Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Reimbursement: hospitals serving Medicaid clients in long term inpatient beds

Revised rate methodology for 90- and 180-day civil commitment beds

Engrossed Substitute Senate Bill 6168; Section 215(24)(e); Chapter 357; Laws of 2020

December 1, 2020

Reimbursement: hospitals serving Medicaid clients in long term inpatient beds

Washington State Health Care Authority

Division of Behavioral Health and Recovery
PO BOX 42730
Olympia, WA 98504-2730
hca.wa.gov

Table of contents

Executive summary

Access to the full array of mental health treatment options remain a challenge for many individuals experiencing mental illness. With the continued transition of civil commitment patients from Western State Hospital into community settings and the ongoing impact of COVID-19, the placement of long-term civil commitment patients remains challenging.

Washington State continues to face a shortage of long-term psychiatric beds for individuals who are civilly committed.

> "As commitment laws and policies have evolved, public behavioral health care systems face new challenges in delivering mental health services under fiscally constrained circumstances. The locus of continuing care and treatment of adults with serious mental illnesses has shifted almost entirely away from state mental hospitals. Behavioral health financing trends—notably privatization and managed care—have transformed public mental health systems, leading to the devolution of longstanding organizational structures and authorities in many jurisdictions, and redefining the notion of accountability for the care of persons with disabling mental illnesses. An apparent shortage of psychiatric beds in many areas has created a situation in which involuntary commitment may be seen as a virtual entitlement—a way to prioritize intensive mental health services for individuals who would have difficulty accessing these services otherwise. Constraints on access greatly influence involuntary commitment practice and policy."[i]

ESSB 6168 (2020), section 215(24) directs HCA to collaborate with the Washington State Hospital Association to refine the rate methodology on 90- and 180-day civil commitment orders that was initially described in the legislative report "Rate Methodology for 90- and 180- Day Civil Commitment Beds [1109 ESHB/ C 415 L19 PV Section 215(24)]". Specifically:

> *(e) The authority in collaboration with the Washington state hospital association must convene a work group to further refine the methodology for reimbursing community hospitals serving these clients. The authority must provide a report to the appropriate committees of the legislature by December 1, 2020. The report must include options for incorporating additional factors into future rate adjustments and identify where there may be overlap within the different options. The report must include the following areas and provide a description of the option and the methodology and implementation costs associated with each option:*
>
> *(i) Acuity adjustments for providers serving individuals with higher levels of behavioral health or physical health care needs;*
>
> *(ii) Retroactive reconciliation adjustments for providers whose total costs for serving clients under this subsection are higher or lower than payments received by the authority and any additional payers.*

This report builds on work done during the summer of 2019. The initial workgroup outlined a methodology for reimbursing community hospitals offering long-term psychiatric inpatient services. The 2020 supplemental budget adopts portions of the 2019 report for fiscal year 2021, and reconvenes the workgroup to address the need for an acuity adjustment and retroactive reconciliation.

Members recommended establishing a sustainable rate methodology for residential evaluation and treatment centers providing 90- to 180- day civil commitments.

Definitions

Acute care hospital: Acute care is a level of health care in which a patient is treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery.[ii] Washington State defines acute care hospitals as those licensed under chapter 70.41 RCW.

Community hospital: Community hospitals are defined as all nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; long-term acute care; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal, short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.[iii] This report uses the term community hospitals to collectively refer to both acute care hospitals as defined under chapter 70.41 RCW and freestanding psychiatric hospitals as defined under chapter 71.12 RCW.

Evaluation and treatment facility (E&T): Evaluation and treatment facility means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to people suffering from a mental disorder, and which is licensed or certified as such by the department. HCA may certify single beds as temporary evaluation and treatment beds under RCW 71.05.745. A physically separate and separately operated portion of a state hospital or an acute care hospital may be designated as an E&T facility. A facility which is part of, or operated by, the Department of Social and Health Services (DSHS) or any federal agency will not require certification. No correctional institution or facility, or jail, shall be an evaluation and treatment facility within the meaning of this chapter.[iv]

Freestanding psychiatric hospital: a specialized psychiatric hospital that is licensed under chapter 71.12 RCW.

Freestanding evaluation and treatment center (residential evaluation and treatment center): A residential evaluation and treatment center may be referred to as RTF throughout this report as they are licensed and certified by the Washington State Department of Health (DOH) as residential treatment facilities (RTF). Treatment in a freestanding evaluation and treatment center means services provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self, due to the onset or exacerbation of a psychiatric disorder. Services are provided in freestanding inpatient residential (non-hospital/non-institute for mental disease [IMD] facilities) to provide medically necessary evaluation and treatment to an individual who would otherwise meet hospital admission criteria. At a minimum, services include evaluation, stabilization, and treatment provided by or under the direction of licensed psychiatrists, nurses, and other mental health professionals, and discharge planning to ensure continuity of mental health care.[v]

Hospital: Hospital means any institution, place, building, or agency that provides accommodations, facilities, and services over a continuous period of 24 hours or more, for observation, diagnosis, or care, of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis. Hospital does not include hotels, or similar places furnishing only food and lodging, or simply domiciliary care; nor does it include clinics, or physician's offices where patients are not regularly kept as bed patient for 24 hours or more; nor does it include nursing homes, as defined and which come within the scope of chapter 18.51 RCW; nor does it include birthing centers, which come within the scope of chapter 18.46 RCW; nor does it include psychiatric hospitals, which come within the scope of chapter 71.12 RCW; nor any other hospital, or institution specifically intended for use in the diagnosis and care of those suffering from mental illness, intellectual disability, convulsive disorders, or other abnormal mental condition.[vi]

Institute for mental disease (IMD): An institute for mental disease is defined in federal statute as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases, including medical attention, nursing care, and related services."[vii]

Long-term psychiatric care: Refers to 71.05.280, additional commitment after the initial 14-day period of intensive treatment.

Psychiatric hospital: The term psychiatric hospital means an institution which:

a) Is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons;
b) Satisfies the requirements of §§1861(e)(3) through (e)(9) of the Social Security Act (general hospital requirements);
c) Maintains clinical and other records on all patients as the Secretary finds necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under Part A;
d) Meets such staffing requirements as the secretary finds necessary for the institution to carry out an active program of treatment for individuals receiving services in the institution.[viii]

Background

The proviso language reflects the intent of the Legislature to ensure that long-term involuntary psychiatric inpatient stays are compensated at a level that enables the facilities to sustain these services. The directive was to refine the methodology used to reimburse community hospitals for the costs specific to the population served, recognizing that long-term needs of individuals may vary from those who are on a short-term stay. The workgroup initially outlined a methodology for reimbursing community hospitals offering long-term psychiatric inpatient services. The 2020 supplemental budget established rates for FY 2021, in part based on the recommendations of the group. The following table compares the workgroup's initial recommendations to the final budget directive for FY 2021 rates.

Table 1: Workgroup's initial recommendations to the final budget directive for FY 2021 rates

	2019 Workgroup Recommendations	2020 Budget Directive
Rate adjustment frequency	**Annual**	**FY21**
Basis for determining cost	Medicare cost report. Update to statewide average	Medicare cost report/change to statewide average
Per diem rate	Retroactive cos-based	1) Prospective 100% cost-based on Medicare cost report for those with rate below cost 2) $940 for those whose current rate is above cost-based on Medicare cost report
"New" providers	Statewide average of provider specific LTCC rates or current per diem, whichever is higher Calculated separately for acute care and freestanding.	Statewide average of provider specific LTCC rates or current per diem, whichever is higher
Acuity adjustment	Based on severity of illness indicators	NA
Teaching hospital enhancement	$244 in first year	NA

Although there are many similarities between the two, the main difference is that the budget does not establish a methodology for setting rates past FY 2021 nor can it establish any kind of annual adjustment given its temporary nature.

The 2020 supplemental budget specifically directs the workgroup to identify additional factors that were not previously addressed by the workgroup and provide additional detail related to incorporating an acuity adjustment and retroactive reconciliation.

Although no cost analysis was completed for establishing rates for non-hospital residential treatment centers, the 2020 supplemental budget increased rates for these facilities by 5 percent above their FY 2020 levels.

Although not in the scope of this report, members of the workgroup propose that a cost analysis and a sustainable cost methodology should be recommended and established for those facilities.

Table 2 – Workgroup participants

Workgroup Participants				
Catrina Lucero (HCA)	Margo Miller (HCA)	Ron Escarda (Fairfax Hospital)	Danielle Cruver (OFM)	Ann Christian (WCBH)
Kevin Bovenkamp (HCA)	Kara Panek (HCA)	Nick Federici (Fairfax)	Lauren Baba (UW)	Joan Miller (WCBH)
Abigail Cole (HCA)	Gary Swan (HCA)	Leanne Krush (Fairfax)	Madeline Grant (UW)	
Sarah Cook (HCA)	Michele Wilsie (HCA)	Dawn Myre (Fairfax)	Dwane Liuska (UW)	
Martha Cortes (HCA)	Gregg Terreson (Cascade Behavioral Hospital)	Ingrid Mungia (Multicare)	Len McComb (WSHA)	Andy Toulon (Legislature – House) Observer only
Brandon Diltz (HCA)	Devon Nichols (DSHS/FFA)	Toni Long (Navos Behavioral Health)	Shirley Prasad (WSHA)	Travis Sugarman (Legislature – Senate) Observer only

The following two tables identify a current list of facilities willing to care for individuals on 90- and 180-day civil commitment orders. These facilities were identified because:

1. The facility volunteered to provide long-term bed psychiatric capacity, and
2. The facility received capital grants from the Department of Commerce to expand behavioral health capacity.[ix]

Table 3: Current and anticipated community hospitals providing 90- and 180-day civil commitment beds

Current and Anticipated Community Hospitals Providing 90- and 180-Day Civil Commitment Beds				
Facility	**Location**	**Number of Beds**	**Online Date**	**Facility Type**
Astria Hospital	Toppenish	14	January 2019	Non-IMD
Cascade Behavioral Health	Tukwila	18	Fall 2020	IMD
Fairfax Behavioral Health	Seattle	20	Fall 2020	IMD
Navos Behavioral Health	Burien	20	TBD	IMD
Providence Health & Services, Northwest	Everett	6	February 2021	Non-IMD
PeaceHealth St. John	Longview	2	May 2019	Non-IMD
UW Medicine Behavioral Health Teaching Hospital	Seattle	Fifty (50) 90- and 180-day long-term involuntary commitment beds, up to 40 geriatric psychiatric beds and 50 beds that will serve psychiatric patients with acute medical/ surgical needs	FY 2024	Non-IMD
Virginia Mason Memorial	Yakima	6 10	November 2018 First quarter 2021	Non-IMD

Table 4: Current and anticipated residential evaluation and treatment facilities providing 90- and 180-day civil commitment beds

Current and Anticipated Residential Evaluation and Treatment Facilities Providing 90- and 180-Day Civil Commitment Beds				
Facility	**Location**	**Number of Beds**	**Online Date**	**Facility Type**
Cascade Mental Health Care	Centralia	4	September 2018	RTF
Kitsap Mental Health Services	Bremerton	4	December 2018	RTF
Telecare North Sound	Sedro-Woolley	3	October 2018	RTF
RI International	Olympia	16	Late 2020	RTF
Compass Health	Everett	16	TBD	RTF
Telecare – Next Steps	Mason County	16	August 2020	RTF
Telecare – Next Steps	Thurston County	11	July 2020	RTF
Frontier Behavioral Health	Spokane County	10	September 2020	RTF

Inpatient psychiatric payment rates

Community hospitals are paid on a per diem basis for inpatient psychiatric services. In the 2019-20 operating budget, the Medicaid per diem rates differentiate between short-term and long-term civil commitment inpatient services for fiscal years 2020 and 2021. Those differences are noted below.

Short-term

Community hospitals' per diem payment rate for short-term inpatient psychiatric care is established as follows:

1. For community hospitals that before 2017 did not have an existing inpatient psychiatric rate and did not have more than 200 psychiatric bed days, the initial rate was set at the statewide average per diem rate. The lowest rate was set at $711.55 per day for hospitals that at rebase (2014) did not have any psychiatric days.

2. For community hospitals with more than 200 psychiatric bed days and an existing inpatient psychiatric rate in 2017, HCA conducted a rate rebase. According to the Medicaid State Plan Amendment 17-0040, the acute hospital rebased rate is the higher of:
    a. Existing inpatient psychiatric per diem rate as of 2017; or
    b. Adjusted cost per day, which was reduced to 78.41 percent.

Freestanding psychiatric hospitals received 68.15 percent of the average cost per day. For new inpatient psychiatric services after 2017, when the hospital does not have an existing psychiatric per diem rate, the facility is paid the statewide average. After 2017, if a hospital reaches more than 200 psychiatric bed days, their rate is rebased as outlined in Medicaid State Plan Amendment 17-0040.

Long-term

To help address the mental health crisis in our state, the Legislature has embarked on an ambitious five-year plan to move most individuals on long-term civil commitment stays out of Eastern and Western State Hospitals and into community facilities such as community hospitals and residential E&T facilities. The 2020 supplemental budget establishes community hospitals' per diem payment rate for long-term civil commitment inpatient psychiatric care as follows:

1. Community hospitals whose costs exceed their current rates based on their most recently filed Medicare cost report will be paid 100 percent of the hospital's eligible costs documented in the most recently filed Medicare cost report.
2. Community hospitals that do not have a Medicare cost report on file with the authority will be paid the statewide average rate based on the average of provider-specific long-term inpatient care rates or the provider's current per diem rate, whichever is higher.
3. Community hospitals whose costs do not exceed their current rates based on their most recently filed Medicare cost report will be paid at $940 per day.

4. Nonhospital residential treatment centers certified to provide long-term inpatient care beds as defined in RCW 71.24.025 will be paid at a rate that reflects a five percent increase from their fiscal year 2020 rate for serving Medicaid clients in long-term inpatient care beds as defined in RCW 71.24.025

Although the methodology established for FY 2021 creates provider-specific rates based on cost, it does not provide guidance for future years.

The workgroup recommends that all costs be analyzed and rates updated annually. The overarching framework for any rate methodology should be guided by the following principles:

- Community hospitals and residential E&T facilities should be paid a rate sufficient to cover 100 percent of cost and incentivize hospitals and E&T facilities to provide services for individuals on 90- and 180-day civil commitment stays.
- Rates should be adjusted annually to ensure that they accurately reflect the current cost of care.

Additional factors: caring for 90- and 180-day civil commitment stays

The workgroup has identified that additional costs may be incurred while caring for long-term psychiatric stays. The Medicare cost report captures many of the costs incurred by community hospitals; however, there may be additional costs that are not reflected in the cost report.

These costs may include:

Professional services fees and costs

Some freestanding psychiatric hospitals have experienced significant (greater than 200%) increases in staffing costs with regard to inpatient psychiatric care. This includes increases in the need for restrictive interventions, one-to-one care, and physician costs.

A key component for caring for this patient population is professional services. Not all professional service fees for psychiatrists, psychologists, and other mental health professionals caring for psychiatric patients are captured in the Medicare cost report. For some freestanding psychiatric hospitals, costs associated with on-call providers are not captured on the Medicaid cost report. This is an unavoidable cost associated with providing 24/7 access to patient care. On-call clinical care is not a billable service, which creates some professional services that are not reimbursable to providers.

Hospitals may bill professional services separately from the inpatient claim. Other costs included in the cost report but billed separately from the inpatient claim include occupational or other additional therapies.

Additionally, a number of costs are not captured in the Medicare cost report and may not always be separately billable. These include program-specific activities such as individual and/or group therapy, physical activities, entertainment, life skill activities; and hygiene and personal care items such as haircuts, trips to outside services, dental appointments, and the like. Furthermore, clothing and other personal items may be necessary to meet the needs of the individual.

Involuntary Treatment Act (ITA) court costs

Concerns brought forth by providers in the workgroup related to internal costs. There are two key groups of ITA court costs:

- Legal process costs such as court fees, transportation (if ITA court is not provided on-site or through video access), attorney costs, security costs, and costs for the documentation of the process.
- Provider-incurred costs associated with either onsite ITA court or infrastructure for remote access to ITA court.

Additionally, discharge planning and continuum of care coordination costs must be considered. These costs may not be captured on the Medicare cost report and are considered a portion of the per diem rate in E&T facilities.

Court costs are included in the proviso related to the 90-180 day beds and are sent to the behavioral health administrative services organizations (BH-ASO) based on number of beds contracted in the region. Associated court costs for long-term beds totaling $61,101 were disbursed for fiscal year 2020.

In their experience serving short-term clients, some providers indicate there are additional costs for individuals detained under ITA. Cost drivers include staff time, attorneys, transportation, court liaisons, and other associated costs.

Other considerations for freestanding psychiatric hospitals

Capital costs

Serving long-term psychiatric patients may require providers to expand existing buildings, build new facilities, or modify physical space to accommodate long-term psychiatric patients (enhanced security and restraint measures, outdoor space, patient rooms, etc.). Hospitals may also face costs related to property damage. These projects are generally financed through the commercial market, especially as IMDs are ineligible for state capital grants. Borrowing costs including interest expense and depreciation are not captured in a provider's Medicaid cost report. When evaluating whether to offer long-term services providers must determine how capital funds would best be utilized to increase capacity for short-term or long-term mental health patients.

To help address this, these capital costs could be considered in determining a hospital's per diem payment rate.

In the last few years, there have been some start-up funds available through capital budget appropriations to the Department of Commerce. However, IMDs are not eligible for these funds. Another option for the Legislature to consider if making similar funds available in the future would be to lift the provisions that currently exclude IMDs from these opportunities.

Opportunity costs/payor mix

Short-term beds maybe financed by a combination of private and public insurance. However, payor mix for long-term beds is predominately publicly funded.

Short-term beds may be reimbursed at a higher rate, depending on the payor.

Inability to cost shift

Freestanding psychiatric hospitals face other cost challenges in caring for long-term civil commitment patients. As illustrated, the current statewide average rate paid to freestanding psychiatric hospitals only covers about 68 percent of the statewide average costs.

Acute care hospitals that provide psychiatric and non-psychiatric services are able to cost shift from higher paying non-psychiatric services to lower paying psychiatric services. However, freestanding psychiatric hospitals only provide these lower paying psychiatric services and are unable to cost shift.

In addition, freestanding psychiatric hospitals care for a significant number of Medicaid and Medicare patients. Based on 2020 hospital discharge data (CHARS), the overall Medicare/Medicaid payer mix for freestanding psychiatric hospitals was 71 percent. As such, these hospitals do not have significant commercial claims to offset lower paying Medicare and Medicaid claims, posing a challenge to freestanding psychiatric hospitals to be sustainable.

Considerations for freestanding evaluation and treatment centers (residential evaluation and treatment center)

The workgroup encourages using data to support actuarial work in conjunction with RTF-reported costs, as the basis for determining the cost for RTFs. This includes establishing a focused workgroup comprised of HCA, RTF providers, the Washington Council for Behavioral Health, and Medicaid actuaries to develop a standardized approach to determining cost.

Capital costs

Providers received grants from the Department of Commerce that do not cover the entire cost of building the facility.

Residential E&T centers experience many of the same capital costs and needs described for community hospitals and these should be considered by the focused workgroup.

Opportunity costs/payor mix

As for hospitals, the payor mix for long-term beds is predominantly publicly funded in residential E&T centers. Short-term beds may be reimbursed at a higher rate, depending on the payor.

Retroactive reconciliation: establishing an interim rate for new providers

It will be 12 to 18 months before the actual cost of providing long-term psychiatric inpatient care is reported to the Centers for Medicare and Medicaid Services (CMS) and analyzed in the Medicare or other cost reports. HCA will require a method to calculate an adequate rate for this interim period for new providers that begin serving 90- and 180-day civil commitment clients in future years but do not yet have a cost report that reflects that experience.

The 2020 supplemental budget directs HCA to calculate the statewide average of providers with a provider specific long-term psychiatric inpatient and assign that rate to new providers until they have a cost report on file.

The workgroup has identified several options.

Option 1

Use the FY 2020 base rate assumed in the 2019-21 operating budget ($1,171) adjusted by a Medicare inflation rate

This option would use an inpatient fixed-weight index to update payments and cost limits. The workgroup recommends using CMS's annually updated 2012-based inpatient psychiatric facilities market basket for this purpose. For example, the market basket for inpatient psychiatric facilities in FY 2020 is 2.9 percent.

Option 2

Use the average facility-specific inpatient psychiatric per diem rate for providers who have indicated an interest in providing 90- and 180-day beds

This option would create a new statewide average rate based on a subset of current providers. Providers would be paid the higher of this rate or their own facility-specific rate. This average rate could be adjusted every year using the Medicare inflation factor, or by updating the subset of providers used to calculate the statewide average. The annually updated average could be used as the interim base rate for "new" providers who do not yet have a facility-specific cost-based rate. The statewide average would be calculated separately for acute care hospitals, freestanding psychiatric hospitals, and RTFs. This is the methodology for FY 2021.

Option 3

Use the current ($1,171 for acute care hospitals and $877.42 for RTFs) rate and then apply a retroactive cost-based rate adjustment

This option would pay providers at the rates established in the 2020 supplemental operating budget until the provider has an updated cost report on file. The rate would be retroactively

adjusted to reflect cost report information. If the provider's current per diem rate is higher than the rates assumed in the 2020 supplemental operating budget, that higher rate would be their initial base rate.

Recommendation

The workgroup recommends Option 2.

Calculating an acuity adjustment for freestanding psychiatric hospitals

Clients on 90- and 180- day civil commitment orders may have higher levels of acuity than short-term psychiatric patients. That higher acuity level may be reflected directly through a higher severity of illness or may be observed through higher ancillary costs that are not adequately captured in a Medicare cost report. Any acuity adjustment would need to be updated annually and applied on an ongoing basis. The workgroup discussed three options for calculating an acuity adjustment.

Option 1

Use a flat percentage increase

Increase base rates by 20 percent.

Option 2

Calculate an acuity factor based on severity of illness indicators

Submitted inpatient claims information contains the severity of illness indicators (SOI), not the Medicare cost reports. The SOI is recorded on a scale of one (1) to four (4) with 1 being low and 4 being high. This option would assign a weight based on the SOI that would adjust the underlying base rate. For example, if a 10 percent weight was added for SOI 3 and a 20 percent weight was added for an SOI 4, a hospital with a per diem of $100 would receive $110 for a client with and SOI 3 and $120 for a client with and SOI 4. In a review of current long-term psychiatric claims, most appear to be coded with and SOI 2. ProviderOne calculates the SOI using the 3M grouper. The grouper assigns the SOI based on diagnosis code. This would be a major systems change and need to get included as part of the update cycle. Those cycles happen every three months. Depending on timing, it could take between three and six months to program this change.

Option 3

Use supplemental data reported by the freestanding psychiatric hospitals to inform and adjustment

Medicare cost reports are a good representation of cost for acute care hospitals. However, there may be areas where they are not fully representative for the freestanding psychiatric hospitals. This option would require freestanding psychiatric hospitals to provide supplemental data to HCA. This data would then be used to inform an adjustment to the base per diem. One possibility may be to calculate an average cost per day based on bed days and total reported supplemental costs and add that to the base rate.

Table 5: Calculating an acuity adjustment

Calculating an Acuity Adjustment		
	Pros	**Cons**
Option 1: Increase base by 20%	Simple/easy to implement Minimal administrative burden	Not tied to actual cost or data Difficult to justify to CMS
Option 2: Calculate an acuity factor based on severity of illness indicators	Tied to actual costs and data Justifiable to CMS Could be updated annually Incentivizes hospitals to care for more complex patients	Would require system change Increases payment complexity System generated SOI limited provider impact
Option 3: Use supplemental data to inform adjustment	Would help account for costs not reflected in a Medicare cost report, a more accurate reflection of the cost of care Could be updated annually Incentivizes hospitals to care for more complex patients	Would require additional reporting by hospitals Would require additional HCA staff time to calculate Would require some systems changes

Recommendation

The workgroup recommends Option 3.

Calculating initial teaching hospital enhancement

In 2019, the Legislature and Governor directed the capital planning and construction of a new 150-bed behavioral health teaching hospital to be operated by the University of Washington School of Medicine's Department of Psychiatry & Behavioral Sciences (UW Medicine).

The new hospital will provide clinical care for long-term involuntary civil commitment patients, geriatric psychiatric patients and voluntary psychiatric inpatients. The hospital will also include a new type of medical/surgical unit that will serve behavioral health patients who also need acute medical care.

In addition to clinical care, the teaching hospital will be responsible for training a behavioral health workforce with an interdisciplinary curriculum and programs that support and encourage professionals to work in teams across the provider spectrum. Training at the hospital will include psychiatric nurse practitioners, registered nurses, physician assistants, medical assistants, social workers and behavioral health counselors, in addition to traditional training and education you undergo to become a physician.

Teaching hospitals incur additional costs associated with faculty salaries and reduced efficiency inherent to student training. Most of the additional costs related to teaching comes from reduced productivity of health care professionals (doctors, nurses, social workers, physician assistant and nurse practitioners) who redirect time from patient care to observe and teach trainees from diverse disciplines. In the case of physicians, time is used that would otherwise be billable patient visits. The time required to conduct a patient visit with a medical student is two to three times greater, due to the teaching aspect. The ratio is similar for other professional staff.

Teaching hospitals also incur costs associated with didactic teaching, which does not involve direct patient care, but does require items such as orientation, classroom-based teaching of trainees from different disciplines, curriculum development and maintenance, testing, and attestation of core competencies. This is non-billable time not directly linked to patient care.

University of Washington Medical Center (UWMC) FY 2018 Medicare cost report data for psychiatry residents suggests a 15 percent teaching factor add-on. This is based on Medicare's teaching education adjustment factor (IME) calculation, which uses the ratio of residents receiving training at the teaching facility to the average daily census of the inpatient unit. This 15 percent adjustment is representative of UWMC's teaching factor add-on in a typical fiscal year.

After the first year, these costs should be reflected in the Medicare cost reports and this additional enhancement will no longer be needed.

Table 6: Calculating teaching hospital enhancement factor

Calculating Teaching Hospital Enhancement Factor		
	Pros	**Cons**
15% enhancement rate	Based on a formula similar to the Medicare teaching adjustment factor	May not align with actual costs of running a teaching facility, if the costs for providing training and instruction increase from baseline calculation.

Recommendation

The workgroup recommends including a 15 percent teaching factor ad-on.

Impact of rate increases

HCA, along with Milliman, measured the impact of the rate increases based on the three hospitals contracted to provide long-term beds in SFY2021. The budget proviso directed us to set the long-term psychiatric per diem at the greater of $940 or 100 percent of the hospitals' average costs per day. One hospital, Virginia Mason Memorial, received an increase in their per diem rate and one hospital's, PeaceHealth St. John, rate decreased by a small amount. At the time of writing this report, the cost-based rate for Toppenish was being developed. Therefore, the amount used for this impact analysis was their SFY2020 long-term psychiatric per diem. The total impact of the new rates for these three hospitals as compared to their previous psychiatric per diems was a total of $41,701. Assuming a blended federal share of 63 percent, the state share of the difference is $15,429. The total amount of estimated payments on an annual basis is $9,526,832 with a state share of $3,524,928.

Conclusion

Recommendations on how to implement this methodology

Bill

Ensuring that rates are updated annually and cover the full costs hospitals and residential E&T facilities incur while serving long-term clients provides them with financial certainty and predictability. Caring for this patient population requires significant long-term investment and hospitals and residential E&T facilities look for this future certainty when evaluating the decision to open and maintain long-term beds. Putting the rate methodology recommended in this report into statue provides clarity and long-term predictability around what rate a provider can expect should they choose to offer long-term inpatient services. This would incentivize providers who may be hesitant to open new beds.

Budget proviso

A budget proviso provides direction but, only for a two-year period. Providers would have limited certainty about what rate they may receive outside of that period. A proviso gives the Legislature flexibility to make changes but it does not allow for the level of certainty a provider needs when evaluating the feasibility of making the long-term financial investments necessary to open new long-term beds.

Recommendation

The workgroup recommends putting the overarching methodology in statute to ensure rate certainty going forward. The statute should grant HCA rule making authority so as to ensure specifics and technical details can be described in WAC.

[i] Substance Abuse and Mental Health Services Administration: Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019.
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