**Appendix B:**

**Medicaid Funding Authorities: States and Institutional Care**

While the new HCBS Settings rule limits reimbursement for services within the Home and Community Based Services waiver and other HCBS funding authorities, other funding authorities exist to pay for institutional or congregate care models. We have included the attached appendix to inform state policymakers and advocates on the three primary institutional funding authorities available to states that choose to finance institutional care. This does not constitute an endorsement of these models by the National Council on Disability, but is instead intended as an informational document on the availability of various financing streams.

1. Intermediate Care Facility Funding Authority:
   1. Eligibility:
      1. Immediate Care Facilities for individuals with Intellectual disability (ICF/ID) is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. Although it is an optional benefit, all states offer it, if only as an alternative to home and community-based services waivers for individuals at the ICF/ID level of care.
      2. Available now only for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. AT does not include services to maintain generally independent clients who are able to function with little supervision and who do not require a continuous program of habilitation services.
      3. States may not limit access to ICF/ID service, or make it subject to waiting list, as they may for HCBS. Benefits are mandatory.
      4. Need for ICF is defined by the state.
         1. Each state establishes a level of care criteria. Said criteria must meet the coverage criteria defined by federal law and regulation.
         2. The need for active treatment must arise from an intellectual disability or a related condition.
         3. The condition must have manifested before the age of 22 and be likely to continue indefinitely.
   2. Services included:
      1. Active treatment-continuous, aggressive, and consistent implementation of a program of specialized and generic training, treatment, and health or related services, directed toward helping the enrollee function with as much self-determination and independence as possible.
      2. Federal rules provide for a wide scope of required services and facility requirements for administering services.
      3. All services include Healthcare Services and nutrition.
      4. Daycare programs are available
      5. Services are provided only in a residential facility
2. Skilled Nursing Facility Funding Authority-
   1. Eligibility:
      1. Only for services provided in a nursing home licensed and certified by the state.
      2. Agency is a Medicaid nursing facility.
      3. All other payment options must be exhausted prior to eligibility.
      4. Medicaid requires coverage to anyone 21 or older in need of said service.
      5. States may not limit access to the service or make it subject to waiting lists, as they may for HCBS.
         1. Benefits are mandatory.
      6. Need for skilled nursing facility is defined by each individual state.
      7. These requirements must provide access to individuals who meet the coverage criteria defined in federal law and regulation.
   2. Services provided:
      1. Must provide, or arrange for, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
      2. There is no exhaustive list of services that a NF must provide, in that unique resident needs may require particular care or services in order to reach the highest practicable level of well-being. The services needed to attain this level of well-being are established an individual’s plan of care.
      3. Screening and resident review.
      4. Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.
3. Institution for Mental Diseases
   * 1. IMD benefits are optional. However, inpatient psychiatric services for individuals under age 21 must be provided in any State as early and periodic screening, diagnosis and treatment services if they are determined to be medically necessary.
     2. IMD exclusion-not available for any medical assistance under title 19 for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21.
     3. IMD defined as an institution for mental diseases of 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. Considered an IMD if the overall character of the facility established and maintained primarily for the care and treatment of individuals with mental diseases.
     4. "IMD over 65". It is an option that most states have chosen to offer in their Medicaid program. Services may be provided either in a hospital or in a nursing facility that is considered an institution for mental diseases (IMD), meaning that the facility meets the federal and state requirements of a hospital or nursing facility, but is also considered an IMD.
     5. Ordinarily states are responsible for the costs of IMDs; the federal Medicaid program specifically excludes reimbursement for residents of an IMD. The two exceptions are individuals over age 65 who receive this service, and younger individuals who receive the[psych under 21 service](http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/inpatient-psychiatric-services-for-individuals-under-age-21.html). Individuals in either type of IMD who are between the ages of 22 and 64 may not receive Medicaid reimbursement