Report to the Legislature

Transition Plan for Remaining Intensive Inpatient Beds
3ESHB 2127, Section 208(5)

December 1, 2012

Aging and Disability Services Administration
Division of Behavioral Health and Recovery
PO Box 45330
Olympia, WA 98504-5330
(360) 725-3700
Fax: (360) 725-2280

Table of Contents

Legislative Requirement

Chapter 7, Laws of 2012
Making 2011-2013 fiscal biennium supplemental operating appropriations
3ESHB 2127, Section 208(5)

> "Within amounts appropriated in this section, the department is required to increase federal match available for intensive inpatient services. During fiscal year 2013, the department shall shift contracts for a minimum of 32 intensive inpatient beds currently provided in settings that are considered institutions for mental diseases to two or more facilities with no more than 16 beds that are able to claim federal match for services provided to medicaid clients or individuals covered under the department's section 1115 medicaid waiver. The department is authorized to conduct a request for proposal process to fulfill this requirement. By December 1, 2012, the department shall provide a plan to the office of financial management and to the relevant fiscal and policy committees of the legislature for transitioning all remaining intensive inpatient beds currently provided in settings that are considered institutions for mental diseases into facilities with no more than 16 beds by June 2017. The plan shall identify the maximum number of additional beds that can be transitioned into facilities with no more than 16 beds during the 2013-2015 fiscal biennium and the remaining number that will be transitioned during the 2015-2017 fiscal biennium, a timeline and process for accomplishing this, and a projection of the related general fund—state savings for each biennium."

Executive Summary

An Institution for Mental Disease (IMD) is a facility with more than 16 beds that primarily treats people who have psychiatric or chemical dependency disorders. Federal Financial Participation is not available for any medical assistance under Title XIX for services provided to an individual who is a patient in an IMD. This federal regulation is commonly referred to as 'the IMD exclusion'. This means that by Federal regulation, no Medicaid funds may be used for services provided to individuals who are between the ages of 21-65 who reside in an IMD. All of the adult chemical dependency residential treatment programs in Washington State are contracted and licensed for seventeen beds or more and are considered IMDs.

The supplemental operating budget from the 2012 legislative session, 3ESHB 2127, Section 208(5), directs the Department of Social and Health Services (DSHS) to shift contracts for a minimum of 32 intensive (chemical dependency) inpatient beds currently provided in settings that are considered IMDs into two or more facilities with no more than 16 beds. By providing services in non-IMDs, the Department is expected to increase federal match available for intensive inpatient services.

On June 1, 2012 the Department initiated the process of developing two non-IMD pilot facilities through a Request for Information (RFI). Sites were chosen and services began in October, 2012.

The supplemental operating budget also directed the Department to submit a plan to the office of financial management and to the relevant fiscal and policy committees of the legislature for transitioning all remaining intensive inpatient beds into facilities with no more than 16 beds by June 2017. Because the plan is due December 1, 2012 and the pilots started in October, 2012, no data regarding the pilot sites are available for the plan.

An addendum to this report will be completed when the pilot sites have been serving clients for at least six months. An anticipated report addendum date is December 1, 2013.

Background

Institutions for Mental Disease:

Institutions for Mental Disease (IMD) are defined in the Federal Social Security Act 1905(i) and in the Code of Federal Regulations (CFR Title 42 Part 435.1010) 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." Whether an institution is an institution for mental diseases is determined by its overall character as a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. The term "mental disease" includes alcoholism and chemical dependency per the *International Classification of Diseases, 9th Revision, Clinical Modification* (*ICD-9-CM*) system classification.

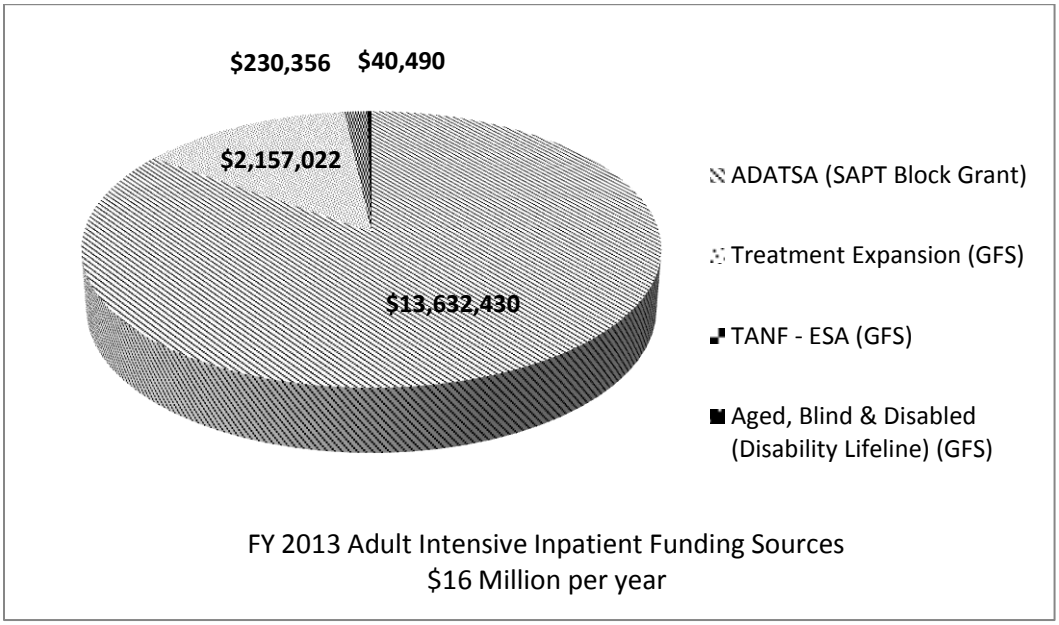
Federal Financial Participation is not available for any medical assistance under Title XIX for services provided to any individual who is a patient in an IMD. This means that by Federal regulation, no Medicaid funds may be used for services provided to individuals who are between the ages of 21-65 who reside in an IMD. All of Washington's intensive chemical dependency inpatient facilities are contracted and licensed for seventeen beds or more and are considered IMDs.

Adult Residential Funding:

Prior to fiscal year 2006, the adult residential treatment system was primarily funded with the Substance Abuse Prevention and Treatment (SAPT) federal block grant for Alcohol and Drug Addiction Treatment and Support Act (ADATSA) clients. There were limited state funds from Economic Services Administration (ESA) to specifically serve Temporary Assistance to Needs Families (TANF) clients in residential treatment. Some Involuntary Treatment Act (ITA) beds have historically been funded with state grant in-aid (GIA).

In 2006, the Legislature increased state funding for outpatient and residential treatment services, referred to as "treatment expansion." The new state funds were primarily used to provide residential treatment services to those clients eligible for Medicaid beginning in fiscal year 2006. Due to the IMD Exclusion rule, there has not been the ability to obtain federal match for any adult residential treatment provided to Medicaid recipients.

The funding breakout in fiscal year 2013 for adult intensive inpatient (IIP), prior to the non-IMD pilots beginning and after the reduction taken by the Legislature is:



FY 2013 Adult Intensive Inpatient Funding Sources
$16 Million per year

SAPT block grant funds can be used to serve any patient that is ADATSA or Medicaid eligible. TANF, treatment expansion, and Aged, Blind & Disabled (Disability Lifeline) funds are used for those populations first. If the dollars are not sufficient to meet their needs, the SAPT block grant funds are used to pay for these Medicaid clients. The SAPT block grant cannot be used to match Medicaid, as it is also a federal funding source.

Prior to the non-IMD pilots beginning, there were 453 adult intensive inpatient beds in 17 IMD facilities. In order to maintain the same amount of beds in non-IMD facilities, there will need to be a minimum of 29 facilities. There is a precedent for non-IMD residential facilities in Washington State. Within the pregnant and parenting women and youth treatment system, there are a number of non-IMD facilities that claim Medicaid match.

Transitioning All Remaining Intensive Inpatient Beds by June 2017

The language in 3ESHB 2127 instructs the Department to plan for a transition of the remaining beds in the adult system to non-IMDs. If there was a decision to move forward with this transition, the Department would us a Request for Proposal process. However, there are significant risks associated with this strategy; chiefly, a system wide loss of infrastructure and capacity and the unknown impact of Medicaid expansion.

Risks to Infrastructure

There are challenges to converting large capacity buildings to separate 16 bed facilities. Individual programs within a facility can be exempted from the IMD exclusion only if there is clear separation in ownership or administration, cost centers, physical location, clinical staffing, certification or licensure and levels of care (see *Guidelines for Determining IMD Status* attached to this report). Building new smaller facilities would take long term capital investment and could easily take two or more years to address zoning, licensing and staffing issues. The loss of economy of scale would drive higher rates to make programs financially viable.

There is also a potential loss of long standing residential staff and program experience. Given economy of scale concerns, it is very likely programs will close without a significant rate increase (currently $90.18 per day) if asked to move to facilities with 16 beds or less. The Non-IMD pilots are receiving a higher rate - $126.45 versus $90.18. The sustainability of the programs at this higher rate is yet to be determined.

There are currently 17 providers providing 453 beds statewide. In order to have the same number of beds, 29 facilities will be needed. As stated before, it is potentially not feasible that the entire adult residential intensive inpatient system could be shifted to non-IMD facilities.

Unknown Impact of Medicaid Expansion

The Affordable Care Act potentially brings a large expansion in the number of Medicaid eligibles for states that choose to participate. States (including Washington) will rely on estimates for the number of new eligibles and the impact on specific service categories such as chemical dependency. States will also be working with the Centers for Medicare and Medicaid Services (CMS) to determine allowable benefit packages. Any decisions related to numbers and benefits will affect the program and fiscal impact of moving the chemical dependency residential facilities to a small facility model.

Further, it is unknown what (if any) impact Medicaid expansion will have on federal SAPT block grant funds. The federal budget could direct more of these funds to prevention activities or funds could be reduced based on

the availability of Medicaid coverage. Any changes to block grant funding will affect programs and savings related to non-IMD treatment.

Recommendation for Development of Non-IMD Facilities

An alternative to transitioning all current beds would be for the Department to continue using SAPT to pay for current large facility beds and only contract with non-IMD facilities for any future Medicaid service expansion. If Washington participates in Medicaid expansion, this plan would allow the state to capture enhanced Medicaid match for the expansion population. A RFP would be used to select providers. The RFP would be distributed broadly to current residential providers, as well as other entities that may have interest in providing this service in Washington State.

The Department will gather information and data from the non-IMD pilot sites to determine the most appropriate rate and staffing patterns for a non-IMD facility. This information will be considered when writing an RFP for expansion of services.

Timeline and Process

FY2013 - Request for Information (RFI) – Non-IMD Pilots (completed)

June 1, 2012	Send out RFI to Adult Intensive Inpatient (IIP) Providers
June 29, 2012	RFI due from Adult IIP Providers
July 17, 2012	Review/Score of RFI by Division of Behavioral Health and Recovery (DBHR) Staff
July 24, 2012	Announce Pilot Sites for Adult IIP Non-IMD
September 14, 2012	Contract (or Amendments) Executed
October 1, 2012	Adult IIP Non-IMD Pilots Begin

FY 2014
Request for Proposal (RFP) – Medicaid Expansion Adult Non-IMD IIP (if applicable)

July 1, 2013	Continue Adult IIP Non-IMD Pilots – issue one year contracts
July 1, 2013	Issue one year contracts to all other Adult IIP providers
August 1, 2013 – October 30, 2013	Adult Non-IMD IIP RFP Development
October 30, 2013	RFP Release
October 30, 2013 – December 31, 2013	Bidder Question and Answer Period
December 31, 2013	RFP Response Due
January 4, 2014 – January 29, 2014	Proposal Evaluation Period
February 1, 2014 – February 29, 2014	DBHR Contracts with Successful Bidders; Debriefs; Protests
May 25, 2014	Contracts Sent to Providers
July 1, 2014	Contracts Executed and Services Begin

FY 2015

July 1, 2014 – June 30, 2015	Contract Adult IIP treatment in non-IMDs based on RFP conducted in FY 2014

Projections of the Related Savings for Each Fiscal Year
For the Two non-IMD Pilot Sites

Biennium	Projected Substance Abuse Prevention and Treatment (SAPT) Savings
Fiscal Year 2013	$92,405
2013-15 Biennium	$247,090
Fiscal Year 2016	$123,545
Fiscal Year 2017	$123,545

Fiscal Year 2013:

The fiscal year 2013 Substance Abuse Treatment and Prevention (SAPT) block grant savings are associated with opening two non-IMD pilot sites, starting October 1, 2012. General Fund-State savings are not included because the majority of the adult intensive inpatient residential budget is funded with the SAPT Block Grant.

2013-15 Biennium:

The 2013-15 biennial SAPT Block Grant savings are calculated assuming the two non-IMD pilot sites will be fully operational in the 2013-15 Biennium. The savings across fiscal years are not cumulative.

Fiscal Year 2016:

The fiscal year 2016 SAPT Block Grant savings are associated with a full year of savings for the two ongoing non-IMD pilot sites that started in October 2012. The savings across fiscal years are not cumulative.

Fiscal Year 2017:

DBHR assumes SAPT Block Grant savings related to the two non-IMD pilot sites that started in October 2012.

Non-IMD Pilot Provider Progress

July 2012

American Behavioral Health Services (ABHS) was chosen as the provider for the Non-IMD Pilots. Services will be provided at two sites, one in Chehalis and one in Spokane. The original rate proposed by the provider was $160.00 per day. DBHR negotiated with the provider for a rate of $126.45 per day. ABHS noted this rate does not cover the expense of providing the services in a 16 bed facility, and that they are subsidizing this rate with revenues earned from other contracts. ABHS began working with the Department of Health (DOH) regarding any construction review issues in their facilities.

August 2012

ABHS continued to work with DOH on facility licensing. DBHR began developing contracts to be sent to ABHS by September 2012. DBHR included the Health Care Authority (HCA) in the planning process for Medicaid and ProviderOne billing issues. If billing codes cannot be set up in time to bill through ProviderOne, DBHR has a backup plan to bill through the residential billing system.

ABHS obtained DOH approval for facilities and began developing an application for treatment services. ABHS is on schedule and plan to be open October 1, 2012 with patients in the facilities. Craig Phillips, ABHS Executive Director, stated that if he did not have buildings that he was able to use, he would never have been able to start up the programs at the reimbursement rate offered, or in the timeframe allotted.

September 2012

Contracts signed and executed by DBHR.

Responses from Stakeholders

During the RFI process and throughout the pilot program development, DBHR received many expressions of concern from chemical dependency providers. Most were concerned about the viability of a business plan that is based on 16 bed facilities. They pointed out the loss of economy of scale and the costs associated with converting existing buildings to small facilities. Their concerns were summarized in a letter to the Department from Beth Dannhardt, Executive Director of Triumph Treatment Services. That letter is attached to this report.

Provider Letter of Concern

Triumph
TREATMENT SERVICES
Individual and Family Help for Alcoholism and Chemical Dependency

Administrative Office/ Outpatient Clinic: Community Drug & Alcohol Center
102 S Naches Avenue
P.O. Box 2849
Yakima, WA 98907
509.248.1800
509.576.3076 (fax)
cdac@triumphtx.org

Men's Inpatient:
James Oldham Treatment Center
P.O. Box 354
Buena, WA 98921
509.865.6705
509.865.5011 (fax)
jotc@triumphtx.org

Triumph Treatment Services
Center for Excellence
Long-term Residential Treatment for Pregnant & Parenting Women & Their Children:

Riel House
613 Superior Lane
Yakima, WA 98902
509.575.4810
509.576.3060 (fax)
rh@triumphtx.org

Casita
605 Superior Lane
Yakima, WA 98902
509.853.4173
509.248.4790 (fax)
casita@triumphtx.org

Beth's Place
608 Superior Lane
Yakima, WA 98902
509.853.4175
509.576.3050 (fax)
bp@triumphtx.org

Cottage Kids
Therapeutic Child Care
604 Superior Lane
Yakima, WA 98902
509.853.4167
509.853.0766 (fax)

Housing Programs
102 S Naches Avenue
P.O. Box 2849
Yakima, WA 98907
509.248.1800
509.576.3076 (fax)
housing@triumphtx.org

Kids Inc.
Child Care Center
3300 Roosevelt Avenue
Yakima, WA 98902
509.457.KIDS (5437)
509.575.2425 (fax)
www.kidsinc.me

June 28, 2012

Sue Green
Behavioral Health Treatment Services Lead
Division of Behavioral Health and Recovery
Post Office Box 45330
Olympia, WA 98504-5330

Dear Sue,

The following is in response to the RFI regarding the pilot projects for non-IMD required of DBHR as a result of the 2012 budget.

I am not responding to the RFI as an agency of interest. Rather, I am responding as not willing to request to be a pilot site. I am attaching a document that outlines the reasons why I and others think this is not a good investment for the state of Washington. I also realize there are many underlying issues involved—many of which I am not privy. I understand some of the politics.

Never the less, I am hoping that this response will be one of many which DBHR can use to go back to the legislature and point out issues. This proposal would impact the viability of the residential CD programs of the state and thus the availability for needy individuals being able to access treatment.

We continue to hear how budget cuts to CD treatment have impacted all services and have cost the state increasingly redundant dollars. That is-- systems are accessed by these individuals in the wrong place at the wrong time and they simply revolve through the door again and again without receiving needed CD treatment.

Should you have any questions or want to discuss this further, do not hesitate to contact me.

Sincerely,

Beth Dannhardt
Executive Director

Attachment

cc: Chris Imhoff
John Taylor

Provider Letter of Concern – Attachment

Non-IMD Projects

DBHR is seeking two pilot sites to provide IIP treatment in a facility with 16 beds or less beginning Oct. 1, 2012. The goal is that these facilities would be able to claim Medicaid match for services provided to Medicaid eligible clients. And then by December 1, 2012, DBHR will provide a plan to OFM and the legislature to transition all remaining IIP beds currently provided in facilities larger than 16 beds to settings that have no more than 16 beds by June 2017. The goal is a projection of the related general fund state savings for each biennium.

Who are we? We are the providers of CD residential treatment.

The first and biggest point we would like to make is that we provide treatment for the individuals we see because we have a passion for them and are lifted up by their successes. People who depend upon the "safety net" have become dehumanized by society in general. That is not our experience. They are real, have hopes and joys and dreams just like the rest of us. But they have become damaged by their life experience and we work to help them overcome that damage.

What are the issues associated with this short sighted plan?

The only buildings that have only 16 treatment beds funded by DBHR are for PPW and are able to capture the federal match. However, they receive a higher rate. Nevertheless, over the years, although these programs were initially somewhat profitable, they now barely break even. 16 beds means they must be at 16 at all times and this is impossible given discharges and the time in between to fill the bed again even if the empty bed is anticipated. Often there are glitches—given the population.

There is an economy of scale in providing treatment funded through DBHR. The larger the number of beds, the more likely the program is to cover the costs associated with providing treatment, care, housing and meals, and supervision @$90.18 per day. There is constant upkeep of the building and furnishings. I once heard someone at a non-profit conference describe non-profits as being on the verge of bankruptcy all the time.

The ultimate effect of reducing all programs to 16 would be closure of programs. These programs would not reopen. The capital outlay to have a new building pass all of the regulations from DOH construction review and licensing—not to mention local codes is terribly expensive, and time consuming. It is prohibitive. The programs that are now operating have gone through this process, often to the detriment of their agency. They would not do this again. So this boils down to the capital outlay. We are talking up to a million dollars, depending upon the building. It is not fiscally feasible to reduce all buildings that now do programming to only 16 beds. There is an agency in Yakima that is building a new 16 bed facility for acutely mentally ill patients. They estimate the cost of approximately 4 million dollars.

If all programs in theory would reduce to 16 beds, there would be a marked reduction in the number of treatment beds available to the indigent population. This is counter-intuitive to the need anticipated to serve Medicaid patients in 2014. CD will be a required service to be offered. Additionally, with the decrease in beds, the savings from the folks we will no longer be treating will start to show up immediately in the CJ system and Emergency Rooms.

The patients served in IIP treatment programs funded by DBHR are disenfranchised. Most of these folks started using drugs and alcohol at a very young age, often in families that also used. We cannot compare them to the typical patient who has treatment paid for by private insurance or family. The deficits our folks have to overcome are tremendous and without the wraparound support of our agencies and other agencies in the community, they would not be successful. But they are. We have state-wide data that proves their success and the savings to other funds—such as the criminal justice system and medical care-specifically EDs and hospital admissions. Take away one leg of the stool and it falls over!

Solution:

Petition the Federal Government/Medicaid for a waiver so the state of WA can collect a match for the beds we now have in our CD treatment system. The IMD exclusion was put into place by the Medicaid system specifically to keep states from charging Medicaid for state run large mental hospitals. Our programs are not "considered institutions for mental diseases" as referenced in the bill from this legislative session and we are not able to charge for mental health services.

It is hard to understand how CD residential treatment programs came to be under the heading of IMD in the first place. We are not and never were intended to be. We are certainly not the size of large state mental health hospitals.

The interim solution would be to leave the system as it is. CD treatment is a very small portion of the DSHS budget and it hardly seems right to try to balance the budget on the backs of providers who are very dedicated, poor and working hard to help disenfranchised folks become contributing members of society, through raising functional, happy families and paying taxes and in short being positive members of the community.

Residential treatment is a good deal for the state of Washington!

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Disability Services Administration
Division of Behavioral Health and Recovery
PO Box 45330, Olympia, WA 98504-5330

Guidelines for Determining IMD Status

There is a federal statutory restriction that states Federal Financial Participation is not available for any medical assistance under Title XIX for services provided to any individual who is a patient in an Institution for Mental Diseases (IMD). This means that by Federal regulation, no Medicaid funds may be used for services provided to individuals who are between the ages of 21-65 who reside in an IMD. Federal regulation also states that Medicaid funding be used to pay for Medicaid recipients and Medicaid services exclusively. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. The term "mental disease" includes alcoholism and chemical dependency.

What is an IMD?

An IMD is defined in the Federal Social Security Act 1905(i) and in the Code of Federal Regulations (CFR Title 42 Part 435.1010) 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. 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, whether or not it is licensed as such."

As IMDs are defined to be institutions with more than 16 beds where more than 50 percent of the residents are treated for a psychiatric diagnosis, the IMD exclusion applies only to institutions with at least 17 beds. Facilities with more than 16 beds whose primary purpose is to provide residential treatment for alcohol and substance abuse are considered IMDs.

In cases in which multiple components within a common facility are involved, the individual programs may be identified as separate programs and considered independent from each other to determine the IMD status of the programs. Use the following guidelines to determine the IMD status of these individual programs within a common facility.

Individual programs within a facility can be exempted from the IMD exclusion if they are clearly separate in:

1. Ownership or administration, and
2. Cost centers, and
3. Physical location, and

4. Clinical staffing, and
5. Certification or licensure, and
6. Levels of care.

How Do I Determine if My Agency is Exempt from the IMD Exclusion?

In order to determine that your agency is not an IMD and therefore excluded from accessing Medicaid funding, does your facility have 16 or less beds?

☐ Yes ☐ No

Note: If yes, your agency is not considered an IMD and you are eligible for Medicaid funding.

If your agency has multiple components within a common facility, all of the following criteria must be met to avoid classification as an IMD:

☐ Ownership or administration: A single administrator over Program Managers as evidenced by on Organizational Charts with distinct clinical staff to support individual program units.

☐ Clinical staffing: Organizational Charts indicate separate clinical staff for individual program.

☐ Physical location: Floor plans demonstrate separate floors or wings dedicated to distinct programs; reviewed activity schedule of the facility's common area such as the Education/Dining Building with the Admin Director; and, floor plans provided in the Program Manual.

Note: Programs must be clearly separated by floors, wings, or other building sections to be considered separately located. Intermixed program beds on the same floor, or program beds separated only by groupings of dormitory rooms will not be considered physically separate. Likewise, programs that share common treatment, recreation, or sleeping areas – even if otherwise separate – do not fully satisfy the physical location criteria.

☐ Cost centers: Programs managed as separate fiscal programs as evidenced by separate accounting oversight and file management.

☐ Separate certification or licensure for each program.

☐ Levels of care: Program descriptions provide for level of care in III.5 or III.5 Enhanced, length of stay, and gender specific programming for trauma and victimization.

Note: Significantly different levels of care must be provided. Program distinction based on gender or race specialty is generally not recognized. Different level of care criteria can be applied to programs located in the same facility that specializes in adolescent vs. adult residential

rehabilitation or detoxification given the need for significantly different clinical approaches to these special populations.

42 CFR 435.1008 and 1010, and the State Medicaid Manual, Part 4, Section 4390