POLICY AND PROCEDURE

DEPARTMENT: Centene Advanced Behavioral Health Utilization Management	**REFERENCE NUMBER:** CC.BH.UM.12
EFFECTIVE DATE: 6/26/20	**P&P NAME:** Institutions for Mental Disease (IMD) Policy
REVIEWED/REVISED DATE: 6/26/20; 8/18/20; 10/21/20; 9/22/21; 9/27/22	**RETIRED DATE:** N/A
BUSINESS UNIT: Centene Advanced Behavioral Health	**PRODUCT TYPE:** Medicaid, Medicare
REGULATOR MOST RECENT APPROVAL DATE(S):	

SCOPE:
This policy applies to all directors, officers, and employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company"). This policy and procedure applies to all Centene Advanced Behavioral Health (CABH), a Centene company, staff involved in the design, implementation, operations, and management of the CABH Utilization Management (UM) Program services for all lines of business and product types. This policy and procedure applies to consultants, and temporary workers who may receive physician/provider calls, contacts, or complaints whether written or verbal regarding our services or staff.

PURPOSE:
To address BH UM processes for managing the 3 sources of IMD services:
1) In Lieu of Services,
2) 1115 Waiver, and
3) SUPPORT Act.

DEFINITIONS:
IMD: An Institution for Mental Disease (IMD) is 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.

In Lieu of Services or Settings (ILOS): An in lieu of service or setting is an alternative service or setting that the state agency, in accordance with 42 CFR 438.3(e)(2) and any applicable state regulations, determines to be a medically appropriate and cost effective substitute for a covered service or setting under the Medicaid State plan.

POLICY:
CABH has a process in place for UM staff to ensure proper protocol is followed regarding utilization management for IMD stays.

An Institution for Mental Disease (IMD) is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. This applies for members aged 21-64. For those members that fall outside of this age range, the normal UM process of applying Medical Necessity Criteria (MNC) will be followed.

In Lieu of Services (ILOS) allows for 15 days per member per month of non-elderly adult stays in an IMD.

1115 Demonstration Waiver allows states to drawdown federal funds to pay for non-elderly adult stays in IMDs where LOS is variable by state.

The SUPPORT Act allows states to use federal Medicaid funds for nonelderly adults receiving IMD SUD services up to 30 days a year, from October 2019 through September 2023. IMD coverage under the SUPPORT Act option is in addition to IMD services covered under managed care in lieu of authority and Section 1115 waiver.

ILOS and 1115 Waiver benefits cannot be combined; however the SUPPORT Act benefit can be used with either ILOS or 1115 Waiver. Therefore all 3 benefit options cannot be used for the same member.
In Lieu of Services

For members that TOTAL 15 inpatient (IP) days at any/all IMD facilities in a month, an administrative denial MUST be issued for day 16 forward (through the end of the month) unless there is a State Specific Mandate that states otherwise (see State Specific Addendum in Policy CC.BH.UM.08 Behavioral Health Adverse Determination (Denial) Process and Notification).
Ex: If a member admits twice in the same month to IMD "A" for 8 days then admits to IMD "B" for 7 days, that totals 15 days (in the same month), we will then administratively deny the remainder of the days (in IMD facilities only) for the month.

PROCEDURE:
1. UM will receive notification of admission to an IMD and complete the clinical review and apply appropriate MNC.
2. If MNC is not met, the UM will follow the Peer Review process.
3. If MNC is met, the UM will authorize according to the Authorization Review Guidelines and follow the appropriate Escalation Protocol.
4. If there is a request for continued stay past day 15, the UM will issue an admin denial, unless there is a State Specific Mandate (see State Specific Addendum in Policy CC.BH.UM.08 Behavioral Health Adverse Determination (Denial) Process and Notification) and determine the line item as follows.
    - 4.1. Status: select "Denied"
    - 4.2. Medical Necessity: select "Admin denial"
    - 4.3. Variance: select "voluntary" or "court commitment"
    - 4.4. Explanation: select "special instructions to claims"
    - 4.5. Enter claim note: "Admin denial as member has reached 15day/mo. limit at IMD."
    - 4.6. Type of decision: select "Clinical Determination"
5. UM will create a "Discharge Follow Up" task in TruCare and follow up weekly. The UM will document updates in a "General Note" to continue to manage the case.
6. If on the first of the following month and the member remains IP, create a new line item and complete the clinical review and apply MNC as appropriate. If the member meets the 15 day limit again, the UM will need to repeat the steps above.

If the member has discharged, request discharge clinical from the facility, enter the discharge date on the authorization, and change the end date on the line item that was administratively denied to the date of discharge.

1115 Demonstration Waiver
For Health Plans that have opted to participate in their state's 1115 Waiver for IMD services for SUD or Mental Health, CABH manages IMD utilization in line with our inpatient medical necessity guidelines and approval processes (as referenced below), while also remaining compliant with state-specific requirements.

SUPPORT Act
The benefit follows the person and is only for SUD. If member has exhausted this entire benefit through other MCO, we cannot approve and should issue administrative denial. However, under COB if partial benefit is used, new MCO is required to apply medical necessity to remaining benefit.
MCO will first verify member previous utilization within the calendar year through state report.

For members that TOTAL 30 inpatient (IP) days at any/all IMD facilities in a year, an administrative denial MUST be issued for day 31 forward (through the end of the year).

Example: If a member admits twice in the same year to IMD "A" for 15 days then admits to IMD "B" for 15 days, that totals 30 days (in the same year), we would then administratively deny the remainder of the days (in IMD facilities only) for the year.

Procedure:
1. UM will receive notification of admission to an IMD and complete the clinical review and apply appropriate MNC.
2. If MNC is not met, the UM will follow the Peer Review process.
3. If MNC is met, the UM will authorize according to the Authorization Review Guidelines and follow the appropriate Escalation Protocol.
4. If there is a request for continues stay past day 30, the UM will issue an admin denial.
    - 4.1. Status: select "Denied"
    - 4.2. Medical Necessity: select "Admin denial"
    - 4.3. Variance: select "voluntary" or "court commitment"
    - 4.4. Explanation: select "special instructions to claims"
    - 4.5. Enter claim note: "Admin denial as member has reached 30 day/ year limit at IMD."
    - 4.6. Type of decision: select "Clinical Determination"

5. UM will create a “Discharge Follow Up” task in TruCare and follow up weekly. The UM will document updates in a “General Note” to continue to manage the case.
6. If on the first of the following year and the member remains IP, create a new line item and complete the clinical review and apply MNC as appropriate. If the member meets the 30 day limit again, the UM will need to repeat the steps above.
7. If the member has discharged, request discharge clinical from the facility, enter the discharge date on the authorization, and change the end date on the line item that was administratively denied to the date of discharge.

ILOS and SUPPORT Act (SUD only)
The SUPPORT Act benefit will be exhausted first, and once used then the ILOS benefit can be used. Follow processes as above.

Example: Member admits in middle of month, exhausts 30 days under SUPPORT Act, and middle of next month ILOS benefit is activated for up to 15 days; therefore member could theoretically stay in IMD for 45 consecutive days if medical necessity met.

1115 Demonstration Waiver and SUPPORT Act (SUD only)
The SUPPORT Act benefit will be exhausted first, and once used then 1115 Waiver benefit can be activated. Follow processes as above.

REPORTING PROCEDURES:
See state-specific reporting requirements in Addendums A-M.

REFERENCES:
CC.BH.UM.02 Clinical Decision Criteria and Application for Behavioral Health
CC.BH.UM.07 Utilization Management Timeliness and Notification Standards
CC.BH.UM.08 Behavioral Health Adverse Determination (Denial) Process and Notification
CC.BH.UM.13 Behavioral Health Utilization Review
CC.BH.UM.28 Behavioral Health Covered Benefits and Services

ATTACHMENTS:
Addendum A- Arkansas Total Care
Addendum B- Iowa Total Care
Addendum C- MHS Indiana
Addendum D- Oregon Trillium Community Health Plan
Addendum E- Missouri Home State Health
Addendum F- Mississippi Magnolia Health Plan
Addendum G- Nebraska Total Care, NHA Expansion
Addendum H- New Hampshire Healthy Families
Addendum I- Nevada SilverSummit HealthPlan
Addendum J- Ohio Buckeye Health Plan
Addendum K- South Carolina Absolute Total Care
Addendum L- MHS Health Wisconsin
Addendum M- North Carolina, Carolina Complete Health

SUPPORT/HELP:
Resources available to support users of the P&P. Phone numbers, training programs, classes, and/or offices available to help with carrying out the procedure/work process.

EXAMPLE:

If you need help with:	Contact: CABH Utilization Management
Questions about ….	
Questions about ….	

REGULATORY REPORTING REQUIREMENTS:
Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED

New Policy Document	New Policy	6/26/20
Ad Hoc Review	Created the following Unique Requirement Attachments: Attachment A - Arkansas - Arkansas Total Care Unique Requirements; Attachment B - Iowa - Iowa Total Care Unique Requirements; Attachment C - Indiana - MHS - Indiana Unique Requirements; Attachment D - Medicare Unique Requirements; Attachment E - Missouri - Home State Health Plan Unique Requirements; Attachment F - Mississippi - Magnolia Health Unique Requirements; Attachment G - Nebraska - Nebraska Total Care, NHA Expansion Unique Requirements; Attachment H - New Hampshire - New Hampshire Healthy Families Unique Requirements; Attachment I - Nevada - SilverSummit Healthplan Unique Requirements; Attachment J - Ohio - Buckeye Health Plan Unique Requirements; Attachment K - New Hampshire - New Hampshire Healthy Families Unique Requirements; Attachment L - South Carolina - Absolute Total Care Unique Requirements; and Attachment M - Oregon - Trillium Community Health Plan. Consolidated NHHF state specific policy content from CC.BH.UM.29.01 Payment to Institutions for Mental Diseases (IMD) – New Hampshire into CBH Standard Operating Procedure CC.BH.UM.12 Institutions for Mental Diseases (IMD), Attachment H to include the content of CC.BH.UM.29.01 Payment to Institutions for Mental Diseases (IMD). Retired CC.BH.UM.29.01 Payment to Institutions for Mental Diseases (IMD) on 5/1/2020.	6/26/20
Ad Hoc Review	Attachment B - Iowa Total Care Unique Requirements updated to include Third Amendment to the MED-20-001 Contract, effective as of July 1, 2020, between the Iowa Department of Human Services (Agency) and Iowa Total Care, Inc. (Contractor).	8/18/20
Ad Hoc Review	Updated formatting of Attachment B - Iowa Total Care Unique Requirements.	10/21/20
Annual Review	Addendum C MHS- Indiana: Added “IHCP BT201637, IHCP BT202003” to References in Section One. Addendum D (Medicare) has been removed due to Medicare not having IMD exceptions. Addendum E (Missouri - Home State Health Plan) Added the “provider notice for administrative denials” letter Addendum H (New Hampshire Health Families) Replaced “CBH” with “CABH”. Added “NH Contract 4.1.3.6 Institution for Mental Diseases (IMD), Medicaid IMD Exclusion” to references of Section One Addendum I (Silver Summit) Updated Addendum to new template format. Replaced “CBH” with “CABH” Addendum J (Ohio Buckeye Health Plan) Added reference information “Ohio Medicaid Managed Care Provider Agreement Appendix G: Coverage and Services – Exclusions” to Section One Addendum K (South Carolina Absolute Total Care) Added “South Carolina Health Planning Committee Department of Health & Environmental Control Certificate of Need Program” to Health Plan Referenced Requirement section. Addendum M (Oregon Trillium Community Health Plan) has been relabeled to Addendum D	9/22/21
Ad Hoc Review	Addendum M (North Carolina Medicaid) created to address Carolina Complete Health ILOS responsibilities based on NC.UM.01.10 In Lieu of Services (ILOS).	6/28/22

Annual Review	Policy reviewed by subject matter experts and Compliance Department. No edits made. Addendums A-M reviewed by Compliance team and the health plan Subject Matter Experts. Addendums B (Iowa), C (Indiana), D (Oregon), J (Ohio) and M (North Carolina) had no revisions. Addendum revisions as follows: • Addendum A (Arkansas) – Added "Internal Process" under "Health Plan Referenced Requirement". • Addendum E (Missouri) - Removed "The only IMDs in MO are state-owned; therefore, CABH would not review, thus the 15-day administrative denial would not apply" based on RFP Amendments 15 (RFPS30034901600685) and 16 (RFPS30034901600685). Updated the Provider Notice Administrative Denial with current template. • Addendum F (Mississippi) - Removed "MS does not allow members older than 21 years of age to seek treatment from IMD type facilities." Added IMD eligibility criteria based on the Mississippi Division of Medicaid Administrative Code Title 23: Medicaid, Part 100, General Provision. Added IMD SUD information based on Amendment 9 (Contract between Division of Medicaid and Care Coordination Organization-Magnolia Health Plan, Inc). • Addendum G (Nebraska) - Added IMD SUD information based on Nebraska's Section 1115 Medicaid Substance Use Disorder Services Waiver. • Addendum H (New Hampshire) - Removed requirement NH Contract 4.1.3.6 Institution for Mental Diseases (IMD), Medicaid IMD Exclusion: "New Hampshire Hospital (NHH) is a state facility and administratively denied upon admission for IMD population." and "Hampstead hospital and Brattelboro Retreat are per-diem IMD facilities." as this is no longer applicable. Removed requirement "NH Contract 4.1.3.6 Institution for Mental Diseases (IMD), Medicaid IMD Exclusion" as it conflicts with the newly added requirements "NH Department of Health and Human Services – Medicaid Care Management Program – Reference Number 22-0003 (Mental Health IMD Services Billing) Section 2", "Amendment # 8 of the NH Medicaid Contract, Exhibit A, Section 4.1.2. Overview of Covered Services, Footnote # 11" and "Amendment # 8 of the NH Medicaid Contract, Exhibit A - Section 4.8.1.6.18." • Addendum I (Nevada) - Added language to clarify that CABH does manage cases/determinations from a UM perspective and that SBH is the payor. Language also updated to clarify exceptions to what SBH will pay for and oversee. • Addendum K (South Carolina) - Removed "Currently working on draft SC IMD policy". • Addendum L (Wisconsin) - Added "BadgerCare Plus and SSI Medicaid follow the general policy (CC.BH.UM.12)" based on the Wisconsin Contract for BadgerCare Plus and/or Medicaid SSI, Article IV (B) 9. Institutionalized Individuals.	9/27/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.