ohio's comprehensive guidance

Ohio's FAQ document includes an overview of the state's goals for using the IMD ILOS authority, including increasing access to intensive mental health treatment, providing services closer to home, reducing readmissions, expanding the provider network, and improving continuity of care and coordination. It also outlines the role of managed care plans and providers.

Plans contract with IMDs and cover medically necessary services. Plans triage, make level-of-care determinations, and ensure and document that inpatient psychiatric services are being provided ILOS covered under the state Medicaid plan. Managed care plans also work with members, clinicians, and facilities during the admission process and are involved in the discharge process, including coordinating with community providers.

Providers (emergency departments, community providers, physicians, and so on) must contact the Medicaid managed care plan if the enrollee requires inpatient psychiatric care and must work with the plan to coordinate admission. Although providers must contact plans, plans will defer to providers' clinical judgment regarding the need for inpatient admission if the plan is not available. In that case, the provider, rather than the plan, must document that the IMD services were provided as an ILOS. Ohio provides a flow chart illustrating this process. The workflow shows that the enrollee must be offered a non-IMD setting (private general hospital or private facility with fewer than 17 beds) before an IMD setting (private IMD or public state hospital). The document also provides information on state psychiatric hospitals and forensic stays (Ohio Department of Medicaid 2017).

- **Payment approaches.** A few states provided detailed information on their approaches for ensuring FFP is not claimed on behalf of beneficiaries with stays longer than 15 days in a calendar month, including disenrolling and prorating (as further described in section E).
- **Voluntary selection of ILOS.** One state noted that its “guidance in the managed care entity manual ...[specifies] that the plan cannot require or create an incentive for a member to have care in an IMD over other types of care.”

States also reported providing informal guidance to plans through presentations, monthly MCO meetings and conference calls, emails, phone calls, and office hours. Eight states reported providing such informal guidance to clarify how the rule would impact various policy and operational details, such as Medicaid capitation rate setting, plan reimbursement, and length of stay, often in response to plans' questions. States also noted that they emailed items such as updated lists of IMDs in the state and templates for reporting to plans. One state noted that its communications in emails and meetings with plans clarified what the MCO and the IMD would be responsible for paying in various scenarios. For example, it specified that the MCO is responsible for paying the IMD for a short stay but not a long stay, and the MCO is responsible for paying for "eligible services delivered to the member prior to the [IMD] inpatient stay and received following the [greater than 15 day IMD] inpatient stay during that calendar month."

2. How do plans determine whether to cover IMD services in lieu of covered services for a given enrollee?

In general, state and plan protocols and guidance focus on ensuring plans and providers establish medical necessity for an acute level of care before beneficiaries' admission to an IMD rather than specifying the circumstances that determine when to choose IMDs over other covered services. In consultations, states and plans said that establishing medical necessity for the level of care is more pertinent than determining the specific setting within that level of care (for example, IMD versus psychiatric unit in a general hospital) for a given enrollee. Although contracts generally focus on delineating the ILOS requirements of voluntary selection of services by the enrollee, cost-effectiveness, and medical appropriateness, a few states provide more detailed guidance on state-specific requirements regarding implementation of the IMD ILOS. For example, Ohio specifies in its FAQ document (see text box) that the plan must first offer a beneficiary requiring inpatient psychiatric care the option of receiving care in settings covered by the state plan before offering care in settings covered by the IMD ILOS authority under § 438.6(e).

In consultations, most states and plans mentioned that determinations about when to use IMDs are based on the availability of beds in alternative settings, as IMD ILOS are used because of lack of bed availability and capacity constraints in non-IMD settings. For example, Medicaid administrators from one state explained that, given a particularly severe shortage of residential SUD treatment and beds for short inpatient mental health stays, their state would not have enough inpatient capacity for Medicaid MCO enrollees without the IMD ILOS authority under § 438.6(e). Because of these capacity constraints, plans focus on finding the right setting in terms of clinical appropriateness for the level of care for the enrollee, and they consider IMD beds to be clinically equivalent to other inpatient settings.

Managed care plans use a variety of criteria to guide their medical necessity and utilization review processes, but guidelines are not specific to IMDs. Environmental scan findings from national behavioral health organizations such as Beacon Health Options and Humana Behavioral Health, which operate in multiple states, illustrate the types of standards and clinical guidelines used by these plans to determine appropriate levels of care. For example, Humana has used guidelines developed by a national guideline developer to make all behavioral health utilization management (UM) decisions unless state or federal laws mandate it uses other criteria (Humana Behavioral Health n.d.). Beacon Health Options' medical necessity criteria draws from a variety of clinical guidelines for psychiatric and SUD services,

such as those from the American Psychiatric Association, the National Institutes of Health, criteria from peer MCO and BHOs, and the American Society of Addiction Medicine (Beacon Health Options n.d.; Beacon Health Options 2019a).⁴⁵ In addition, Beacon’s medical necessity criteria document explicitly notes that behavioral health organization care managers must consider an individual’s unique needs and social factors in their review (Beacon Health Options 2019b). Neither organization appears to have specific guidance related to IMD stays; their guidelines apply to various inpatient settings.

Consistent with findings from the environmental scan, in consultations, representatives from two multistate managed care organizations mentioned using nationally recognized guidelines to determine medical necessity and reported no difference in criteria for IMD versus other inpatient settings. Representatives from another managed care organization noted that the criteria it uses to determine medical necessity for inpatient care are based on age, SUD versus psychiatric disorder, and symptoms. The organization also uses level of incapacity, and it applies the same criteria to Medicaid and non-Medicaid beneficiaries. Respondents indicated that plans might also consult with organizations that develop medical necessity guidelines for plans regarding how and when to cover services.

A few states and plans have established guidance regarding prior authorization, utilization review, and discharge planning. The environmental scan revealed some examples of guidance designed to help providers understand and comply with IMD ILOS requirements. For example, one plan issued a provider reference guide, which explains prior authorization procedures for IMD services and recommends that providers submit initial requests by phone. The plan offers a 24/7 phone line for urgent precertification requests (AmeriHealth Caritas Louisiana n.d.). Another state, Ohio, describes the roles of plans and providers in determining the level of care and coordinating admission and discharge processes in a FAQ document (see text box above). A few states’ protocols differ by enrollee diagnosis type. For example, one state limits initial authorization to three days in an IMD with continued review for patients with psychiatric disorders, whereas for patients with SUD, the state limits initial authorization to seven days in an IMD. Providers must contact the plan within 48 hours of a beneficiary’s admission to an IMD for authorization of services, and the plan must ensure that no more than 15 days are authorized each month. The state explained in its survey responses that the plan will not pay when the length of stay exceeds 15 days in a calendar month. If a stay lasts longer than 15 days, the member is suspended from managed care enrollment, and the state does not make a capitation payment to a plan on the member’s behalf.

3. How do states ensure that federal Medicaid matching funds (FFP) are not used for full capitation payments to managed care plans for enrollees who receive treatment in an IMD in lieu of covered services for more than 15 days in any one month?

CMS was also interested in learning more about state processes for ensuring FFP is not used for full monthly capitation payments on behalf of individuals with stays exceeding 15 days. To this end, states

⁴⁵ As states continue to apply for 1115 waivers to provide SUD treatment in IMDs, it is likely that states will increasingly use American Society of Addiction Medicine (ASAM) criteria for determining the appropriate level of care for beneficiaries requiring SUD services because this is a requirement of the demonstration waiver. At least one state explicitly noted switching to ASAM criteria to meet the 1115 waiver requirement and two states mentioned using the IMD ILOS under § 438.6(e) to provide higher ASAM levels of care (level 3.5 and above), suggesting the criteria’s use.

have developed a range of monitoring and oversight processes to ensure FFP is not used to make a full month's capitation payment to plans:

- **Requiring plans to submit periodic reports.** Of the oversight and monitoring practices cited, states most frequently reported that they monitor enrollees' length of stay in IMDs by reviewing periodic reports that managed care plans submit to the state. Twelve states reported requiring plans to submit reports, usually monthly, with a few requiring less frequent reporting (such as quarterly, semiannually, or annually). Most states indicated that the reports identify enrollees with IMD stays of more than 15 days in a given month, whereas a few states specified that these reports track IMD utilization more broadly, including length of stay for all enrollees.

Findings from the environmental scan generally align with survey findings and provide additional examples of monitoring approaches states have used over time. For example, one state requires plans to report quarterly the number of IMD admissions, number of discharges, number of unduplicated beneficiaries, total number of bed days, average length of stay, and readmission rate within 30 days (State of North Carolina n.d.). Another state's monthly report template organizes beneficiaries into four categories reflecting facility type and length of stay: private IMD more than 15 days, public IMD more than 15 days, private IMD fewer than 15 days, and private IMD fewer than 15 days. The template also provides a broader picture of IMD utilization because it includes columns for IMD days during the current month and the prior month (Division of Medical Assistance and Health Services 2017). Contract language from other states provides clues to the evolution of reporting processes. For example, one state required plans to manually complete an Excel spreadsheet until a work group developed a more automated approach.

- **Generating reports themselves.** Rather than rely on managed care plans to report IMD ILOS stays, two states generate periodic reports themselves. For example, one state is developing a process to internally generate a quarterly report to identify enrollees with stays of more than 15 days in a given month using encounter data and to calculate the capitation rates paid and FFP claimed to make expenditure adjustments. Another state generates quarterly reports of enrollees with stays of more than 15 days in a calendar month and shares it with managed care plans, which have 10 days to review and comment before the state retroactively adjusts payments for months in which enrollees have stays of more than 15 days.
- **Requiring immediate reporting.** Two states require plans to report IMD stays of more than 15 days in a given month within 1 to 5 business days of identifying the long stay. A few other states' responses also suggest rapid reporting but do not specify the timeframe. One state requires plans to report long stays and "to coordinate transition of care with [the state's behavioral health agency] to find appropriate placement for the individual." Another state requires the plan to submit a state-developed template via email when an enrollee has a long stay; the state's member services department monitors the mailbox and uploads details in the MMIS for the time period.
- **Using encounter data.** Ten states review encounter data to identify long stays, monitor length of stay and utilization, monitor compliance with regulations, or check the accuracy of plans' reporting. Half of these states also use an oversight method described previously, suggesting that this review of encounter data often augments or validates other efforts.

Although the extent to which managed care plans and states are each involved in monitoring and overseeing IMD utilization varies, responsibility is most commonly shared. Sometimes, state vendors such as actuaries or fiscal contractors are involved. IMDs also sometimes play a direct role. For example, in one state that exclusively contracts with public IMDs, the IMDs contribute to the oversight process by reporting real-time admission and discharges to the state, and the state's information system processes these data and sends them to the MCO.

A few states' plans might use UM processes to limit the length of IMD stays. For example, one state requires its plans to coordinate with IMD discharge planners to ensure beneficiaries no longer requiring an inpatient level of care are discharged or transferred to an appropriate post-discharge setting. If the plan fails to ensure transfer within 2 days of when the beneficiary is deemed to no longer require acute care, then the plan must reimburse the IMD at the average skilled nursing facility rate or administrative day reimbursement rate, whichever is greater. Similarly, the environmental scan revealed that two plans in a state using the IMD ILOS authority under § 438.6(e) have established a protocol to reduce the occurrence of beneficiaries receiving more than 15 days of IMD care (MercyCare 2017). These plans arrange for beneficiaries receiving IMD treatment who require stays of longer than 15 days to be safely transferred to a non-IMD facility when possible by:

- At admission, the plans notify the IMD of the estimated number of IMD days the member has already used that month. Within 24 hours of admission, the IMD must develop a discharge plan and share it with the assigned plan's UM consultant.
- By the 10th day, the UM consultant and IMD staff discuss discharge coordination.
- By the 13th day, they determine whether medically necessary care is required beyond the 15 days and whether a safe transfer can occur to a non-IMD inpatient facility.
- On the 14th day, the UM consultant will contact the IMD to ensure that discharge can happen or an appropriate transfer is arranged.
- On the 15th day, discharge or transfer occurs and the IMD must provide this discharge information to the plan on the same day.

E. The extent to which permitting plans to cover services for enrollees receiving treatment in IMDs in lieu of Medicaid-covered services and settings affected capitated payments to managed care plans (Study topic 5)

1. Did permitting plans to cover services for people receiving treatment in IMDs in lieu of Medicaid-covered services and settings change states' capitation rates?

Per 42 CFR 438.6(e), states may use the utilization of IMD services when developing the inpatient psychiatric or SUD component of the capitation rate, but they must price utilization at the cost of the same services delivered by providers covered under the state plan. The survey asked states whether permitting plans to cover services for people receiving IMD treatment in accordance with 42 CFR 438.6(e) (which permits FFP when the requirements are met) changed the inpatient psychiatric or SUD component of the state's capitation rate. If the capitation rate changed, the survey instructed states to indicate which part of rate-setting rules in § 438.6(e) contributed to the change and to describe how the capitation rate changed.

In total, 15 of the 27 states responding to the question reported that permitting plans to cover IMDs in accordance with 42 CFR 438.6(e) - the IMD ILOS authority - changed the inpatient psychiatric or SUD component of their capitation rate (Table III.5). Twelve states indicated that including or changing IMD utilization in its rate setting affected rates, whereas nine states noted that pricing utilization of IMDs at the cost of equivalent services delivered by providers included under the state plan affected rates. Seven states attributed the capitation rate change to both of these rate-setting policies.

Table III.5. 438.6(e) effects of IMD ILOS rate setting policies on capitation rates (N = 27)

	N	Percentage
States reporting NO changes to capitation rates as a result of IMD ILOS authority under § 438.6(e)	12	44%
States reporting changes to capitation rates as a result of IMD ILOS authority under § 438.6(e)	15	56%
IMD ILOS rate setting policies that affected rates (N = 15)^a		
Including or changing utilization of services provided in IMDs	12	80%
Pricing utilization at the cost of the same services through providers included under the state plan	9	60%
Other ^b	1	7%

Source Mathematica analysis of survey responses, 2019.

Notes: The table is limited to the states that answered associated survey questions.

^a Percentages in this section of the table do not sum to 100 percent because states could select both rate-setting policies.

^b The study team was able to reclassify nearly all states' "other" selections into the respective policy categories based on the additional information states provided. But the team was unable to reclassify one state that selected "other" because the state provided outdated information from before the 2016 final rule.

ILOS = in lieu of services; IMD = institution for mental diseases.

Fifteen states responded to the question regarding the effect of implementing the IMD ILOS authority on the capitation rate: five states reported an increase, four states reported a decrease, and five states provided information that could not be used to determine the direction of change.⁴⁶ One state reported a more neutral or variable effect, explaining that it recalculates its rates semiannually to reflect current costs and capitation rate impacts are minimal and vary by the period in question.

⁴⁶ Regarding the five states that provided information that could not be used to determine the direction of change, (i) one state included outdated information on how its rate changed before the 2016 final rule, so the study team does not know how IMD ILOS authority rate-setting policies currently affect its capitation rate, (ii) two states provided ambiguous language, (iii) one state reported its adherence to the rate-setting policies, (iv) and the final state did not comment directly on the impact of the policies on its capitation rate but noted its projected net savings, reporting that the overall statewide impact of the IMD adjustment was a 0.2 percent decrease in the overall projected claim costs, or a decrease of about \$15 million.

In general, states reported that removing IMD stays of more than 15 days in a month when accounting for IMD utilization in their rate setting decreased rates, and pricing utilization at the cost of the same services delivered by providers covered under the state plan increased rates. It is likely that states that reported decreased rates after removing long IMD stays were states that had offered IMD ILOS prior to the 2016 final rule and were adjusting accordingly to adhere to the requirements of the regulation. One state explicitly attributed the reduced rate to this reason.⁴⁷ Four states reported an interplay between these factors that resulted in a net decrease in rates in two states and a net increase in rates in the other two states. One of the states attributed its net decrease to more than half of the state's mental health IMD stays being deemed "unallowable" under the IMD ILOS authority,⁴⁸ so these stays were excluded from capitation rate setting. Four other states, which attributed the capitation rate change to just one of the 2016 final rule's rate setting policies, noted that rates decreased after removing long stays and rates increased because of differences in costs of services provided in IMDs versus inpatient hospitals. One state reported that the rate-setting policy of including IMD utilization had the opposite effect as the rest of the states in this sample: it increased the state's capitation rates because the state was allowing IMD services to be covered by plans for this population for the first time.⁴⁹

Closer look: Effects of IMD ILOS rate-setting policies on one state's capitation rate

One state's actuarial contractor leveraged available encounter data to remove all claims from the behavioral health capitation rates for enrollees with non-SUD IMD stays longer than 15 days in a given month. [The SUD claims were not subject to the 15-day limit because this state has an 1115 waiver that covers SUD treatment in IMDs up to 90 days]. The adjustment resulted in a \$0.13 or 0.2 percent decrease to the 2019 contract year projected medical per member per month rate. The contractor also reviewed the average cost per diem of non-SUD IMD stays compared with the average per diem cost of non-IMD facilities for similar state plan services and applied a repricing adjustment. The repricing adjustment resulted in a \$0.16 or 0.3 percent increase in the 2019 projected medical per member per month rate, and it ultimately resulted in a net impact of a \$0.03 or 0.1 percent increase to the total 2019 contract year projected medical component.

2. What data are used to project managed care benefit costs associated with providing IMD services in lieu of other services in the capitated rates consistent with the requirements of 42 CFR 438.6(e)?

As noted, the 2016 final rule established requirements for states to follow in pricing utilization of IMDs into their capitated rates. Experts with whom the study team spoke shared that states using the IMD ILOS authority under § 438.6(e) should collect and use data on IMD stays to follow rate-setting requirements.

⁴⁷ Please refer to the introduction for more information on states' prior use of IMD ILOS.

⁴⁸ Presumably, most of the "unallowable" stays were long IMD stays (that is, more than 15 days in a calendar month).

⁴⁹ States often did not explicitly reference the inpatient psychiatric or SUD component of their capitation rate when responding to the survey. It is possible that some states reflected on effects of the rate-setting policies outlined in 438.6(e) for IMD stays on their overall capitation rates rather than the inpatient psychiatric or SUD component, for example. Regardless of the actual aspect of the capitation rate considered, states' responses reveal common reasons behind specific directional changes of capitation rates.

They acknowledged, however, that states do vary in the type of data on IMD stays they use and how those data are specified. Experts also explained that, within the bounds of the regulations, states might approach pricing utilization of ILOS differently. In one approach that experts perceived as common and most consistent with the 2016 final rule, states develop rates by pricing the utilization of IMD services at the rate of the covered inpatient psychiatric state plan services that IMDs are replacing, then use reports on allowed IMD stays to estimate utilization. Experts reported that states could develop more complex formulas to prorate capitation payments to cover days a beneficiary was not in an IMD during a month when the beneficiary had an IMD stay longer than 15 days.⁵⁰ But experts acknowledged that the differences in the rates would likely be minor and, given the small size of the relevant population, states might not find the undertaking worth the effort.

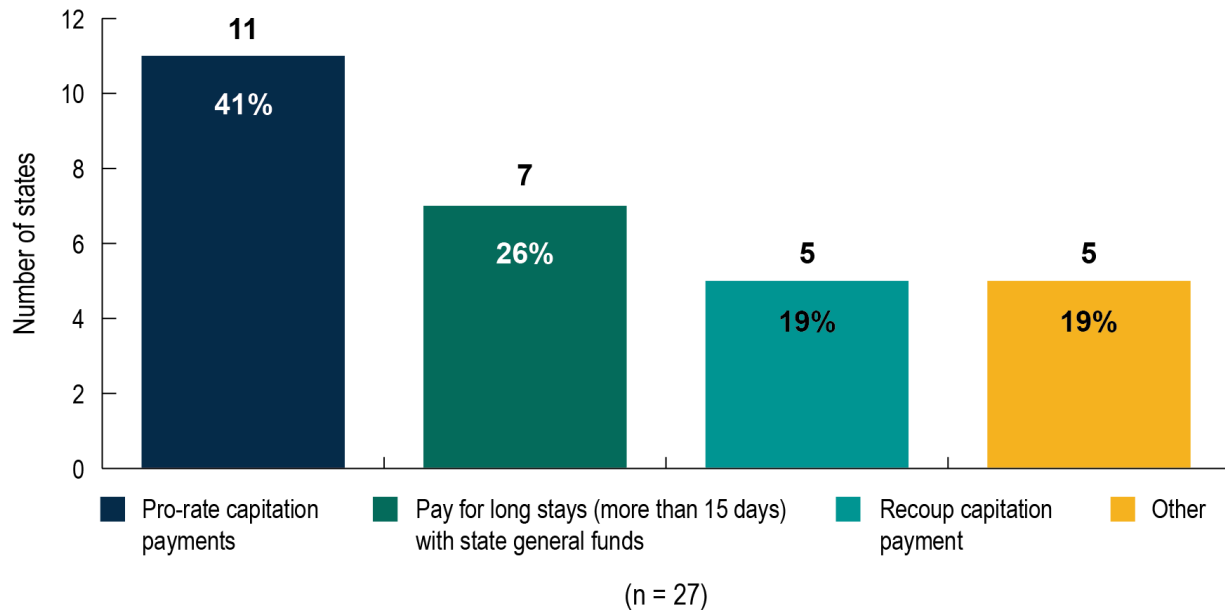
In consultation discussions, states reported using billing claims and encounter data to identify IMD utilization to set capitation rates. In one state that previously used the in lieu of authority for IMD services under a waiver, but only recently adopted managed care, state Medicaid officials reported that they were developing queries in their MMIS to produce reports on IMD stays from encounter data. Because they were not fully confident in the quality of the encounter data, state actuaries relied on claims data, available because of previous IMD coverage, to find historical utilization and exclude IMD stays longer than 15 days to develop rates. One state that implemented managed care for inpatient behavioral health many years ago primarily uses encounter data received from plans, in addition to eligibility and enrollment data, to track beneficiary IMD stays. The state's contracted actuarial firm also relies on encounter data to establish capitation rates.

3. How do states approach payments for beneficiaries whose stays are longer than 15 days in a given month?

FFP is not available to states for full monthly capitation payments to managed care plans for an enrollee who receives services in an IMD for more than 15 days in a month. CMS has clarified, however, that prorating is allowed—that is, states can adjust the monthly capitation payment amount so that it is proportional to the number of days in the month when the enrollee is not in an IMD and the enrollee is eligible to receive all other Medicaid-covered services.

⁵⁰ In prorating, the state calculates the monthly capitation payment amount for a beneficiary who stays in an IMD more than 15 days in a given month based on the proportion of that month the beneficiary was not in an IMD.

Figure III.2. State methods for ensuring federal financial participation is not used for capitation payments for enrollees with institution for mental diseases stays of more than 15 days in a month



Source: Mathematica analysis of survey responses, 2019.

Note: Only 27 states answered the relevant survey question and are included in this table. Percentages are out of 27. The sum of the number of states across rows is 28 because one state reported using two methods.

To better understand how states ensure FFP is not used for full monthly capitation payments for enrollees with long stays, the survey asked states to report what they do when they become aware that an enrollee has an IMD length of stay of more than 15 days in a given month. States selected which methods they use: (1) prorating capitation payments for such enrollees, (2) paying for IMD stays of more than 15 days in a month using state general funds, (3) using another method, or (4) some combination of these options.

States most commonly reported retrospectively prorating the capitation payment when enrollees' stays were more than 15 days in a month, followed by paying for long stays with state general funds, and then full recoupment of the capitation payment (Figure III.2).^{51,52} Of the 27 states that responded, 11 retrospectively prorate the capitation payment, 7 pay for long IMD stays with state general funds, and 5 recoup the entire month's capitation payment from the plan for the month. Most states that use state general funds reported fully recouping the monthly Medicaid capitation payment and replacing it with a payment funded exclusively by state general funds. Only one state reported using two methods:

⁵¹ Interpret results in this section with caution. To reduce respondent burden, the survey asked the question using a select-all-that-apply format, which might not fully capture the complexities of state approaches. For example, only one state indicated using a combination of the options, suggesting some states might have overlooked the instruction to select all that apply. In addition, the multiple-choice format could have caused states to select among the discrete options. Full recoupment was a popular option as a write-in; it is possible that this approach is under-represented if some states chose to pick an existing option or to skip this question.

⁵² It is unclear whether the managed care plans then become responsible for the full cost of the IMD stay in cases of prorating or recoupment. Such a result is not required by 42 CFR § 438.6(e), which only addresses limits on FFP.

prorating capitation payments for enrollees with long stays and paying for long stays with state general funds.

Some states described how their monitoring and oversight processes directly inform their payment adjustments. They noted the following examples:

- **State general funds approach.** One state explained that its Fiscal Intermediary MMIS searches encounter and claims records for mental health IMD stays. For long stays, the MMIS creates an adjustment per member per month payment record that reverses the existing FFP-funded per member per month payment record and replaces it with a state general fund per member per month payment record. Another state explained during a consultation that it instituted a monthly reporting process during which each managed care plan sends the state a file listing enrollees who have remained in an IMD for more than 15 days that month. The state completes an internal review to verify the information and sends the list to another part of the Medicaid agency to update an internal tracking system, which, in turn, alerts the financial operations division to reprocess the claim for FFP and return the federal share.
- **Full recoupment approach.** One state pulls encounter data for all people in psychiatric IMD facilities and recoups the entire capitation paid to the managed care plan(s) for enrollees with long stays. The state completes this process monthly with an 18-month lookback to allow for any lag in the receipt of encounter data and ensure it captures all stays.

States' contracts and formal guidance documents also sometimes described detailed payment adjustment processes, including interactions among stakeholders. For example, some states included guidance language that describes required interactions among plans. In one state, if separate contractors (that is, plans) are responsible for physical and behavioral health care, the behavioral health contractor must notify the physical health contractor of long stays that occur or are anticipated, and report the long stay to the state within one day of identification. The contractors must continue to submit encounters for all medically necessary services including the IMD stay, regardless of the length of the IMD stay. When the state receives the report of a long stay, it changes the beneficiary status to a non-capitated status, which triggers recoupment of the capitation payments from both contractors. The contractor is not permitted, however, to recoup payment made to providers. After recouping the capitation payment as an interim step, the state prorates the capitation payment to reflect the non-IMD days that month (Arizona Health Care Cost Containment System 2018).

Five states reported using “other” processes related to payment for stays that exceed 15 days. For example, one state suspends the member with the long stay from managed care and does not make a

Closer look: Disenrollment from Managed Care Plans

- A state that indicated that it prorates capitation payments provided contract provisions and formal guidance describing its disenrollment approach, in which beneficiaries with long stays who have been ordered to a state hospital but are awaiting placement will be disenrolled from the plan and enrolled in traditional fee-for-service Medicaid instead. The plan shall “ensure the member is properly transitioned and there is not a break in coverage.” For long stays in which the enrollee is not awaiting placement in a state hospital, the enrollee will remain in the plan.
- Findings from the environmental scan indicate that one state that selected the state general funds option might also disenroll beneficiaries with long stays in public IMDs from their managed care plan, using instead state funds to pay for services provided by the public IMD. Because the environmental scan was conducted before the fielding of the survey and drew upon publicly available documents from a wider date range, it is unclear whether this state still takes this more multifaceted approach or whether this additional piece of information represents an older approach.
- Another state described during a consultation that the approach it takes depends on the type of IMD used. If a beneficiary is admitted to a private IMD and stays longer than 15 days in a month, the state continues capitation payments to the plan but does not claim FFP for that beneficiary month. But if a beneficiary is admitted to a state or county IMD, he or she is disenrolled from the plan immediately and the state pays the plan a prorated per member per month rate reflecting the number of days in the month before the client was admitted to the IMD and disenrolled from the plan.

capitation payment on the member’s behalf. See the textbox for additional disenrollment examples.⁵³

⁵³ It is possible that disenrollment is underrepresented if some states chose an existing option or to skip this question. The environmental scan, consultation discussions, and other survey responses suggest that disenrollment is used more frequently than is indicated by these survey responses; disenrollment approaches are further described in the text box.

IV. CONCLUSIONS

Consistent with findings from other recent surveys, the study found that most states with risk-based Medicaid managed care rely on and comply with the IMD ILOS authority at 42 CFR 438.6(e) to ensure availability of FFP and plan to continue to do so in the future (Kaiser Family Foundation 2019). When sharing their rationale for using the authority, either now or in the future, states cited a desire to increase access to inpatient behavioral health services as the primary driver. The number of beneficiaries receiving services in IMDs under the IMD ILOS authority under § 438.6(e) varies considerably by state, a finding that reflects similar diversity in state managed care arrangements, provider and service delivery systems, historical use of IMDs, and a host of other factors. But average lengths of stay per stay varied less across states, with average lengths of fewer than 10 days in about 80 percent of states that provided data on lengths of stay. Our finding of an average length of stay of under 10 days in most states suggests that many stays fall within the 15-day limit that allows the state to use FFP for capitation payments to the managed care plan for the enrollee for the month of the stay. However, the full distribution and range of stay lengths is unknown, so the extent to which states must forgo FFP for capitated payments because enrollees are in IMDs for more than 15 days in a month is unknown.

States and plans consistently noted that they focus on ensuring that beneficiaries require an inpatient level of care rather than specifying the circumstances that determine when to choose IMDs over other inpatient services. Many states use national guidelines to identify the appropriate level of care notwithstanding the type of setting, and some states and plans have established clear requirements for prior authorizations, utilization reviews, and discharge planning. States also have developed a range of monitoring and oversight processes as well as payment strategies such as prorating and recoupment to ensure FFP is not used for full capitation payments to plans for enrollees with IMD stays of greater than 15 days.

As with any study, it is critical to keep in mind its limitations when interpreting the results. This study did not use rigorous quantitative methods to independently assess the extent to which states are using the IMD ILOS authority under § 438.6(e) to serve Medicaid beneficiaries, nor did it permit an assessment of the effects of the authority on access to or quality of care. The study relied on data voluntarily reported by states that were not independently validated and which might be incomplete or of marginal quality. Findings from the survey, environmental scan, and consultations represent a snapshot of the point when the information was gathered. For that reason, readers should interpret and apply the findings with significant caution. Future research using more robust qualitative and quantitative methods could address such limitations.

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Appendix A. Table of study topics, expanded research questions, and data sources

Expanded research question, by study topic	Study data sources used to address research question		
	Relevant survey question	Environmental Scan	Expert consultations
21st Century Cures Act study topic 1: The extent to which states, including the District of Columbia and each territory or possession of the United States, are providing capitated payments to such organizations or plans^a for enrollees who are receiving services in IMDs			
A. To what extent do states and territories provide capitated payments to managed care plans for enrollees who receive treatment in IMDs in lieu of covered services?			
1. How many and which states permit managed care plans to cover services for enrollees receiving treatment in IMDs in lieu of Medicaid covered services?	Does your state/territory permit any of its Medicaid MCOs or PIHPs to cover services for enrollees aged 21-64 who are receiving inpatient psychiatric and/or SUD treatment in IMDs in lieu of covered services under any of its Medicaid managed care contracts as permitted under 42 CFR 438.6(e) as of July 1, 2018?	✓	
2. Why did states choose to use the IMD in lieu of services authority?	<ul style="list-style-type: none"> • Indicate the number of Medicaid managed care programs that were permitted to cover services for enrollees who are receiving inpatient treatment in IMDs in lieu of covered services, whether plans in the program are MCOs or PIHPs, and whether they offer inpatient psychiatric or inpatient SUD services. • Describe why your state/territory decided to permit plans to cover services for enrollees who are receiving treatment in IMDs in lieu of covered services as permitted under 42 CFR 438.6(e). How did your state/territory determine which types of plans to permit to cover services for such enrollees? • Does your state/territory plan to use the authority in the future? 	✓	✓

Study data sources used to address research question			
Expanded research question, by study topic	Relevant survey question	Environmental Scan	Expert consultations
3. What are states' perceptions of the effects of the IMD ILOS authority under § 438.6(e) on access?	Based on your experience so far, has the option to provide capitation payments to MCOs and PIHPs for enrollees aged 21-64 who are receiving inpatient psychiatric or inpatient SUD treatment in IMDs up to 15 days in any one month increased or decreased access to inpatient psychiatric and inpatient SUD treatment for adult Medicaid managed care enrollees?		
21st Century Cures Act study topic 2: The number of individuals receiving medical assistance under a state plan under such Title XIX, or a waiver of such plan, who receive services in IMDs through such organizations and plans ^a			
B. How many Medicaid beneficiaries receive services in IMDs in lieu of covered services through managed care plans?			
1. In each state, how many people ages 21 to 64 are enrolled in Medicaid managed care programs that cover services for enrollees receiving treatment in IMDs in lieu of covered services?	Indicate the total number of Medicaid beneficiaries ever enrolled in the managed care programs in which plans are permitted to cover individuals receiving IMD treatment in lieu of covered services.		
2. In each state, how many people ages 21 to 64 enrolled in managed care programs that cover IMD services in lieu of covered services actually received services in IMDs covered by such plans in the last 12-month contract period?	Indicate the total number of Medicaid beneficiaries ever enrolled in managed care programs with one or more admissions to an IMD in lieu of covered services.		
21st Century Cures Act study topic 3: The range of and average number of months, and the length of stay during such months, that such individuals are receiving such services in such institutions			
C. What is the average number of stays and length of stay in IMDs for Medicaid beneficiaries receiving treatment in IMDs in lieu of Medicaid covered services?			
1. What was the average number of stays per beneficiary?	For each program, indicate the total number of individuals aged 21-64 ever enrolled who had one or more admissions to an IMD in lieu of covered services, the total number of stays in IMDs among all enrollees aged 21-64		
2. What was the average length of stay per Medicaid beneficiary per stay?			

Study data sources used to address research question			
Expanded research question, by study topic	Relevant survey question	Environmental Scan	Expert consultations
3. What was the average number of days per Medicaid beneficiary per year?	who received treatment in IMDs through MCOs and/or PIHPs in lieu of covered services, and the total number of days that all individuals aged 21-64 who received inpatient treatment in IMDs through MCOs and/or PIHPs in lieu of covered services as permitted under 438.6(e) spent in IMDs in the last 12-month period for which data are available.		
21st Century Cures Act study topic 4: How such organizations or plans ^a determine when to provide for the furnishing of such services through an institution for mental diseases in lieu of other benefits (including the full range of community-based services) under their contract with the state agency administering the state plan under Title XIX, or a waiver of such plan, to address psychiatric or substance use disorder treatment			
D. How do managed care plans determine when to furnish treatment for psychiatric or substance use disorders in IMDs in lieu of other services covered by the contract with the state Medicaid agency?			
1. Do states provide direction to plans, either in contract provisions or other guidance, regarding provision of treatment in IMDs in lieu of other Medicaid services?	<ul style="list-style-type: none"> States and territories that permit plans to cover services for individuals aged 21-64 receiving inpatient treatment in IMDs in lieu of covered services as permitted under 438.6(e) are required to have contract provisions governing the provision of services in IMDs. Please share the relevant language from your state/territory's managed care contracts. Does your state provide guidance (formal or informal) to plans about the provision of services in IMDs in lieu of covered services beyond required contract provisions? 	✓	
2. How do plans determine whether to cover IMD services in lieu of Medicaid covered services for a given enrollee?		✓	✓

Study data sources used to address research question			
Expanded research question, by study topic	Relevant survey question	Environmental Scan	Expert consultations
3. How do states ensure that federal Medicaid matching funds (FFP) are not used for full capitation payments to managed care plans for enrollees who receive treatment in an IMD in lieu of Medicaid covered services for more than 15 days in any one month?	Describe how your state/territory ensures that federal Medicaid matching funds (FFP) are not used for full capitation payments to plans for enrollees who receive treatment in an IMD in lieu of covered services for more than 15 days in any one month:	✓	
	(1) How does your state/territory monitor the length of time a plan enrollee receives services in an IMD? (2) How does your state/territory become aware that an enrollee has an IMD length of stay of more than 15 days in a given month?		
21st Century Cures Act study topic 5: The extent to which the provision of services within such institutions has affected the capitated payments for such organizations or plans^a			
E. How has permitting plans to cover services for enrollees receiving treatment in IMD in lieu of covered services affected capitated payments to managed care plans?			
1. Did permitting plans to cover services for people receiving treatment in IMDs in lieu of Medicaid covered services and settings change states' capitation rates?	Did permitting plans to cover services for enrollees aged 21-64 who are receiving treatment in IMDs in lieu of covered services change the inpatient psychiatric or SUD component of your state/territory's capitation rate?		
2. What data are used to project managed care benefit costs associated with providing IMD services in lieu of other benefits in the capitated rates consistent with § 438.6(e)?			✓
3. How do states approach payments for beneficiaries whose stays are longer than 15 days in a given month?	What happens if your state/territory becomes aware that an enrollee has an IMD length of stay of more than 15 days in a given month?	✓	✓

^a Medicaid managed care organization or prepaid inpatient health plan.

BHO = behavioral health organization; FFP = federal financial participation; IMD = institution for mental diseases; MCO = managed care organization; PIHP = prepaid inpatient health plan; SUD = substance use disorder