



## **Center for Medicaid and CHIP Services**

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### ***CMCS Informational Bulletin***

**DATE:** November 28, 2012

**FROM:** Cindy Mann, Director  
Center for Medicaid and CHIP Services (CMCS)

**SUBJECT:** Inpatient Psychiatric Services for Individuals under age 21

This Informational Bulletin clarifies that states may structure coverage and payment for the benefit category of inpatient psychiatric hospital or facility services for individuals under age 21 (hereinafter referred to as inpatient psychiatric facility benefit) to ensure that children receiving this benefit obtain all services necessary to meet their medical, psychological, social, behavioral and developmental needs, as identified in a plan of care. This clarification is intended to describe flexibility currently available to states to ensure the provision of medically necessary Medicaid services to children in inpatient psychiatric facilities.

### **Background**

Under section 1905(a) of the Social Security Act (the Act), there is a general prohibition on Medicaid payment for any services provided to any individual who is under age 65 and who is residing in an Institution for Mental Diseases (IMD) unless the payment is for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(a)(16) of the Act, as defined in section 1905(h) of the Act. Implementing regulations at 42 Code of Federal Regulation 440.160 and 441 Subpart D define these inpatient psychiatric hospital services as services furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility that meets certain requirements. These requirements include that the services must be provided under the direction of a physician, pursuant to a certification of need and plan of care developed by an interdisciplinary team of professionals, and must involve “active treatment” designed to achieve the child’s discharge from inpatient status at the earliest possible time.

The Centers for Medicare and Medicaid Services (CMS) has historically prohibited states from claiming expenditures under the inpatient psychiatric facility benefit unless the expenditures were made to qualified providers of such services. This had the effect of denying coverage for other medically necessary Medicaid items and services, such as prescription drugs or practitioner services that were not included by the state as part of the rate paid to the facility for care. These items and services would be available under other benefit categories for individuals who did not reside in an IMD, such as the benefit for Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and states had separate payment methodologies for such items and services.

Recently, several Departmental Appeals Board decisions have clarified that other covered services can be furnished as part of the inpatient psychiatric facility benefit even when payment was made to an individual practitioner or supplier other than the inpatient psychiatric facility itself, when such services are furnished to a child residing in such a facility, authorized under the child’s plan of care, and provided under an arrangement with the facility. In essence, the Departmental Appeals Board indicated that payment for such services does not need to be bundled into a single per diem rate for

the IMD facility, but could be authorized under the approved State plan to be paid directly to the treating practitioner. In light of these decisions, CMS is currently applying this flexibility in the approval of State Plan amendments, and seeks to clarify the ability that states have in covering and paying for a more robust benefit for children receiving the inpatient psychiatric facility benefit.

### **Services Provided under Arrangement**

The inpatient psychiatric facility benefit is defined in part to include a needs assessment and the development of a plan of care specific to meet each child's medical, psychological, social, behavioral and developmental needs. In some cases a psychiatric facility may wish to obtain services reflected in the plan of care under arrangement with qualified non-facility providers. Such services would be components of the inpatient psychiatric facility benefit when included in the child's inpatient psychiatric plan of care and furnished by a qualified provider that has entered into a contract with the inpatient psychiatric facility to furnish the services to its inpatients. To comply with the requirement that services be "provided by" a qualified psychiatric facility, the psychiatric facility must arrange for and oversee the provision of all services, must maintain all medical records of care furnished to the individual, and must ensure that all services are furnished under the direction of a physician. Services being furnished under arrangement do not need to be provided at the psychiatric facility itself if these conditions are met.

### **Payment for Services Provided under Arrangement**

States have a number of options in electing a methodology in their Medicaid State plans to pay for the inpatient psychiatric facility benefit. Traditionally, many states make a direct payment to the facility through either an all-inclusive per diem rate or a base per diem rate with add-on payments. Under this direct payment method, if the facility obtains services under arrangement with outside providers, the facility would be responsible for paying the providers of the arranged services.

An option that may be more flexible, and has been approved in State Plan amendments, is to directly reimburse individual practitioners or suppliers of arranged services using payment methodologies that are applicable when the services are otherwise available under the State plan. States electing this option would pay the same fees to such practitioners or suppliers as would otherwise be applicable when the services are furnished to Medicaid beneficiaries outside the inpatient psychiatric facility benefit. This option would allow states greater ability to capture potential efficiencies, and monitor the quality of care, through the use of existing delivery and billing processes. States electing to make separate payments under this option will need to assure there is no duplication of payment between the inpatient facility rate and the items paid for separately using existing State plan fees. It is important to note that while the state may directly reimburse individual providers, CMS will require expenditures for all services provided to individuals receiving services through the inpatient psychiatric facility benefit to be reported and claimed on the Mental Health Facility Services line item of the CMS 64 form, and not under the line item applicable to the furnished Medicaid service.

We are ready to work with states to provide assistance in implementing this benefit, and we look forward to our continuing collaboration. If you have questions, please contact Ms. Barbara Edwards, Director, Disabled and Elderly Health Programs Group, at 410-786-7089, or at [Barbara.Edwards@cms.hhs.gov](mailto:Barbara.Edwards@cms.hhs.gov).