Inpatient Psychiatric Care Risk Model Report

Prepared for:
State of Washington Office of Financial Management

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1. Executive Summary

The State of Washington, Office of Financial Management, contracted Public Consulting Group, Inc. (PCG) to analyze how best to develop a psychiatric managed care capitation risk model that integrates long-term civil inpatient psychiatric hospital services as defined in RCW 71.24.025 into managed care capitation rates and non-Medicaid contracts and holds managed care entities at full financial risk. Substitute Senate Bill 5883 (Chapter 1, Laws of 2017, 3rd Special Session) required the Health Care Authority (HCA) to develop this model, which must:

1. Integrate civil inpatient psychiatric hospital services, including 90- and 180-day commitments provided in state hospitals or community settings, into Medicaid managed care capitation rates and non-Medicaid contracts;
2. Phase in the financial risk such that managed care entities bear full financial risk for long-term civil inpatient psychiatric hospital commitments beginning January 2020;
3. Address strategies to ensure that Washington is able to maximize the state's allotment of federal disproportionate share funding.

This report provides context for and answers to these questions by first presenting an overview of the state's mental health system with a focus on inpatient psychiatric care using data provided by Washington. Next, research is provided regarding program structures employed by states with managed care models for high acuity behavioral health patients. State and federal laws and regulations that govern contracts between health plans and inpatient psychiatric facilities with civil commitments are analyzed and qualitative feedback collected by PCG via stakeholder interviews provides additional context.

The risk model is needed because Washington's current interest in including all long-term, involuntary psychiatric inpatient stays (that fall into the categories of 90- and 180-day commitments) in managed care contracts has no exact precedent and raises a number of complex financial, operational and legal questions, many of which PCG posed in our *Washington Mental Health System Assessment: Final Alternative Options and Recommendations* report submitted in December 2016.

In developing the risk model, PCG considered numerous factors that could potentially impact its success or failure, including how the risk model is designed and implemented. Topical considerations related to authority and clinical decision making; oversight and monitoring; populations and member services; financing; and system capacity and operations are also addressed.

The result of PCG's analysis is a set of recommendations designed to address several policy questions integral to supporting Washington in developing a comprehensive and effective risk model. These recommendations are intended to support Washington in achieving its aims of enabling Fully Integrated Managed Care (FIMC) organizations to manage care for patients with complex behavioral health needs and reduce the need for institutional care at the state hospitals for these patients. On the following pages is a list of PCG's recommendations, organized by topical area, with summary data and justification for why each recommendation was included.

Populations

Include each of the core adult inpatient civil populations, including geropsychiatric and intellectual disability/developmental disability patients, in the risk model beginning January 1, 2020. Given that the goal of the risk model initiative is to improve care integration and to establish clear incentives and a system of financial accountability for appropriate care, we believe it is appropriate that the model include all civilly committed populations with the exception of "forensic flip" patients, which are addressed in a separate recommendation.

Apply the risk model only to new long-term civil commitments, excluding individuals currently committed to a state hospital. This recommendation would allow FIMC organizations to take on risk for these care-intensive populations gradually and predictably, enabling the inevitable shifts in cost and utilization to be implemented more smoothly, with less disruption and within a shorter transition framework.

Exclude "forensic flip" patients from the risk model. This population poses a unique challenge to developing a risk model for civil inpatient commitments, largely because the entities responsible for paying for their care (FIMC organizations or Behavioral Health Organizations [BHOs]) typically have no advance notice of when an individual will flip (and thus end up on their caseload) and no control over the numbers of individuals whose status will change from forensic to civil. Accordingly, if the FIMC organization or BHO had no relationship to the patient prior to the flip, they also would have had no ability to manage the patient's care in a manner conducive to preventing deterioration to the point of crisis and subsequent detention.

Facilities and Services

Include in the model all facilities licensed or otherwise authorized to provide 90- and 180-day civil commitment stays. This will include both state-operated and community-based hospitals and evaluation and treatment centers to ensure adequate placement options and acknowledge limited capacity to serve long term psychiatric patients outside of the state hospitals at present due to licensing and facility limitations and fiscal and operational concerns about accepting long-term civil commitments. While efforts are underway to generate additional capacity, research and stakeholder consensus suggest that this will be a multi-year effort.

Require FIMC organizations and BH-Administrative Service Organizations (ASO) to compensate at a minimum based on the fee-for-service per diem rates to the hospital providers. In order for community hospitals to participate in the provision of care to long-term civilly committed patients, they will need assurances that the financial benefit will be sufficient to address the costs of caring for these complex patients. For that reason, FIMC organizations and BH-ASOs must be required to compensate based upon at least the established fee-for-service per diem rates so that hospitals have sufficient and predictable revenue streams for providing this care.

Recognize that community capacity building for long-term civil commitments is going to be driven by establishing higher per diem rates, expanding certification and direct capital investment in facility building by the state. The lack of sufficient alternative placement options for civilly committed patients was a primary concern of stakeholders and reflects the myriad challenges associated with building this capacity: funding, facility needs, and complexity of patient needs, among other factors. It is important to acknowledge that development of additional capacity will not be achieved solely through infusing FIMC organizations with funds but will likely require significant capital investment by the state as well as higher per diem rates and the

expansion of certification options for potential providers. The state has already taken steps to engage potential hospital-based partners in relevant discussions and can build on these relationships and acquired knowledge to determine how best to provide meaningful and effective support for capacity building. To hasten the development of such capacity, PCG also recommends that Washington set a target date of January 1, 2022 for ceasing all new civil admissions to the state adult psychiatric hospitals. This date may be re-evaluated in light of progress on establishing alternative options but setting a goal sends an important message to all involved parties regarding the state's intentions.

Include in the risk model all services currently offered to civil inpatient commitments in the state hospitals. The services offered at ESH and WSH have been developed over time and are designed to address the behavioral and physical health needs of civilly committed patients. These recommended services should be available at the two state hospitals as well as any community hospitals where civil inpatient commitments are served to ensure continuity of care, provide a consistent level of service and reduce administrative complexity associated with making large-scale changes to the service array available to long-term civilly committed patients.

Explore an Institution for Mental Diseases-Disproportionate Share Hospital (IMD-DSH) waiver to reduce the reliance of IMD-DSH at the state hospitals. Under such a waiver, WSH and ESH could bill regular Medicaid Federal Financial Participation (FFP) for services provided to Medicaid patients for the 21-64 population, effectively reducing the DSH claim in future years. Essentially, the state would be claiming regular FFP instead of IMD-DSH FFP for patients that had previously been served in ESH or WSH. This would relieve pressure on the IMD-DSH cap felt at the state hospitals.

Financing

Assign the Medicaid portion of funding in the risk model to the FIMC organizations and require them to be the payer. Assign the non-Medicaid portion of funding to the contracted Behavioral Health – Administrative Services Organization (BH-ASO) in each region and also require them to be the payer. Allocating federal match (Medicaid) and state-only funds to separate entities is intended to limit administrative complexity for these entities as well as the state regarding management of separate funding streams. At the same time, other recommendations address coordination among these entities to ensure that they work in tandem to address the full range of patient needs and ensure seamless transitions of care, particularly when patients leave inpatient psychiatric care. For the BH-ASO portion of funds, all state revenue (not Medicaid, Medicare, DSH or commercial insurance) for new 90- and 180-day admissions after 1/1/20 will be redirected to the BH-ASOs under this risk model.

Capitate the FIMC organization (Medicaid) portion of funds but do not capitate the BH-ASO (non-Medicaid portion.) State business processes and information technology that drives accurate and accountable capitation rate setting begins in the Medicaid eligibility system. Legally, these Medicaid capitation rates are governed by federal rules requiring them to meet actuarial soundness rules. Medicaid rules do not apply to non-Medicaid benefit costs. PCG is not aware of capitation methods that mix Medicaid and non-Medicaid dollars into a single capitated rate nor business processes supporting assignment of capitation rates that do not extend from the Medicaid eligibility system; therefore, operational capacity for capitation payments will be unsupported. We do not believe a capitation payment method is the only, or, in this case, the optimal method, of putting the managed care entity "at risk" of financial penalties associated with inefficient and ineffective patient care; rather, performance metrics related to risk may be employed for similar purposes.

For the capitated portion, establish a risk corridor beyond which the state supplements payment. As payment responsibility for long term involuntary psychiatric stays expands under a capitation model, PCG recommends the adoption of risk corridors for a minimum of two years to ensure the stability of Medicaid managed care should the role of community hospitals in long term civil commitments significantly expand by 2020. After two years, the risk corridor may be re-evaluated for possible continuation by the state as needed.

The Department of Social and Health Services (DSHS) should implement acuity based payment rates for Western and Eastern State hospitals that more accurately reflect case complexity. Daily bed rates for these facilities are currently developed using cost centers that reflect categories that include Geropyschiatric, Intellectual/Development Disabilities (ID/DD) and all other civil cases. This provides little insight into the acuity level and care needs of the populations. Thus, for more appropriate rate setting we recommend the development and use of acuity-based models such as the diagnosis-related group (DRG) model used by Medicare to reimburse state IMDs. Acuity-based state adult psychiatric hospital rates will enhance the accuracy of capitation rate development as a greater share of long term civil commitments are paid for under a capitated model over the next several years.

Continue to monitor federal activities and updates related to DSH and build models that account for the revised IMD-DSH claim, the reduced IMD-DSH limit, and the expected diversion of civil patients away from state hospitals. These activities are designed to maximize federal share FFP for the state, taking into account both regular FFP claiming for FIMC capitation payments and FFP claiming for IMD-DSH. Washington will also want to stay apprised of any additional delays or changes to DSH reductions from the federal government.

Consider legislation extending IMD-DSH payments to non-state hospitals as an option to maximize any reductions brought on by changes in the forensic vs. civil patient ratio of the state hospital population. Private hospitals (IMD and general acute) would be incentivized if targeted DSH became available. It is important to note that IMD-DSH claiming at non-state hospitals is an entirely different reimbursement process for the state. Washington currently draws federal reimbursement for the IMD-DSH claim submitted based on the Certified Public Expenditures (CPEs) at ESH and WSH. Claiming IMD-DSH at non-state hospitals would require Washington to make the full IMD-DSH payment and then draw down FFP after the payments are made.

Contract Requirements and Oversight

Adopt a new set of requirements for DMHPs and FIMCs related to civil commitments that retains the integrity of the process and DMHP independence while enabling FIMC organizations to inform the process with firsthand information about the patient and thoughtful recommendations regarding care approaches. Section 9.3.9 includes detailed sub-recommendations that address permitting the submission of care plan recommendations to civil court judges at the same time the Designated Mental Health Professional (DMHP) files a petition and assigning the facility placement decision to the DMHP based on a "regional care" model and bed availability. The goal of the combined sub-recommendations is to allow for as much pertinent information as possible to inform civil commitment decisions while maintaining ultimate decision making regarding commitment and placement with the appropriate authorities.

Require FIMC organizations/BH-ASOs to be represented on the hospital clinical discharge planning team. This recommendation is designed to support meaningful engagement in care management

and transition planning by the entities responsible for long-term civilly committed patients under the risk model. FIMC organization and/or BH-ASO direct participation in discharge planning as part of the responsible team will help to ensure full understanding of patient needs by all parties and support appropriate placement of the patient upon discharge from the hospital.

Establish contractual performance measures and withholds for FIMC organizations. Meaningful and measurable performance metrics are essential to ensuring that the entities responsible for managing care for long-term civilly committed patients are achieving both the model's intended objectives and the provision of improved, high quality care for these patients. To that end, PCG has proposed several specific measures designed to incentivize FIMC organizations and BH-ASOs to provide a high level of care management and ensure swift and appropriate care transitions for civilly committed patients. These measures may build on performance measures already embedded in FIMC contracts and will need to be effectively and reliably monitored to determine appropriate rewards and penalties. PCG's recommendations for specific performance metrics are itemized in section 9.3.7.

Require FIMC organizations and BH-ASOs to begin phasing in value-based purchasing models for long-term civil commitments by 2022. This recommendation builds on initiatives already underway at HCA to move from encounter- to value-based payment (VBP) in state-financed programs including Medicaid. HCA's goal is to have 80 percent of provider payments under the VBP model by 2019. To align with HCA's current efforts to link quality to payment, PCG recommends implementing the VBP and performance incentive arrangement in FIMC contracts for long-term inpatient psychiatric care. This model should be applied to both Medicaid and non-Medicaid funded contracts, MCEs and BH-ASOs, as the population included in the capitation model will be covered by both entities.

The full report offers additional detail about each of these recommendations as well as background, regulatory and best practice information that offers additional context in which to understand them.

2. Introduction

2.1 Purpose of this Report

In 2016 the State of Washington, Office of Financial Management (OFM), contracted Public Consulting Group (PCG) to examine the structure and financing of the of the mental health system, as required by Engrossed Substitute Senate Bill 6656 (Chapter 37, Laws of 2016, 1st Special Session).

As part of the examination, PCG was required to identify the populations appropriately served at the state-operated adult psychiatric hospitals and to determine if managed care entities should be placed at financial risk for state hospital civil utilization for patients within their catchment areas.

In the final examination, PCG identified three key recommendations:

1. State adult psychiatric hospitals should become forensic centers of excellence with a focus on serving forensic populations.
2. Services for individuals on a civil commitment should be transitioned from the state adult psychiatric hospitals to the community, where patients can receive care closer to their communities of residence.
3. The Director of the Health Care Authority should be required to submit a state psychiatric hospital managed care risk model to support holding Medicaid managed care entities at financial risk for civil commitments in the community.

Substitute Senate Bill 5883 (Chapter 1, Laws of 2017, 3rd Special Session) required the Health Care Authority to incorporate long-term inpatient care, as defined in RCW 71.24.025, into the psychiatric managed care capitation risk model. The model must also:

1. Integrate civil inpatient psychiatric hospital services, including 90- and 180-day commitments provided in state hospitals or community settings, into Medicaid managed care capitation rates and non-Medicaid contracts;
2. Phase in the financial risk such that managed care entities bear full financial risk for long-term civil inpatient psychiatric hospital commitments beginning January 2020;
3. Address strategies to ensure that Washington is able to maximize the state's allotment of federal disproportionate share funding.

Funding was provided to OFM which subsequently entered into a new contract with PCG to analyze how best to develop a psychiatric managed care capitation model that integrates civil inpatient psychiatric hospital services into managed care capitation rates and non-Medicaid contracts and holds Fully Integrated Managed Care (FIMC) organizations at full financial risk. With no exact precedent for this type of model, many policy questions must be addressed before a financial risk model can be successfully implemented.

This report provides context for and answers to these questions by first presenting an overview of the state's mental health system with a focus on inpatient psychiatric care using data provided by Washington. Next, research is provided regarding program structures employed by states with managed care models for long-term care high acuity behavioral health patients. State and federal laws and regulations that govern contracts

between health plans and inpatient psychiatric facilities with civil commitments are analyzed and qualitative feedback collected by PCG via stakeholder interviews provides additional context.

2.2 Context of this Report

This report provides key findings coupled with specific recommendations. Key findings presented in Sections 3 through 8 provide the foundation for specific recommendations relative to those sections. Section 9 focuses directly on the risk model itself and provides a definition, considerations, and detailed recommendations for risk model implementation.

The report will be followed by an Implementation Plan scheduled to be completed on January 20, 2018.

The intended audience of this report is policy and program leaders in the State of Washington. This includes elected officials and their staff, state agencies, and key stakeholders impacted by the implementation of a risk model including managed care entities, providers, hospitals, patients, patient advocates and others.

3. Approach

To efficiently process the many data sources described in Section 2.1, PCG's approach encompassed four work streams. Figure 3.1 below summarizes data collection and analysis processes as well as applicable limitations for each work stream.

Figure 3.1 Work Streams for Analysis

Work Stream	Process
Quantitative Data Analysis	• Confirmed with the state data points required to accurately describe Washington's current civil inpatient commitment process • Reviewed data request with the state on November 17, 2017 • Processed data received and conducted follow up as needed
National Trends	• Conducted literature review of trends in managed care, including: o The transition of high-need, high-cost populations to managed care o Expansion of new services, including behavioral health services, under managed care • Reviewed public data sources on lessons learned from implementation of new services and populations into managed care • Reviewed publicly available managed care entity (MCE) contracts to identify the required involvement of MCEs related to patient discharge, the civil commitment process, and court-ordered treatment
Regulatory Analysis	• Conducted resource review of federal and state regulations and standards related to managed care, performance metrics, and provider contracting • Reviewed how other states implemented policies related to civil commitments and managed care and behavioral health metrics
Stakeholder Input	• Conducted in-person and phone-based interviews from November 3 – 22, 2017 with state-identified stakeholders • Collected and reviewed materials sent by stakeholders • Reviewed input, identifying major themes and conflicting views

4. Current State of Adult Inpatient Psychiatric Care

4.1 Overview of Inpatient Psychiatric Care in Washington State

In PCG's October 2016 Initial Findings Report, we provided an overview of the service infrastructure and capacity of Washington's public behavioral health system. While the present analysis is more narrowly focused on inpatient psychiatric care, it is important to remember that the effectiveness of inpatient care within the state is dependent on the availability and quality of services within the broader community system, and to recognize that robust coordination of institutional and community services cuts across a wide array of different payers and funding sources providing financial reimbursement for behavioral health services.

As Medicaid expansion has resulted in the Medicaid program becoming even more influential on service delivery, its regulations have also required shifts in funding streams under different circumstances that impact both the level of state funds expended and federal funds received. Thus, understanding the current conditions of treatment and funding for Medicaid patients is a focal point for developing an inpatient risk model, although the model encompasses a broader payment system than Medicaid.

At the outset of this report, it is important to note that Washington is in the midst of a major shift in the model of how behavioral health services are delivered. In April 2016, Southwest Washington became the first early adopter Fully Integrated Managed Care (FIMC) region, meaning that behavioral health services are provided through managed care organizations (MCOs), referred to in this report as "FIMC organizations" so as to distinguish them from MCOs currently providing only physical health services in Washington. By 2020, all regions of the state are expected to shift to the FIMC model and away from the Behavioral Health Organization (BHO) model in effect across most of Washington at present. FIMC is intended to streamline service delivery for Medicaid clients by having physical and behavioral health services funded through a single entity, the FIMC organization, rather than separately.

In the current system, inpatient service populations continue to be divided along payer lines and by inpatient setting. For Medicaid and uninsured, higher acuity clients, community services are administered by BHOs or, in Southwest Washington, by the two FIMC organizations, Community Health Plan of Washington and Molina Healthcare. BHOs and FIMC organizations are responsible for coordinating care for these individuals across mental health and substance use disorder treatment. Currently, there are ten BHOs and two FIMC organizations in the state contracted to provide behavioral health treatment services.

As noted in PCG's previous report, an individual has many pathways through which he or she may access the inpatient mental health system as a civil patient. Importantly, the breadth of services available, as well as the level of care management provided to guide patients toward appropriate services and continued treatment, varies greatly depending on both the payer and the geographic region in which the patient resides.

Inpatient care is integral to the state's crisis care infrastructure as well as to its long-term treatment capacities. Crisis care can take many forms, ranging from stabilization services in the patient's home or community to care provided on an inpatient basis by both licensed Evaluation and Treatment (E&T) centers and community hospitals. For inpatient crisis care, community hospitals provide a full range of physical health services, while E&T centers specialize in mental health. For BHO clients requiring inpatient care, rehabilitation case management services are intended to coordinate inpatient and outpatient services. If a patient is remanded to

state psychiatric hospitalization, the BHO or FIMC organization is required to coordinate transitional care with the state hospital to support the patient's admission and discharge.

The continuum of community and institutional care requires significant coordination and communication among the many parties involved. The full range of medical and non-medical care for people with mental health conditions in Washington state is disparate and difficult to conceptualize. This challenge reflects the breadth and complexity of the mental health infrastructure by payer type, provider type, multiple home and community based waivers, facility type, regional variation in the availability of privately administered services and the need for multiple agencies to fund and coordinate care for a single patient. The shift toward fully integrated managed care underway in Washington is expected to mitigate some of the current challenges to understanding and navigating the system of care.

For Medicaid clients, higher acuity community services are provided by BHOs or the FIMC organization, but also vary depending on the service region. When a court has remanded an adult Medicaid patient to one of the state's two state-operated adult psychiatric hospitals, the BHOs or FIMC organizations are no longer responsible for the cost of care and the state, combined with available federal funding streams, funds the patient's treatment directly. Community hospital stays and other forms of inpatient and residential care, conversely, are reimbursed by the BHOs or FIMC organizations, which will also assume responsibility for the patient's cost of care upon discharge from the state hospital.

One of the goals of the present initiative is to develop a risk model that will address some of the disincentives to providing community and outpatient treatment that the current reimbursement system introduces into care coordination. Before we develop our recommendations in detail, we begin by reviewing the current state of inpatient psychiatric care in the State, outlining the present role of the state hospitals and their relationship to other types of inpatient and outpatient treatment within the state.

4.2 Determination of Need for Inpatient Care

As noted in Section 4.1, a subset of individuals requiring mental health services will be admitted to inpatient care, either in a community hospital, E&T facility or a state psychiatric hospital. The role of state hospitals has evolved over the last several decades, and state hospital admissions nationwide increasingly focus on forensic patients and high acuity patients with severe and co-occurring behavioral or medical complications. However, without a mechanism for incentivizing community inpatient providers to assume the state's traditional function of providing long-term civil inpatient treatment, this capacity can be lost in competition with forensic or other specialized psychiatric beds.

In our previous report, we identified four main pathways for civil inpatient care. First, if the patient is willingly seeking services, the patient will be assessed for voluntary inpatient treatment and admitted to an inpatient facility based on the level of need and the availability of a bed. For those patients who have previously engaged in care, the patient's case manager or referring provider may coordinate with the inpatient facility to support this transition. The remaining three pathways involve involuntary commitment to treatment, either through community hospitals, through revocation of less restrictive alternatives or following the conclusion of the competency determination process and dismissal of charges.

Currently, inpatient beds in state-operated and community-operated settings are largely differentiated by their responsibilities to target short-term or long-term psychiatric needs. For example, individuals requiring 14-day

detention are often placed in an E&T center, with other types of beds reserved for longer detentions. In fiscal year 2015, 14,151 distinct individuals received an initial 72-hour involuntary treatment examination. Of these, 7,526 were detained and approximately 4,200 unique individuals were placed in one of the 14 E&T centers. As noted in Section 4.4, E&T centers typically require that admitted patients are medically stable; those who do not meet this requirement are more appropriately treated in a community hospital with psychiatric beds. As of December 1, 2015, there were 13 community hospitals in the state that were certified for involuntary admissions. These facilities staffed 453 beds at an average occupancy rate of 83 percent.[1] At that time, there were nine hospitals certified to admit those who voluntarily sought treatment. These hospitals staffed 151 beds with an average occupancy of about 68 percent.

The inadequacy of the state's current specialized infrastructure is evidenced by the growing use of single bed certifications to fill the gap. Under Washington Administrative Code section 388-865-0526, a single bed certification permits a licensed facility to admit and temporarily treat an individual even if that facility is not currently certified to treat involuntary patients.[2] Such facilities used single bed certifications to treat an average of 670 patients from October 2015 to March 2016. The number of hospitals holding single bed certifications increased from 36 in December 2014 to 62 in March 2016.[3] Following a 14-day detention, the court may order 90-day and 180-day extensions, as clinically appropriate. This decision occurs independent of BHO or FIMC organization involvement.

The forensic population of the state hospitals is not a focus of the present report, and will not be analyzed in detail except to note overall bed capacity in relation to current civil beds. One exception, however, is a significant sub-population among civil patients who have been involved with the criminal justice system, who are known within the system as "forensic flips." Forensic flips or "felony flips" refer to individuals who have had their felony charges dismissed because they have been found incompetent by a criminal court. A flip can occur if (1) the individual has received multiple rounds of restoration services and is determined "not restorable"; or (2) the parties and court have agreed that the person is not restorable and, therefore, have dismissed the charges without completing multiple restoration periods.[4] In such instances, the charges are dismissed without prejudice and the individual may be placed in the state psychiatric hospital for a civil commitment evaluation. The statute does not provide a specific timeframe for the person to be transported to the state hospital following dismissal of the charges, but state staff have indicated that the hospitals aim to transport patients as quickly as possible, generally within seven days or less.

Once the patient is admitted to the state hospital, s/he must be evaluated within 72 hours for purposes of filing a civil commitment petition. If a petition is not filed, the hospital must notify the prosecutor of its intent not to file a petition. If a petition is filed, a hearing must be held within ten days. At the hearing, a court will determine whether the individual meets criteria for civil commitment and, if so, an order for up to 180 days will be entered if the grounds for commitment include the felony grounds.[5] When the patient "flips," charges are dismissed without prejudice, allowing the court to re-charge the individual in the future, if the individual is determined to have become competent.

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[1] Washington State Institute for Public Policy, data received August 2016.
[2] Washington Administrative Codes at WAC 388-865-0500.
[3] https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/mental-health-reports
[4] See RCW 10.77.086(1)(c) and (4).
[5] See RCW 71.05.280(3); See also Detention of R.H., 316 P.3d 535 (2013).

4.3 Inpatient Bed Capacity and Utilization

As described in section 4.2, civil commitments for 72-hour detention and 14-day detention are typically carried out in freestanding E&Ts and community hospitals, while the longer commitment civil sentences (90-day and 180-day) are fulfilled in the two state adult psychiatric hospitals: Western State Hospital (WSH) and Eastern State Hospital (ESH.) In this section, we present some of the most important population and service characteristics of these two state hospitals, with the understanding that these facilities operate within a broader system of inpatient care, and the interventions and outcomes seen at these hospitals necessarily shape and are shaped by the character of treatment received at other inpatient settings within the system. The risk model is heavily focused on the long-term populations now served by WSH and ESH and its scope will be measured to a large degree by the number of individuals currently occupying civil beds within the two hospitals. However, to appreciate potential challenges in transitioning responsibility for these individuals to FIMC organizations, or the needed scale of community infrastructure, it is necessary to place state adult psychiatric hospital capacity and utilization within the context of the operational characteristics of the broader inpatient system.

A note on data is useful here. Given the fact that community inpatient capacity does not exist under a single payer or provider, it is difficult to acquire completely up-to-date data on the entire system. In reviewing overall system capacity and making direct comparisons between state and community facilities, PCG has relied on the most current state fiscal year (SFY) 2015-16 data available across the system. In instances in which only state facilities are under discussion, we have used the most recent data available from the Department of Social and Health Services (DSHS), which is typically state fiscal year 2017. In all cases, we cite year and data source to mitigate potential confusion regarding the relevant timeframe or slight discrepancies among statistics derived from different years.

Community Hospital and E&T Facility Utilization

This subsection will identify the relative capacity and utilization of community hospitals and freestanding E&T inpatient facilities. Freestanding E&T centers offer short term psychiatric treatment for high acuity patients who do not require additional physical health monitoring or treatment. E&T centers represent the first phase of inpatient treatment for many patients. As shown in Figure 4.1, these facilities are not intended to support longer lengths of stay, averaging 14 days for most patients. Involuntary 72-hour detentions and 14-day court-ordered commitments occur in this type of facility. Note that the number of beds for all but one of the facilities is limited to 16. Federal funding for Medicaid patients is limited to E&T facilities with 16 beds or less.

Figure 4.1 Freestanding Evaluation and Treatment Centers (CY 2015)

Facility name	City	Beds	Average daily census	Occupancy Rate*	Annual admissions	Average length of stay (days)
Thurston County E&T Center (BHR)	Olympia	15	13.9	93%	380	18.9
Telecare Recovery Partnership (Telecare)	Lakewood	16	15.6	98%	271	22.0
Snohomish (Compass Health)	Mukilteo	15	n/a	n/a	n/a	n/a
Navos Inpatient Services	Seattle	34	31.9	94%	755	15.6
Kitsap Mental Health Services - adult	Bremerton	15	14.7	98%	369	14.7
Greater Lakes Recovery Center (GHMC)	Parkland	16	15.5	97%	336	17.1
Foothills (Frontier Behavioral Health)	Spokane	16	15.0	94%	645**	8.6
Kalispell (Frontier Behavioral Health) *	Spokane	16	15.0	94%	645**	8.6
Clark County Telecare E& T Center	Vancouver	11	8.3	75%	261	11.8
Bridges (Comprehensive Mental Health)	Yakima	16	11.5	72%	405	10.4
Recovery Pathways (Recovery Innovations)	Lakewood	16	13.4	84%	231	21.7
North Sound Telecare E&T (Pioneer)	Wooley	16	13.7	86%	298	16.7
MDC Evaluation and Treatment Center	Tacoma	16	12.6	79%	210	18.9
Total		218	181.1	83%	4,806	14.2

*Approximated from available data
**Assumes even distribution of admissions to Foothills and Kalispell based on even distribution of beds. Data received for these facilities was combined.
Data Source: Washington State Institute for Public Policy Annual Report, 2015

Psychiatric units in community hospitals offer an additional resource for inpatient treatment for some patients. Unlike E&T centers, community hospitals can support patients with chronic medical conditions and other physical health needs in an inpatient setting. Figures 4.2 and 4.3 identify 21 community psychiatric hospital units providing certified involuntary and voluntary treatment beds. Two thirds of these units are owned by voluntary, non-profit (VNP) organizations. Occupancy rates for these units are lower overall than beds in state hospitals, supporting an average length of stay from five to 24 days. Costs per day for community hospitals are significantly higher than the cost per day for state hospital beds. Patients in voluntary treatment units typically experience considerably shorter lengths of stay than those in involuntary units.

Figure 4.2 Certified Involuntary Treatment Beds

Name	City	Hospital Ownership*	Total Beds	Average Daily Census	Occupancy Rate**	Annual Admissions	Average Length of Stay
Cascade Behavioral Health	Tukwila	P, C	48*	36.0	75%	825	16.6
Fairfax	Kirkland	P, C	107*	91.2	85%	3,352	10.2
Fairfax –Snohomish	Everett	P, C	30	24.2	81%	638	14.0
Harborview Medical Center	Seattle	G, County	61*	56.0	92%	1,285	16.1
Lourdes Counseling Center	Richland	VNP, Church	20	14.8	74%	535	10.2
Navos IMD (West Seattle)	Seattle	VNP, Other	40	36.8	92%	767	18.2
Northwest Hospital (geriatric)	Seattle	VNP, Other	27	24.0	89%	395	23.3
Peace Health St. John	Longview	VNP, Church	22	14.7	67%	611	9.0
Peace Health St. Joseph's	Bellingham	VNP, Church	20	14.6	73%	493	11.1
Providence Sacred Heart	Spokane	VNP, Church	28†	27.0	96%	1,027	9.8
Skagit Valley Memorial Hosp.	Mt. Vernon	G, Hospital	15	7.8	52%	346	8.3
Swedish Medical Center	Edmonds	VNP, Other	23	20.2	88%	523	14.6
Yakima Valley Memorial Hosp.	Yakima	VNP, Other	12^	8.9	74%	282	11.5
Total Certified Involuntary Treatment Beds			453	376.2	83%	11,079	12.7

*P = Proprietary, C=Corporation, G= Governmental, VNP = Voluntary Non-Profit
**Approximated from available data
Data Source: Washington State Institute for Public Policy Annual Report, 2015[6]

Figure 4.3 Certified Voluntary Treatment Beds

Name	City	Hospital Ownership Type*	Total Beds	Average Daily Census	Occupancy Rate**	Annual Admissions	Average Length of Stay
Auburn Regional (geriatric)	Auburn	VNP, Other	38	24.0	63%	442	20.5
Overlake Hospital Medical Center	Bellevue	VNP, Other	14	11.2	80%	836	4.9
Peace Health Southwest Washington	Vancouver	VNP, Other	14	12.7	91%	393	9.4
Providence St. Peter Hospital	Olympia	VNP, Church	17	15.9	94%	699	8.3
St. Joseph (CHI Franciscan)	Tacoma	VNP, Church	23	20.9	91%	1,167	6.5
Swedish Medical Center - Cherry Hill	Seattle	VNP, Other	10	9.6	96%	422	8.5
University of Washington	Seattle	G, State	14	9.9	71%	419	8.8
Cascade Behavioral Health (geriatric) ***	Tukwila	P, C	21				
Total Certified Voluntary Treatment Beds			151	104.2	69%	4,378	8.6

*P = Proprietary, C=Corporation, G= Governmental, VNP = Voluntary Non-Profit
**Approximated from available data
***Included in total Cascade data. Discrete information for voluntary geriatric beds not available.
Data Source: Washington State Institute for Public Policy Annual Report, 2015

State Hospital Utilization

This subsection will identify the relative capacity and utilization of the state adult psychiatric hospitals. As described in this section, state hospital civil commitments are typically reserved for patients with 90-day and 180-commitments, although ESH also accepts 14-day civil commitments in its E&T wing.

[6] Data is based on the 2015 Washington State Institute for Public Policy Annual Report, as this is the last complete set of adjudicated utilization data available. Additional beds have been added since 2015.

Figure 4.4 State Adult Psychiatric Hospital Bed Statistics

Bed Type		Eastern State Hospital				Western State Hospital			
		Bed Count	Average Daily Census	Occupancy Rate	Average Length of Stay (months)	Bed Count	Average Daily Census	Occupancy Rate	Average Length of Stay (months)
Forensic Beds	Competency Restoration*	49	39	80%	1.97	124	114	92%	2.07
	Forensic Evaluation	6	5	80%	1.97	7	6	92%	2.07
	NGRI**	70	59	84%	78.62	154	154	100%	39.44
	Total Forensic	125	103	83%	45.74	285	274	96%	23.00
Civil Beds	Habilitative Mental Health	10	10	100%	12.71	30	29	97%	22.45
	Adult Psychiatric	91	89	97%	3.13	414	407	98%	11.38
	Geropsychiatric	91	66	73%	3.86	113	110	98%	11.99
	Total Civil	192	165	86%	4.01	557	547	98%	12.09
Hospital Total		317	268	85%	4.39	842	821	98%	15.73

*Conditional release bed counts are combined with the Competency Restoration bed counts for Western State Hospital.
**Not Guilty by Reason of Insanity (NGRI) for Western State Hospital is composed of NGRI-only and NGRI + Competency Restoration bed types. In Eastern State Hospital, NGRI is composed of NGRI-only and NGRI + Conditional Release bed types.
Eastern State Hospital Data Source: OTB Solutions, Updated September 2016
Western State Hospital Data Source: OTB Solutions, Updated July 2016

Patient bed types are categorized as:

- Civil Beds
  - Adult Psychiatric: patients age 18-50
  - Geropsychiatric: adult patients over the age of 50[7]
  - Habilitative Mental Health: patients with developmental or intellectual disabilities
  - Other/unspecified: additional beds available contingent on appropriate staffing (Eastern State Hospital indicated that these beds may be used for evaluation and treatment as necessary.)

- Forensic Beds[8]
  - Forensic Evaluation: psychological evaluation to determine competency to stand trial
  - Competency Restoration: treatment intended to restore competency so that the individual may return to the criminal justice system
  - Not Guilty by Reason of Insanity (NGRI): court-rendered decision wherein the patient is treated for a period of time not to exceed the sentence that would have been applicable for the offense

To understand the relative need for each bed type, Figure 4.4 provides facility statistics from 2016 for Washington's two state adult psychiatric hospitals. Because capacity is "capped" based on availability of state

[7] Geropsychiatric categorization can vary widely among providers. State hospital sources indicated that 50 years old is there guideline for geropsychiatric. However other providers in the state and national may use more traditional guidelines, such as over 65.
[8] The list of forensic beds is limited to specific bed types at the state hospital. Jail-based and personal recognizance evaluations are not included here, though they may result in inpatient evaluations or admissions for competency restoration.

hospital beds, while occupancy represents the usage of available capacity it likely does not represent the full scope of need within the system. In addition to occupancy rates, the table also presents the average length of stay for patients according to each bed type.

Based on these statistics, both ESH and WSH operate at high occupancy rates: ESH operates at 86 and 83 percent capacity, respectively, for civil and forensic beds while WSH operates at 98 and 96 percent. Prevailing guidelines suggest that hospitals aim to achieve a maximum 85 percent occupancy rate, although recent literature suggests that occupancy below 85 percent may foster a safer psychiatric treatment milieu.[9] NGRI patients compose the majority of forensic patients for both hospitals, at nearly 60 percent of the forensic population, and have particularly long average stays: three years at WSH and 78 months at ESH.

For both hospitals, occupancy rates for civil patients are higher than for forensic across most categories. For ESH, habilitative mental health and adult (non-geriatric) psychiatric needs present the highest strain against the current bed count. These patients represent 60 percent of the average civil census and all but two beds were occupied as of September 2016. For WSH, adult psychiatric and geropsychiatric beds operate at 98 percent occupancy and represent 95 percent of the average civil census.

With the exception of habilitative mental health patients, the average civil patient remains in a state adult psychiatric hospital for one year or less per admission. Although representing a smaller portion of the total population, average length of stay for habilitative mental health patients is nearly twice that of other civil patients at WSH. The average length of stay across all civil beds at ESH is significantly lower than WSH, at 4.39 versus 15.73 months.

Note that the average lengths of stay for each bed type are based on the bed type from which the patient was discharged. Therefore, the lengths of stay included in the average for a bed type may include days that the patient spent in another bed type.

State Hospital Utilization by Civil Commitment Type

To further explore the utilization statistics of the civil commitment population in the state adult psychiatric hospitals, Figure 4.5 has summarized the discharge statistics for civil commitments from the state hospitals to represent the average and median length of stay (LOS) of these discharges.

[9] Teitelbaum, A. et al. 2016. Overcrowding in Psychiatric Wards is Associated with Increased Risk of Adverse Incidents. Med Care. 54(3):296-302

Figure 4.5 State Adult Psychiatric Hospital Civil Group Discharge Statistics, SFY2017

State Hospitals	Civil Groups	SFY2017		
		Discharges	Average LOS (Days)	Median LOS (Days)
ESH	*Forensic Flip*	67	207	154
	180 Day Court Commitment	240	194	114
	90 Day Court Commitment	86	38	36
	14 Day Court Commitment	5	25	17
	Other Civil	3	30	17
WSH	*Forensic Flip*	108	563	360
	180 Day Court Commitment	325	623	266
	90 Day Court Commitment	45	60	49
	Other Civil	1	8	8

State Hospital Data Source: DSHS DBHR, Behavior Health Service Summary Data, December 2017

According to the state adult psychiatric hospital civil group discharge statistics, 180-day commitments make up the majority of civil commitments in state hospitals, with 90-day commitments being significantly less at WSH when compared to ESH. In addition, at both hospitals the average LOS for the 90-day detention population is significantly less than the actual commitment term while for 180-day commitments the average LOS is longer – at WSH, more than three times longer. Also important to note is that the average LOS for forensic flips is comparable to that of 180-day commitments at both ESH and WSH.

Figure 4.6 below identifies the number of patients from each BHO that resided in the state adult psychiatric hospitals in state fiscal year 2017, broken out by civil commitment group. The significant variation in totals for each BHO is at least partly accounted for by differences in total population served and regionally available behavioral health services, including crisis services.

Figure 4.6 State Adult Psychiatric Hospital Civil Commitment Patients by BHO, SFY2017

SFY 2017			
BHO	Civil Groups	ESH	WSH
Southwest Washington Regional Service Area*	180 Day Court Commitment	-	52
	90 Day Court Commitment	-	4
	Forensic Flip	-	15
Greater Columbia	14 Day Court Commitment	1	-
	180 Day Court Commitment	84	2
	90 Day Court Commitment	20	-
	Forensic Flip	31	-
Great Rivers	180 Day Court Commitment	1	41
	90 Day Court Commitment	-	2
	Forensic Flip	1	16

SFY 2017			
BHO	Civil Groups	ESH	WSH
King	180 Day Court Commitment	4	283
	90 Day Court Commitment	-	15
	Forensic Flip	2	82
	Other Civil	-	1
North Central	180 Day Court Commitment	22	-
	90 Day Court Commitment	13	-
	Forensic Flip	19	-
North Sound	180 Day Court Commitment	1	148
	90 Day Court Commitment	1	15
	Forensic Flip	1	48
Optum Pierce	180 Day Court Commitment	1	102
	90 Day Court Commitment	-	9
	Forensic Flip	-	66
Salish	180 Day Court Commitment	-	56
	90 Day Court Commitment	-	3
	Forensic Flip	1	9
Spokane	14 Day Court Commitment	4	-
	180 Day Court Commitment	229	-
	90 Day Court Commitment	63	-
	Forensic Flip	55	1
	Other Civil	4	-
Thurston Mason	180 Day Court Commitment	2	50
	90 Day Court Commitment	2	9
	Forensic Flip	-	8
Total		562	1,037

*Includes data for all three entities operating in the Southwest Washington FIMC region: Molina, CHPW and Beacon
State Hospital Data Source: DSHS DBHR, Behavioral Health Service Summary Data, December 2017

4.4 Inpatient Psychiatric Populations in Washington State

Inpatient Diagnosis

Figure 4.7 compares the primary diagnoses of individuals receiving inpatient mental health services in Washington in 2015[10], organized by system-wide prevalence. Note that individuals originally treated in community hospitals and later admitted to a state hospital would be represented in both columns. In 2015,

[10] Note that this timeframe was used to the fact that only 2015 data was available for all inpatient beds across the system.

just over 1 percent of the approximately 180,000 individuals who received an outpatient service were also admitted to a state hospital.[11]

As illustrated in Figure 4.7, of all individuals admitted to the state adult psychiatric hospitals in 2015, 66.5 percent had a primary diagnosis of a psychotic disorder and 14.1 percent had a primary mania/bipolar diagnosis. The state hospitals also had a slightly higher drug-related diagnosis rate than other inpatient settings, amounting to roughly 5 percent of all admissions. Stakeholders interviewed for the 2016 mental health system report indicated that Washington lacks sufficient residential options for substance use disorder (SUD) patients, which may be a contributing factor to SUD-related admissions to state hospitals. Conversely, depression and anxiety are the two largest diagnoses encountered in outpatient programs.

This mix of diagnoses across facility types is consistent with observations in other states. Less than three percent of the state hospital population present with a primary diagnosis of dementia and less than 0.04 percent have a primary diagnosis of developmental disability. Community hospitals show a slightly lower percent presenting with dementia, at just over 1 percent and slightly higher incidence of developmental disability, at less than 0.42 percent. Although individuals with primary diagnoses of developmental disability and dementia are typically treated in facilities tailored to those specific needs, inpatient admissions are not uncommon for these patients, especially when the patient presents a suicide risk or is experiencing a crisis.[12] Lack of long-term facilities equipped to treat such patients likely also plays a role in their few but continuous admissions to the state hospitals.

Figure 4.7 Primary Mental Health Diagnosis at Admission or Intake by Facility Type, 2015

Calendar Year 2015	Community Hospitals	Evaluation & Treatment	Community Outpatient	State Hospitals
Diagnosis Category	% of Total	% of Total	% of Total	% of Total
Depression	26.5%	22.6%	34.5%	2.4%
Anxiety	3.0%	3.1%	23.3%	0.9%
Psychotic	32.1%	40.3%	9.9%	66.5%
Mania/Bipolar	22.9%	17.9%	9.7%	14.1%
Other/Unspecified/Misc.	2.4%	0.52%	13.1%	3.22%
Adjustment	1.6%	0.8%	3.5%	0.8%
Disrupt/Impulse/Conduct	1.7%	0.3%	2.3%	< .02%
ADHD	0.4%	0.3%	2.1%	< .02%
Drug Use	3.9%	1.3%	0.5%	4.6%
Delirium/Dementia	1.2%	< .02%	0.4%	2.4%
Alcohol Use	3.2%	0.3%	0.3%	0.9%
Missing	0.0%	11.9%	0.0%	3.4%
Personality	0.4%	< .02%	0.2%	< .02%
Pervasive Developmental	< .4%	< .02%	0.1%	< .02%

[11] Query search in System for Communicating Outcomes, Performance & Evaluation (SCOPE). See https://www.dshs.wa.gov/node/8941 Different state data sources provide different estimates of the number of persons receiving outpatient services.
[12] Ziegenbein, et al. BMC Health Serv Res. 2006; 6: 150.

Calendar Year 2015	Community Hospitals	Evaluation & Treatment	Community Outpatient	State Hospitals
Diagnosis Category	% of Total	% of Total	% of Total	% of Total
Developmental	< .02%	< .02%	0.0%	< .02%
Dissociative/Conversion	0.3%	< .02%	0.0%	0.0%
Eating Disorder	0.1%	0	0.0%	0.0%
Total Persons Served	7,767	4,379	179,373	2,814

Data Source: Data provided by the Department of Social and Health Services Research and Data Analysis team.

Although useful, diagnosis data alone provides limited insight into the appropriate treatment level required. Hospital administrators and other stakeholders have previously confirmed that there is no standardized acuity assessment across, or even within, these facilities. Thus, the acuity level of individuals with a psychotic disorder diagnosis in a community hospital cannot be directly compared to individuals with the same diagnosis in the state hospitals, E&T centers or served in an outpatient setting.

E&T centers have a high proportion of psychotic disorder and mania/bipolar patients. However, E&T centers are designed for short term stays with average length of stays of 8 to 22 days. About 55 percent of stays at community hospitals involve diagnoses of psychosis or mania/bipolar and one-quarter of all stays involve depression. The average length of stay in a community hospital's psychiatric unit in 2015 was 11.5 days. Community hospitals in general continue to provide an important treatment resource, providing approximately 183,000 days of psychiatric care in calendar year 2015.[13] However, as shown in Figure 4.4, the average length of stay for a civil patient at WSH in 2016 was over 12 months, far longer than the average stay at a community facility.

Regarding the civil commitment populations in the state hospitals, there is a very clear trend of prevalent diagnoses based on commitment type, with mood disorders such as depression and bi-polar disorders treated mainly on a short-term basis and diverted to non-state hospitals, while diagnoses requiring longer-term interventions, like psychosis, are more heavily concentrated among the populations with longer detentions. This trend is visible in Figure 4.8 on the next page.

[13] Washington State, Department of Health, Comprehensive Hospital Abstract Reporting System (CHARS) see http://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalDischargeDataCHARS

Figure 4.8 Primary Mental Health Diagnosis at State Adult Psychiatric Hospitals, SFY 2017

SFY 2017			
Patient Groups	Diagnosis Admission	ESH	WSH
14 Day Court Commitment	*Alcohol/Drug Abuse*	20.0%	-
	Mania/Bipolar	40.0%	-
	Psychotic	40.0%	-
90 Day Court Commitment	*Alcohol/Drug Abuse*	1.0%	0.0%
	Delirium/Dementia	5.1%	0.0%
	Depression	4.0%	3.5%
	Mania/Bipolar	19.2%	0.0%
	Other	32.3%	35.1%
	Psychotic	38.4%	61.4%
180 Day Court Commitment	*Alcohol/Drug Abuse*	0.9%	0.0%
	Anxiety	0.6%	0.0%
	Delirium/Dementia	2.3%	0.1%
	Depression	3.5%	0.4%
	Mania/Bipolar	7.3%	0.3%
	Missing	0.0%	0.1%
	Other	53.5%	15.2%
	Pervasive Developmental	0.0%	0.3%
	Psychotic	32.0%	83.5%
Forensic Flip	*Alcohol/Drug Abuse*	0.9%	0.8%
	Delirium/Dementia	2.7%	0.0%
	Depression	0.0%	0.8%
	Mania/Bipolar	6.4%	1.6%
	Other	64.5%	15.1%
	Psychotic	25.5%	81.6%

Data Source: State Hospital Administrative Data

The prevalence of psychotic diagnoses among patients of all civil commitment types is clearly demonstrated in the statistics in Figure 4.8 and is consistent with analysis that shows that patients with psychotic diagnoses are typically higher in acuity and require more care than those with less acute diagnoses, such as mania/bipolar and depression.

State Hospital Civil Commitment Demographics

Figure 4.9 shows the state hospital patient demographics by civil commitment type for patients that were discharged over the course of state fiscal year 2017. As you can see, a majority of civilly committed patients are male and represent a racial minority demographic. The average age at admission for the different commitment types at the two state hospitals ranges from 30 to 50 years old.

Figure 4.9 Civil Commitment Demographics in State Adult Psychiatric Hospitals, SFY 2017

State Hospitals	Civil Groups	SFY2017			
		Discharges	Age at Admission	Female	Minority
ESH	*Forensic to Civil Flip*	67	38	29.9%	46.3%
	180 Day Court Commitment	240	43	37.9%	27.1%
	90 Day Court Commitment	86	48	39.5%	20.9%
	14 Day Court Commitment	5	50	40.0%	0.0%
WSH	*Forensic to Civil Flip*	108	41	15.7%	53.7%
	180 Day Court Commitment	325	45	39.7%	31.7%
	90 Day Court Commitment	45	42	53.3%	20.0%

Data Source: DSHS Research and Data Analysis Division, Integrated Client Databases

Figure 4.10 Civil Commitment Medical Risk in State Adult Psychiatric Hospitals, SFY 2017

State Hospitals	Civil Groups	SFY2017	
		Patients	% with high medical risk score*
ESH	*Forensic to Civil Flip*	110	23.6%
	180 Day Court Commitment	344	48.5%
	90 Day Court Commitment	99	39.4%
	14 Day Court Commitment	5	20.0%
WSH	*Forensic to Civil Flip*	245	21.6%
	180 Day Court Commitment	735	46.9%
	90 Day Court Commitment	57	38.6%

* Received a DxRx risk score at or above the average level of health risk in the Disabled Medicaid population.
Data Source: DSHS Research and Data Analysis Division, Integrated Client Databases

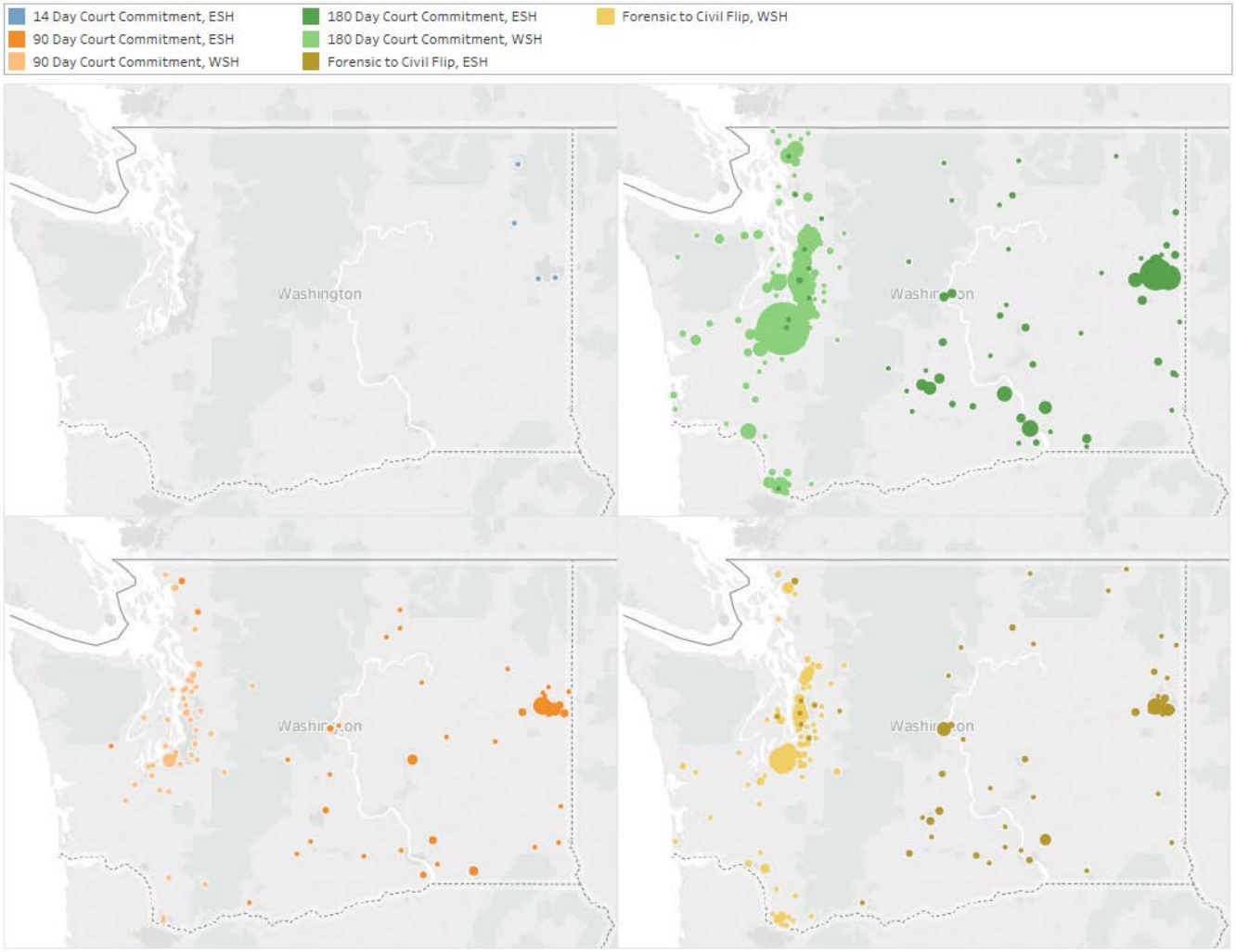
Figure 4.10 shows the percentage of patients by commitment type that present with a high medical risk score. For longer civil commitments in state hospitals, patients in those categories also experience significantly higher medical risk when compared to the short-term civil commitment patients. This data is consistent with the previous analysis on the diagnosis distribution and prevalence levels for patients with different civil commitment terms, where longer commitments were mainly patients with higher acuity diagnoses (i.e. psychotic) who experienced longer stays at the state hospitals.

State Hospital Civil Commitment Geographical Statistics

As geographic location can impact both access to services and the prevalence of chronic conditions, understanding where patient referrals originate can help identify potential areas of focus. State hospital admissions are divided geographically, with ESH serving the eastern region of the state and WSH serving the

western region. The figure below maps civil admissions by commitment type to ESH and WSH by patient zip code. The map presents total admissions for state fiscal year 2017.[14]

Figure 4.11 Civil Commitment Admissions, SFY 2017



Data Source: DSHS Research and Data Analysis Division, Integrated Client Databases

4.5 Payment for Inpatient Psychiatric Stays

For all inpatient psychiatric settings and facilities, daily bed rates are not differentiated among the various types of civil commitments (i.e. 72-hour, 14-day, 90-day, 180-day), or between civil and forensic commitments. For community hospital reimbursement rates, Washington establishes different psychiatric daily rates for patients covered under Medicaid and patients covered by the state. The figures on the next page identify the

[14] Note that residence zip code at admission is not reported to DBHR by the state hospitals. For the data provided here, the Research and Data Analysis (RDA) Client Services Data Base (CSDB) was used. CSDB includes administrative data for all people served by DSHS and HCA (among other state agencies). Using all available sources, geography is determined for a person within a date range, using an algorithm. Court data are not included in the process that establishes location.

Medicaid rates and state rates for each community hospital separately for the three (3) fiscal years that are included in this analysis.

Figure 4.12 State Adult Psychiatric Hospital Reimbursement Rates

Facility	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Western State Hospital	$541	$549	$715	$860
Eastern State Hospital	$611	$691	$812	$974

Data Source: DSHS DBHR, Behavioral Health Service Summary Data, December 2017

Figure 4.13 Community Hospital Medicaid Reimbursement Rates (Involuntary)

Name	City	Hospital Ownership*	SFY 2015 Rate	SFY 2016 Rate	SFY 2017 Rate	Average Length of Stay
Cascade Behavioral Health	Tukwila	P, C	$711.55	$789.95	$789.95	16.6
Fairfax	Kirkland	P, C	$789.95	$789.95	$789.95	10.2
Fairfax –Snohomish	Everett	P, C	$789.95	$789.95	$789.95	14.0
Harborview Medical Center	Seattle	G, County	$1,294.00	$1,294.00	$1,294.15	16.1
Lourdes Counseling Center	Richland	VNP, Church	$746.00	$746.00	$738.15	10.2
Navos IMD (West Seattle)	Seattle	VNP, Other	$789.95	$789.95	$789.95	18.2
Northwest Hospital (geriatric)	Seattle	VNP, Other	$1,088.00	$1,088.00	$1,087.57	23.3
Peace Health St. John	Longview	VNP, Church	$1,293.25	$1,293.25	$1,306.18	9.0
Peace Health St. Joseph's	Bellingham	VNP, Church	$1,001.56	$1,001.56	$1,011.58	11.1
Providence Sacred Heart	Spokane	VNP, Church	$891.41	$891.41	$900.32	9.8
Skagit Valley Memorial Hospital	Mt. Vernon	G, Hospital	$1,081.00	$1,070.19	$1,081.39	8.3
Swedish Medical Center	Edmonds	VNP, Other	$1,339.00	$1,339.00	$1,339.25	14.6
Yakima Valley Memorial Hospital	Yakima	VNP, Other	$1,010.54	$1,010.54	$1,020.65	11.5
Total Certified Involuntary Treatment Beds						12.7

*P = Proprietary, C=Corporation, G= Governmental, VNP = Voluntary Non-Profit
Data Source: https://www.hca.wa.gov/billers-providers/claims-and-billing/hospital-rates-and-billing-guides

Figure 4.14 Community Hospital Medicaid Reimbursement Rates (Voluntary)

Name	City	Hospital Ownership*	SFY 2015 Rate	SFY 2016 Rate	SFY 2017 Rate	Average Length of Stay
Auburn Regional (geriatric)	Auburn	VNP, Other	$711.55	$718.67	$718.67	20.5
Overlake Hospital Medical Center	Bellevue	VNP, Other	$948.08	$957.56	$957.56	4.9
Peace Health Southwest Washington	Vancouver	VNP, Other	$1,410.60	$1,424.71	$1,424.71	9.4
Providence St. Peter Hospital	Olympia	VNP, Church	$1,191.00	$1,191.00	$1,190.69	8.3
St. Joseph (CHI Franciscan)	Tacoma	VNP, Church	$1,271.75	$1,271.75	$1,284.47	6.5
Swedish Medical Center - Cherry Hill	Seattle	VNP, Other	$1,807.00	$1,788.93	$1,806.81	8.5
University of Washington	Seattle	G, State	$1,325.00	$1,325.00	$1,325.19	8.8
Cascade Behavioral Health (geriatric)	Tukwila	P, C	$711.55	$789.95	$789.95	
Total Certified Voluntary Treatment Beds						8.6

*P = Proprietary, C=Corporation, G= Governmental, VNP = Voluntary Non-Profit
Data Source: https://www.hca.wa.gov/billers-providers/claims-and-billing/hospital-rates-and-billing-guides

Figure 4.15 Community Hospital State (non-Medicaid) Reimbursement Rates (Involuntary)

Name	City	Hospital Ownership*	SFY 2015 Rate	SFY 2016 Rate	SFY 2017 Rate	Average Length of Stay
Cascade Behavioral Health	Tukwila	P, C	$605.10	$671.77	$671.78	16.6
Fairfax	Kirkland	P, C	$671.67	$671.67	$671.78	10.2
Fairfax –Snohomish	Everett	P, C	$671.67	$671.67	$671.78	14.0
Harborview Medical Center	Seattle	G, County	$1,101.13	$1,101.13	$1,100.55	16.1
Lourdes Counseling Center	Richland	VNP, Church	$634.57	$634.57	$627.72	10.2
Navos IMD (West Seattle)	Seattle	VNP, Other	$671.86	$671.86	$671.77	18.2
Northwest Hospital (geriatric)	Seattle	VNP, Other	$925.81	$925.81	$924.87	23.3
Peace Health St. John	Longview	VNP, Church	$1,100.24	$1,100.24	$1,110.78	9.0
Peace Health St. Joseph's	Bellingham	VNP, Church	$851.84	$851.84	$860.25	11.1
Providence Sacred Heart	Spokane	VNP, Church	$757.68	$757.68	$765.63	9.8
Skagit Valley Memorial Hosp.	Mt. Vernon	G, Hospital	$919.93	$910.73	$919.62	8.3
Swedish Medical Center	Edmonds	VNP, Other	$1,138.41	$1,138.41	$1,138.90	14.6
Yakima Valley Memorial Hosp.	Yakima	VNP, Other	$859.85	$859.85	$867.96	11.5
Total Certified Involuntary Treatment Beds						12.7

*P = Proprietary, C=Corporation, G= Governmental, VNP = Voluntary Non-Profit
Data Source: https://www.hca.wa.gov/billers-providers/claims-and-billing/hospital-rates-and-billing-guides

Figure 4.16 Community Hospital State (non-Medicaid) Reimbursement Rates (Voluntary)

Name	City	Hospital Ownership*	SFY 2015 Rate	SFY 2016 Rate	SFY 2017 Rate	Average Length of Stay
Auburn Regional (geriatric)	Auburn	VNP, Other	$605.10	$611.15	$611.16	20.5
Overlake Hospital Medical Center	Bellevue	VNP, Other	$805.82	$813.88	$814.31	4.9
Peace Health Southwest Washington	Vancouver	VNP, Other	$1,200.52	$1,212.53	$1,211.57	9.4
Providence St. Peter Hospital	Olympia	VNP, Church	$1,013.15	$1,013.15	$1,012.56	8.3
St. Joseph (CHI Franciscan)	Tacoma	VNP, Church	$1,081.65	$1,081.65	$1,092.31	6.5
Swedish Medical Center - Cherry Hill	Seattle	VNP, Other	$1,536.30	$1,520.94	$1,536.51	8.5
University of Washington	Seattle	G, State	$1,126.22	$1,126.22	$1,126.94	8.8
Cascade Behavioral Health (geriatric)	Tukwila	P, C	$605.10	$671.77	$671.78	
Total Certified Voluntary Treatment Beds						8.6

*P = Proprietary, C=Corporation, G= Governmental, VNP = Voluntary Non-Profit
Data Source: https://www.hca.wa.gov/billers-providers/claims-and-billing/hospital-rates-and-billing-guides

Figure 4.17 Freestanding E&T Reimbursement Rates

Facility name	City	Beds	SFY 2015 Rate*	SFY 2016 Rate*	SFY 2017 Rate*	Average length of stay (days)
Thurston County E&T Center (BHR)	Olympia	15				18.9
Telecare Recovery Partnership (Telecare)	Lakewood	16				22.0
Snohomish (Compass Health)	Mukilteo	15				n/a
Navos Inpatient Services	Seattle	34				15.6
Kitsap Mental Health Services - adult	Bremerton	15				14.7
Greater Lakes Recovery Center (GHMC)	Parkland	16				17.1
Foothills (Frontier Behavioral Health)	Spokane	16	$657.00	$801.00	$824.00	8.6
Kalispell (Frontier Behavioral Health)	Spokane	16				8.6
Clark County Telecare E& T Center	Vancouver	11				11.8
Bridges (Comprehensive Mental Health)	Yakima	16				10.4
Recovery Pathways (Recovery Innovations)	Lakewood	16				21.7
North Sound Telecare E&T (Pioneer)	Wooley	16				16.7
MDC Evaluation and Treatment Center	Tacoma	16				18.9
Total		218				14.2

*Trended statewide weighted average estimates. Individual E&T rates will vary according to specific contract terms with BHOs.
Data Source: Mercer documentation provided by the DSHS Research and Data Analysis team, December 2017

Overall, the daily bed rates for community hospitals are higher than the daily bed rates for the state adult psychiatric hospitals, while the daily bed rates for freestanding E&Ts are on par with the daily bed rates for the state adult psychiatric hospitals.

5. National Trends in Medicaid Managed Care for High Need Patients

5.1 Medicaid Managed Care for High Need Patients

Managed care is presently the most prominent delivery system for Medicaid programs. As managed care programs have proliferated, their scope of services has continued to expand. States are now moving more populations and services under managed care, creating ever more comprehensive risk-based models. Requiring mandatory managed care enrollment of subpopulations with special needs such as pregnant women, persons with intellectual and developmental disabilities (ID/DD), and adults with serious mental illness (SMI) has become more common. As of July 2016, the number of states now requiring mandatory Managed Care Organization (MCO) enrollment for these subpopulations is 28 for pregnant women, 10 for persons with ID/DD, and 16 for SMI adults[15]. Additionally, from fiscal year 2016 through 2017, 13 states added new populations under managed care either through voluntary or mandatory structures. Notably, long-term services and supports (LTSS) has seen a significant migration from the fee-for-service delivery system to managed care. In 2008, eight states had Medicaid LTSS (MLTSS) programs but by the end of 2016, 21 states had implemented or are preparing to implement such a program. [16]

MCO expansion is not just limited to adding new populations. States have been shifting behavioral health services from a carve-out to a carve-in model under managed care contracts. These behavioral health services include specialty outpatient mental health, inpatient mental health, outpatient substance use disorder (SUD), and inpatient SUD. Specific services within these categories may be carved in or out and vary by state. For example, a state may choose to carve in inpatient medical detoxification services but carve out non-medical detoxification and short-term residential treatment for SUD.

The overall trend of increasing the mandatory services and populations covered under managed care looks different for each state. When adding new populations or services under risk-based managed care, states have approached this differently in the structure, scope, and model of care. While Washington state is not new to introducing new populations or services under managed care, the following section provides lessons learned and examples on implementing managed care risk models for patients with complex needs.

5.2 Implementing Managed Care Risk Models for High Need Patients

Implementation of a new or expanded managed care risk model is particularly challenging when it involves a population with greater health care needs and higher costs. The implementation approach should consider having minimal impact on enrollees' continuity of services. Other impacted stakeholders, including MCOs, providers, and state agencies must appropriately plan, coordinate, and communicate to ensure success of implementation. Understanding the impact on and the roles and responsibilities of each stakeholder under a new risk model creates a foundation upon which the delivery system can run as intended. Below is a review of best practices and lessons learned on implementing risk-based models for high cost, high need patients.

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[15] https://www.kff.org/report-section/implementing-coverage-and-payment-initiatives-managed-care-initiatives/
[16] https://www.chcs.org/media/State-MLTSS-Considerations-for-D-SNP-Contracting-FINAL-updated.pdf

The integration of behavioral and physical health as well as the delivery of LTSS comes with unfamiliar territory for managed care. While these services have continued to emerge within managed care, challenges still exist for MCOs in understanding new populations and services and how to coordinate care with new provider types.[17] Below are lessons learned drawn from MLTSS and behavioral health integration efforts. They address considerations for state agencies, MCOs and providers.

- The state can encourage neutral conversations between the MCOs and providers to share information and business practices. This ideally would occur before contract negotiations and enable engagement that is educational and informative for both entities.
- When a new benefit or population is incorporated into managed care, having a designated specialist in this area should be listed as a requirement or at the least encouraged in MCO contracts. This person(s) would be the point of contact for providers and a subject matter expert for their colleagues.
- Establish Continuity of Care requirements with the MCOs to prevent members from experiencing disruption in care. This will allow members to continue with existing care plans prior to a benefit or population becoming effective under managed care. Additionally, providers will have a clear understanding of the funding stream for ongoing services provided to a patient. For example, in MLTSS implementation, a member is able to see their current provider (pre-managed care) for thirty days before switching to an in-network provider.
- Clear contract language included in the state agency and MCO contract can promote successful implementation. States can use contracts to encourage improved care coordination between the MCO and providers. Some states have required MCOs to subcontract with certain community providers, such as with BHOs or local behavioral health centers. Although this example is pertinent to states where behavioral health services are carved out of MCO contracts, they exemplify how the state has the flexibility to require MCOs to contract with certain providers to ensure they have a qualified network.
- The state agency can develop program monitoring and quality improvement measurements to track health outcomes of the focal population. States have noted there are a limited number of performance measures for behavioral health services.[18] The Healthcare Effectiveness Data and Information Set (HEDIS) is often relied on by states but these measures are often not as effective for high-need, high-cost members. Clinical outcomes such as HEDIS measures (e.g., follow up after 7 or 30 days after hospitalization for mental illness) can be used with measures that align with behavioral health efforts at the national level and for developing measures using national standards. Performance metrics are discussed more in detail in Section 6.2 Performance Metrics.

For MCOs, it is key to have a solid understanding of the new services and populations and to appropriately contract with providers to meet these new requirements.

- MCOs tend to be more familiar with a traditional health care model; therefore, an expansion of services and populations requires a different perspective and learning what works best in a new model of care. For example, some states' experience with transitioning to MLTSS found that MCOs had preconceived notions of the LTSS population as being comprised of frail seniors needing nursing

[17] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/transitioning-ltss.pdf
[18] http://www.integratedcareresourcecenter.com/PDFs/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf

home care. This perception made it difficult for MCOs to manage LTSS members who were younger and had disabilities.[19] As mentioned previously, forums between MCOs, new providers, and state agencies can help close knowledge gaps.

Shifting behavioral health services or LTSS under a managed care entity involves contracting with many providers to appropriately serve members. While carving in long term inpatient psychiatric care may not require as wide an array or as many providers, the impact on the service provider is still significant. Lessons learned from the perspective of the providers include:

- New providers should asses risk in contract negotiations. Accountability of patient outcomes is on the MCOs in their contract with the state and in turn the MCOs place accountability on providers in their subcontracts. Both sides understandably will try to limit their risks. Contract negotiations should focus on risk and consequences of the terms of the contract for non-compliance or not meeting performance measures and the impact that would have on the provider's operations and finances.
- Providers may be unfamiliar about contract requirements under managed care as they are used to the state's terms to receive payments. Generally, contracts between MCOs and providers include more requirements than contracts or agreements between the state and providers. Providers must identify new expectations and adapt to them to comply with contract requirements.
- Providers who operate on limited financial reserves require prompt payment as to not negatively impact their financial liability. MCOs may have stricter billing practices for claims and prior authorization, therefore providers may see delays on payment for services they have provided to members. Training from the MCO will be beneficial for timely payments to new providers.

5.3 Care Management Decisions in Managed Care for Civilly Committed Members

5.3.1 Care Decisions and the Civil Commitment Process

Medicaid managed care and civil commitments are each widely researched; however, they are generally addressed as independent topics and a limited amount of research exists discussing the relationship between the two.[20] As behavioral health services have become covered under managed care, questions have emerged concerning who is responsible for paying for court ordered treatment. States have regularly clarified in contracts and through legislation that a managed care entity is financially responsible for paying for behavioral health treatment ordered by the courts. However, the managed care entity's role in the legal process of civil commitment is less defined.

Examining how court ordered treatment has been addressed relative to the advent of behavioral health managed care offers a useful perspective from which to consider the issue. The same challenges and concerns cited in a 2000 report on civil commitments under managed care by the U.S. Department of Health and Human Services (HHS) are still relevant today. The report cites concerns regarding payment responsibility for civil commitments, who decides what type of treatment is necessary, and where the treatment is provided.

[19] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/transitioning-ltss.pdf
[20] Moran, G.E., Robins, C., & Kurzban, S. Civil commitment under medicaid managed care (DHHS Publication No. [SMA] 00-3455). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2000.

The report explores the relationships between states and managed care entities to see how concerns with civil commitments were addressed.[21] The study was conducted using a combination of methods including literature reviews, case studies of four states (Iowa, Colorado, Minnesota, and Wisconsin), contract analysis, and stakeholder interviews. The conclusions of the report emphasize (1) the importance of using contracts as a way to address fiscal responsibility and avoid cost-shifting possibilities by the MCO; (2) the benefits of collaboration between the courts and MCOs to potentially reduce the incidence of court-ordered inpatient services, (3) the impact of restrictive medical necessity policies resulting in denial of payment for services; and, (4) the importance of a comprehensive system of community-based supports in reducing the need for civil commitments.

Especially relevant is the report's conclusion on the MCO's role in the civil commitment process, particularly if the entity is responsible for payment of court-ordered services. To avoid MCOs denying payment of court ordered services, states included clear provisions on the types of services and the populations for which the MCO bore financial responsibility and broadened the definition of medical necessity. Once the payment role of an MCO is defined, the next consideration is what, if any, role an MCO would have on the legal components of the civil commitment process. The civil commitment process is prescribed by a state's regulations and codes. A judge ultimately decides whether a person requires treatment, the type of treatment and where it will occur. Each state has variations in how this legal process proceeds, but the decision is generally made either independent of or with limited MCO engagement. If a state wants the MCO to engage in any way with the courts, it must work within the civil commitment regulations to define an appropriate role for the MCO.

The level of engagement of the MCOs as defined in their contracts for the four case study states were each different. Iowa required two court liaisons to be employed by an MCO, Colorado encouraged its MCO to work with the judiciary, Minnesota allows MCO participation in the treatment decision if the MCO is the payer, and Wisconsin allows MCO representatives to provide education to judges. The report found that MCO collaboration and coordination with the courts allows for judges to better understand treatment options and settings which may result in treatment in less restrictive settings.

The approach a state chooses can depend on several factors. If the MCO is financially responsible for court-ordered treatment, the state may choose to involve the MCO but may limit its role to providing information to the courts rather than directly influencing decisions. Moreover, state regulations and codes may include specific language prescribing the roles of the parties involved in the civil commitment process; hence, an MCO's exclusion from the legal components is also seen in contract requirements to align with the regulation. Additionally, if the state has not experienced issues or challenges related to MCO involvement in the civil commitment process, they may opt not to address this topic in contracts.

Minnesota exemplifies how statute and contract language align with one another to make clear the role of an MCO in the civil commitment process. Minnesota Statute 253B.07 clarifies that the pre-petition screening investigation must include "…input from the proposed patient's health plan company to provide the court with information about services the enrollee needs and the least restrictive alternatives." Furthermore, Minnesota's MCO contracts require that the entity "work with hospitals, pre-petition screening teams, family

[21] Moran, G.E., Robins, C., & Kurzban, S. Civil commitment under medicaid managed care (DHHS Publication No. [SMA] 00-3455). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2000.

members, and current providers to assess the enrollee and develop an individual care plan that includes diversion planning and least restrictive alternatives with the Commitment Act. This may include testifying in court and preparing and providing requested documentation. Report to the court regarding enrollee's care plan status and recommendations for continued commitment, including as needed, requests to the court for reconvocation for a provision discharge. Provide input to court appointed independent examiners."

A review of current behavioral health managed care contracts[22] suggests that contract language is relatively consistent with what was used in the early phases of behavioral health managed care. States have generally addressed the MCO role in the civil commitment process in one of the following ways:

- The contract remains silent on the role of the MCO, therefore the MCO plays a passive role and is not involved in the civil commitment process in any way, even if some court-ordered treatment is the financial responsibility of the MCO.
- The contract simply encourages an MCO to coordinate with the courts. The MCO has the flexibility to choose on a case-by-case basis whether to engage with the judiciary.
- The contract requires the MCO to coordinate with the courts when a member is under review for civil commitment. This may be structured in a few ways: the MCO may be required to provide input on treatment plans, employ court liaisons, or have designated staff who provide legal and technical assistance for and coordinate with the judiciary.

In Washington's FIMC model, much of this work is carried out by the ASO who coordinates directly with the courts. The FIMC organizations are the payer for treatment services when those are court-ordered but are not responsible for the initial court engagement.

It should be noted that in all cases MCO involvement is restricted to no more than an informative and coordinating role - the courts make treatment decisions independently. However, these examples offer some precedence for how states might determine the level of MCO engagement in the civil commitment process. The state may determine the appropriate role of the MCO by reviewing state regulations, payment authority, and how to effectively coordinate care for patients in the appropriate settings.

5.3.2 MCO Role: Clinical Decisions in the Discharge Process for Members Civilly Committed to State Hospitals

PCG addressed state hospital discharge best practices in its Initial Findings Report for the Washington Mental Health System Assessment completed in October of 2016. This report specifically addresses the discharge process as it relates to the MCO's required role and relationship with the hospitals. Accordingly, key findings from the previous report are included here but are expanded upon with new research along with more specific information on the role of an MCO in the discharge process.

Discharge planning is ideally a collaborative effort among parties including the patient, his or her treatment team, other hospital staff and those who will have some responsibility for the care of the patient at discharge. Effective discharge planning is best initiated at the time of admission and state hospital discharge guidelines

[22] MCE behavioral health contracts (2017) from the following states were reviewed: Tennessee, Colorado, Minnesota, Iowa, and Kentucky.

generally require this as standard practice. That said, neither the specific elements of discharge planning nor the parties involved are always standardized.

The patient and his or her unique needs and preferences must be at the center of the discharge planning process. Cultural and linguistic competency in discharge planning is frequently cited in guidance as a determinant of successful discharge planning and thus early identification of the need for translators, peers or other individuals who can help address and work through communication barriers is of utmost importance. The treatment team - which may include the psychiatrist, psychologist, counselor, social worker, case manager, peer specialist and others - will play a major role in developing the discharge plan. Beyond that, other parties that may be appropriate for participation include relatives and friends, external peer support specialists and representatives from community programs and agencies that will or might play a role in supporting the client's health care or other needs in the community at discharge.

Certain conditions or circumstances may pose particular barriers to successful discharge; among these are the presence of co-occurring disorders requiring more complex care, behavioral problems, individuals living in poverty and those lacking family, friends or other support persons nearby that can participate in the discharge planning process and help support a successful transition to the community.

Federal guidance related to psychiatric discharge planning is limited although guidelines issued by HHS' Medicare Learning Network in 2014 note that the process should address anticipated problems after discharge and suggested means for intervention including: accessibility and availability of community resources and support systems, including transportation; accessibility and availability of medications and counseling by a pharmacist; and special needs related to the patient's functional ability to participate in aftercare planning.[23]

An increasing number of resources and programs focused on effective discharge planning, including specific to psychiatric hospitalization, are available to assist with designing or refining the process. One of the more widely praised models is the Re-Engineered Discharge (RED) program developed at Boston University Medical Center and adapted into a toolkit for the Agency for Healthcare Research and Quality (AHRQ.) The toolkit addresses the essential elements of successful discharge planning from the point of admission until well after discharge and offers step-by-step instructions for introducing new discharge planning processes to staff and patients, and implementation and outcome measures and tools to be in used in conjunction with patients as part of the process. RED meets Joint Commission standards, is endorsed by CMS and has shown proven results in reduced hospital readmissions and emergency room visits.[24]

A 2012 study on care transition interventions in mental health identified nine key themes from a review of multiple intervention models: prospective modeling, patient and family engagement, transition planning, care pathways, information transfer/personal health records, transition coaches/agents, provider engagement, quality metrics and feedback.[25] While addressing broader considerations, the model contains many components that have clear implications related to discharge planning and is designed to ensure that care and support for the needs of psychiatric patients is as effective as possible prior to, during and after hospitalization.

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[23] "Discharge Planning." U.S. Department of Health and Human Services Learning Network. ICN 908184. October 2014

[24] Jack BW, Paasche-Orlow MK, Mitchell SM, et al. An overview of the Re-Engineered Discharge (RED) Toolkit. (Prepared by Boston University under Contract No. HHSA290200600012i.) Rockville, MD: Agency for Healthcare Research and Quality; March 2013. AHRQ Publication No. 12(13)-0084.

[25] https://www.integration.samhsa.gov/Care_transition_interventions_in_mental_health.pdf

A 2011 AHRQ Statistical Brief analyzing 30-day rehospitalization rates among Medicaid enrollees found that two of the top ten conditions with the highest number of readmissions were for enrollees with mental health conditions and an additional two were for enrollees with substance use disorders. Effective discharge processes and planning can reduce readmissions and result in cost savings. Issues related to proper discharge and readmission prevention are whether incentives exist to discharge patients quickly and if comprehensive services are available in the community. Both the National Association of State Mental Health Program Directors (NASMHPD) and the Substance Abuse and Mental Health Services Administration (SAMHSA) provide assessments of effective discharge and transition frameworks across states.[26] In the SAMHSA report, the idea of shared accountability is described for patients discharging from the hospital and transitioning to outpatient care. The shared accountability applies to inpatient and outpatient providers as well as clinical organizations and payers.

Another effective component of discharge practice is information transfer/personal health records for communication between different entities including providers, clinics and payers. The pathway to share information must be established, privacy regulations followed, and protocols agreed upon by all parties.[27] This allows for efficiency and clear communication of patient needs across the care continuum. Other frameworks include a three-stage approach in which a caseworker, such as nurse or social worker, works with patients, hospitals, and providers during pre-discharge, post-discharge and follow-up. This approach helps the caseworker to identify risks and needs early on, work with patients on transitions, and track a patient's progress to address emerging needs. In a managed care environment, the identified case worker would be employed by the MCO and work in collaboration with the hospital and patient.

These frameworks provide value for stakeholders to effectively discharge patients at the right time to the right setting. However, the precise role of the MCO is not defined, particularly when it comes to long term inpatient psychiatric care. Discharge decisions for civil commitments vary by state; in some states, the hospital is responsible for the clinical decision of when a patient is ready for discharge while in other states separate boards make formal recommendations to the courts on patient discharge readiness. As previously noted, the MCO role in discharge and transition processes is often addressed in its contract with the state. A pattern of MCO coordination with psychiatric hospitals is consistently seen in a review of several state MCO behavioral health contracts:

- Minnesota requires the MCO to provide mental health case management coverage which includes discharge planning. This work should not be duplicative of the hospital's activities but rather coordinated with the hospital.
- Kentucky has several contractual requirements for MCOs in the discharge process. The MCO must coordinate with several stakeholders, including the state-operated or state-contracted psychiatric hospitals, behavioral health providers, and nursing facilities regarding admission, discharge, and treatment objectives. Also, MCOs are expected to enter into a collaborative agreement with the state-operated or state-contracted psychiatric hospital assigned to their region. Accordingly, the MCO must participate in quarterly Continuity of Care meetings facilitated by the hospital.

[26]https://www.nasmhpd.org/sites/default/files/Assessment%20%233_Care%20Transitions%20Interventions%20toReduce%20Psychiatric%20Rehospitalization.pdf
[27] Ibid.

- Tennessee's contract language is less comprehensive, stating that the MCO will evaluate members discharged from psychiatric inpatient hospitals for mental health and substance abuse services and provide behavioral health follow-up services, as appropriate.
- Colorado's contract provisions define a clear role for MCOs to work with state psychiatric hospitals to discharge patients. The MCO must establish policies, procedures, and strategies for helping to transition members from an institutionalized setting to alternative environments. In addition, the MCO must engage and coordinate with the state hospitals to plan for medically necessary covered services upon member discharge and have a liaison to serve as the point of contact with the state hospital staff. The responsibilities of the liaison include participating in monthly or as requested treatment planning meetings with the state hospital, discharge planning meetings, face-to-face planning with members, and timely communication with treatment providers in the community.

Washington currently requires BHOs and FIMC organizations to engage with state psychiatric hospitals on discharge planning. This is described in Section 9.3.10.

Overall, how comprehensive and engaged the MCO is during the discharge process varies. State regulations may require that the hospital or another entity make the ultimate clinical decision on a patient's discharge readiness. Drawing from best practices, the role of the MCO is to work consistently with the hospital and patient from the time of admission to begin discharge and transition planning. This helps to ensure timely discharge by identifying early on what the patient's needs are and the level of care and types of services that he or she will require post-discharge.

6. Regulatory Analysis

6.1 Review of State and Federal Managed Care Laws and Regulations

6.1.1 Contracting Requirements Among MCEs, State Psychiatric Hospitals and Community Hospitals

Provider contracting requirements extend to hospitals including state-operated psychiatric hospitals and community hospitals. 42 CFR 434.6 provides general requirements for all contracts and subcontracts related to Medicaid managed care. Contracts must meet the following specifications:

> (1) Include provisions that define a sound and complete procurement contract, as required by 45 CFR part 75.
> (2) Identify the population covered by the contract.
> (3) Specify any procedures for enrollment or reenrollment of the covered population.
> (4) Specify the amount, duration, and scope of medical services to be provided or paid for.
> (5) Provide that the agency and HHS may evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under the contract.
> (6) Specify procedures and criteria for terminating the contract, including a requirement that the contractor promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.
> (7) Provide that the contractor maintains an appropriate record system for services to enrolled beneficiaries.
> (8) Provide that the contractor safeguards information about beneficiaries as required by part 431, subpart F of this chapter.
> (9) Specify any activities to be performed by the contractor that are related to third party liability requirements in part 433, subpart D of this chapter.
> (10) Specify which functions may be subcontracted.
> (11) Provide that any subcontracts meet the requirements of paragraph (b) of this section.
> (12) Specify the following:
>> (i) No payment will be made by the contractor to a provider for provider-preventable conditions, as identified in the State plan.
>> (ii) The contractor will require that all providers agree to comply with the reporting requirements in § 447.26(d) of this subchapter as a condition of payment from the contractor.
>> (iii) The contractor will comply with such reporting requirements to the extent the contractor directly furnishes services.

Additionally, 42 CFR 438.230(2)(c) describes the sub-contractual relationships and delegation for managed care entities and providers. Contracts and written agreements between the MCO and any subcontractor must meet the following requirements:

> (i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.
> (ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, PAHP's, or PCCM entity's contract obligations.

(iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, PAHP, or PCCM entity determine that the subcontractor has not performed satisfactorily.

Furthermore, MCOs would need to comply with 42 CFR 438.214 on provider selection. The MCO "must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment." This is particularly relevant since under the risk model, the state hospitals and selected community hospitals would be treating patients with a high degree of need and risk.

Another consideration for the state is whether to include specific language in the contract between the MCO and the procuring state agency that requires the MCO to subcontract with certain hospitals, the intent of which would be to ensure that the MCO has sufficient network capacity to meet the demand for inpatient psychiatric beds. Michigan and Texas have such provisions in contracts with their MCOs. Michigan requires its MCO to subcontract with county BHOs while Texas requires its MCOs to subcontract with local mental health authorities.[28] This required relationship leverages the historical knowledge and services of one entity to more effectively manage care and to ensure maintenance of a qualified network by the MCO.

6.1.2 MCE Benchmarks on State Psychiatric Hospitals and Community Hospitals

42 CFR 438.6(c)(1) describes provider payment initiatives and allows MCOs to implement value-based purchasing models, such as performance arrangements and bundled payments, for provider reimbursement. This is intended to place focus on value and outcomes as opposed to service volume. The payment arrangement must go through an approval process set forth in 42 CFR 438.6(c)(2). Specific value-based purchasing models include[29]:

- Bundled Payments: this model pays providers based on episode of care. The amount per episode type includes services to treat a specific condition or for a specific treatment. This model promotes coordination of care and incentivizes hospitals to provide care at or below the payment amount for the episode of care.
- Shared Savings/Risk: this model provides incentives for provider entities to keep costs below projected costs for a defined patient population. A portion of the realized savings is offered to those provider entities that succeed in keeping costs low.
- Rewards: this model incentivizes provider entities to meet targets for performance measures, quality measures, patient satisfaction, and costs. Meeting or exceeding targets and showing improvement results in bonuses.
- Penalties: this model directly penalizes provider entities deemed to provide a low quality of care. Lower or no payments are offered if certain standards in care are not met.
- Global Payment: this model pays provider entities on a per-member-per-month arrangement. The amount is intended to cover a range of services for the member and the provider entity bears the financial risk for costs of services that exceed the payment amount.

[28] http://www.integratedcareresourcecenter.com/PDFs/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf
[29] https://www.chcs.org/media/VBP-Brief_022216_FINAL.pdf

The above performance arrangements can be paired with measures that hospitals would be responsible for tracking and reporting. For example, Medicare has the Hospital Value-Based Purchasing (VBP) Program in which payments can be withheld and are based on both how well the hospital performed compared to others and how much the hospital improved as compared to the previous baseline period.[30] Performance is assessed using the following measure outcomes: mortality and complications, health care-associated infection, patient safety, patient experience, process, and efficiency and cost reduction. For inpatient psychiatric care, examples of specific measures to track can be found in the Manual for Joint Commission National Quality Measures.[31] Measures identified for hospital-based inpatient psychiatric services are listed in Figure 6.1.

Figure 6.1 Measures for Hospital Based Inpatient Psychiatric Services (Manual for Joint Commission National Quality Measures)

Measure Name	Description	Improvement Noted As:
Appropriate Justification for Multiple Antipsychotic Medications	Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification	Increase in the rate
Hours of Physical Restraint Use	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint	Decrease in the rate
Hours of Seclusion Use	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion	Decrease in the rate
Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed	Patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of admission for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths.	Increase in the rate

A number of data elements are used to appropriately assess performance on the measures listed in Table 6.1. These elements are: appropriate justification for multiple antipsychotic medications, discharge disposition, event date, event type, minutes of physical restraint, minutes of seclusion, number of antipsychotic medications prescribed at discharge, patient status at discharge, patient strengths, psychiatric inpatient days, psychological trauma history, substance use, total leave days, violence to others, and violence to self.

6.2 Performance Metrics

Performance metrics may be used to incentivize MCOs to manage patients in the community such that the need for long-term inpatient psychiatric hospital admission is lessened. States can use the same methods employed for physical health to incentivize MCOs to meet performance and quality targets for behavioral

[30] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html
[31] https://manual.jointcommission.org/releases/TJC2017B1/HospitalBasedInpatientPsychiatricServices.html#Set_Measures

health services including a new benefit such as long-term inpatient psychiatric care. 42 CFR 438.6 addresses incentive, risk-sharing and withhold arrangements. Incentive arrangements allow states to provide additional funds to MCOs above the capitation rate for meeting specified targets. States may provide payment in the amount of no more than 105 percent of the capitation rate. Incentive arrangements must be structured as follows:

- be for a fixed period of time;
- not be automatically renewable;
- be made available to public and private contractors under the same terms of performance;
- not be conditioned on an intergovernmental transfer (IGT) agreement; and,
- be necessary for the specified activities, targets, performance measures or quality-based outcomes that support program initiatives specified in the quality strategy at 42 CFR 438.340.

A withhold arrangement can also be established by a state to promote targets being met by MCOs. A withhold arrangement allows the state to hold a portion of a capitation rate and release it upon the MCO meeting specified targets. The capitation payment minus any portion of the withhold that is not reasonably achievable must be actuarially sound. The total withhold must be reasonable and account for the entity's operating needs taking into consideration enumerated factors. Withhold arrangements must be structured according to the same requirements as for incentive arrangements.

With each performance payment arrangement, the state will need to choose performance metrics that are in alignment with the state's quality strategy. There are three types of measures[32]:

- Outcome: this measure assesses results of care (e.g., percent of patients adhering to antipsychotic medication)
- Process: this measure evaluates an action taken (e.g., percent of patients that had a follow-up visit within seven days of psychiatric hospital discharge)
- Structural Measures: this measure assesses the setting and operations in providing and coordinating patient care (e.g., electronic health record implemented)

Related to behavioral health, performance measures across the three types are still evolving and their use is still expanding. A Health Affairs study on quality measures in behavioral health, which identified gaps, opportunities and challenges on this subject found that recommended behavioral health care was obtained less than half of the time by patients.[33] This measure was based on Healthcare Effectiveness Data and Information Set (HEDIS) reports from commercial health plans. The study reviewed behavioral health quality measures and found that only a limited number of measures are used and recommended a coordinated effort to increase the investment on developing, evaluating, and implementing behavioral health measures. As few behavioral health measures are widely implemented, states have drawn measures mainly from HEDIS.

Other behavioral health measures and quality standards are recommended or proposed by other sources, such as the National Quality Forum's (NQF) endorsed behavioral health measures and the Medicaid Adult Core Set. States can align their MCOs' performance monitoring with these broader national efforts in order to track

[32] https://nashp.org/wp-content/uploads/2017/01/Measuring-Integration-Brief.pdf
[33] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0027

the quality of behavioral health and improve patient outcomes. Figure 6.2 provides a list of behavioral health measures included in HEDIS and/or the Medicaid Adult Core Set. Those measures that are NQF endorsed are indicated as such. Of note, although the risk model discussed in this report relates to coverage specifically for long-term inpatient civil commitments, measures related to adult behavioral health are still presented as preventative services along the care continuum and may reduce inpatient hospitalizations and readmissions and promote diversion from hospitals. Additionally, a full list of NQF identified behavioral health measures is available in Appendix A. States may want to review measures annually as behavioral health measures continue to emerge and become recognized nationally.

Figure 6.2. Behavioral Health Measures found in HEDIS and the Medicaid Adult Core Set

Measure	Measure Set	Steward
Antidepressant Medication Management	HEDIS 2018[34], Medicaid Adult Core Set 2018[35]	NCQA
Follow-Up After Hospitalization for Mental Illness (7 and 30 days)	HEDIS 2018, Medicaid Adult Core Set 2018, NQF endorsed[36]	NCQA
Follow-Up After Emergency Department visit for Mental Illness	HEDIS 2018	NCQA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS 2018, Medicaid Adult Core Set 2018	NCQA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS 2018, Medicaid Adult Core Set 2018, NQF endorsed	NCQA
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS 2018, NQF endorsed	NCQA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	HEDIS 2018, Medicaid Adult Core Set 2018, NQF endorsed	NCQA
Annual Monitoring for Patients on Persistent Medication	HEDIS 2018	NCQA
Use of Opioids at High Dosage	HEDIS 2018	NCQA
Use of Opioids from Multiple Providers	HEDIS 2018	NCQA
Initiation of Engagement and Alcohol and Other Drug Abuse or Dependence Treatment	HEDIS 2018, Medicaid Adult Core Set 2018, NQF endorsed	NCQA
Identification of Alcohol and Other Drug Services	HEDIS 2018	NCQA
Mental Health Utilization	HEDIS 2018	NCQA
Depression Screening and Follow-Up for Adolescents and Adults	HEDIS 2018	NCQA
Utilization of the PHQ-9 to Monitor Depression Symptom for Adolescents and Adults	HEDIS 2018	NCQA

[34] https://www.ncqa.org/Portals/0/HEDISQM/HEDIS2018/HEDIS%202018%20Measures.pdf?ver=2017-06-28-134644-370
[35] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-adult-core-set.pdf
[36] http://www.qualityforum.org/ProjectDescription.aspx?projectID=69293

Measure	Measure Set	Steward
Depression Remission or Response for Adolescents and Adults	HEDIS 2018	NCQA
Unhealthy Alcohol Use Screening and Follow-Up	HEDIS 2018	NCQA
Medical Assistance with Smoking and Tobacco Use Cessation	Medicaid Adult Core Set 2018, NQF endorsed	NCQA
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Medicaid Adult Core Set 2018	Pharmacy Quality Alliance
Concurrent Use of Opioids and Benzodiazepines	Medicaid Adult Core Set 2018	Pharmacy Quality Alliance

Additionally, a review of other states' MCO contracts reveals additional behavioral health measures.[37] Measures not included in the above table include:

- average length of stay in psychiatric hospital;
- readmission rate;
- days per 1,000;
- admits per 1,000;
- inpatient utilization (per 1,000 members);
- inpatient services exceeding $50,000;
- community tenure (average # of days between MH hospitalization per contract period shall not fall below 94 days);
- integrated services and supports (at least 18% of MH expenditures used for integrated services);
- treatment of the dually diagnosed (25% receive mental health and substance abuse treatment follow up within 7 days, 50% within 30 days); and,
- mental health discharge plan (discharge plan on day of discharge for 90% of enrollees.)

States could also develop their own measures to fill any gaps they see in their state's behavioral health services. The National Quality Form has a framework with five criteria to develop measures: (1) Importance to Measure and Report; (2) Scientific Acceptability of Measure Properties; (3) Feasibility; (4) Usability and Use; and (5) Related and Competing Measures. This framework is beneficial for states to address the needs of their particular state and test measures that have the potential to improve health outcomes and quality.

Ultimately, performance measure requirements are chosen for a number of reasons, including measures states find they need to improve upon, the capability of entities to report on measures, and what other reporting requirements are already in place. A state additionally must consider its quality strategy and choose measures

[37] https://www.machc.com/sites/default/files/documents/CHCS%20BH%20Models%20Matrix%2006042012.pdf
Other state behavioral health managed care contracts reviewed include: Oregon, Colorado, and Maryland.

that best align with it. For a list of performance metrics included in Washington's current FIMC organization contracts, please refer to Appendix B.

7. Washington State Perspective

7.1 Stakeholder Input

Stakeholder input is vital to ensuring a comprehensive understanding of the health care system and developing thoughtful and informed recommendations. To that end, Public Consulting Group (PCG) conducted a series of stakeholder interviews in November of 2017 with individuals having direct involvement in Washington's behavioral health system. Stakeholders were identified by the state and included representatives of the following:

- State agencies including the Department of State Health Services (DSHS), Health Care Authority (HCA) and Office of Financial Management (OFM)
- Behavioral Health Organizations (BHOs)
- Fully Integrated Managed Care (FIMC) organizations
- Provider organizations
- Washington State Hospital Association
- Office of the Governor
- Legislative staff
- Tribal representatives

The stakeholder interview guide and feedback matrix can be found in Appendices C and D.

Worth stating at the outset is that stakeholders generally were in favor of a new model for managing care for civilly committed patients, almost uniformly acknowledging that the existing bed allocation model has not worked as intended and may create financial and other incentives for BHOs and FIMC organizations to rely too heavily on inpatient care at the state hospitals. However, stakeholders emphasized the critical importance of ensuring that the new model is comprehensive and well informed, designed and executed in order to increase the likelihood of its success. With that in mind, major areas of stakeholder input, including particular considerations and concerns, are identified and summarized below.

Community Capacity

An overwhelming concern among stakeholders was the issue of capacity for handling civil commitments outside of the two state adult psychiatric hospitals. Most believe that sufficient capacity does not exist and many suggested that building this capacity will take several years and require significant investment of time, money and community building on the part of state and FIMC organization representatives. BHO representatives also pointed out that developing community-based facilities to handle civil commitments will likely require significant community relationship and trust building due to the sensitive nature of the undertaking and that sufficient time for this to occur must be accounted for. Perhaps in acknowledgment of these challenges, DSHS received only three responses to an informal request for information issued in November designed to gauge potential interest among licensed community hospitals and evaluation and

treatment centers (E&Ts) in contracting with the state to provide long term inpatient psychiatric care for civilly committed adult patients.

Regarding financial considerations, stakeholders pointed to the requirements associated with building physical capacity and suggested that this would likely be a challenge and may be unappealing to FIMC organizations. First, building or retrofitting a facility requires significant capital investment that may not be readily available or which FIMC organizations (or other entities) may be hesitant to invest due to uncertainty around return on investment. Existing facilities that could potentially add capacity often have major infrastructure and design issues to contend with in order to support the needs of patients committed to longer terms of stay.

Several of those interviewed questioned whether it is actually less expensive to treat civilly committed patients in community-based facilities rather than at the two state hospitals once facility, staffing, equipment and other considerations are fully accounted for. One stakeholder suggested that the economies of scale at Western and Eastern State Hospitals would be very difficult to replicate in smaller facilities, particularly those with only 16 beds. Further, securing adequate staffing at psychiatric hospitals is an issue statewide and stakeholders reported that some newer, privately operated inpatient psychiatric facilities in Washington have struggled to secure the required personnel to enable them to open their doors. Some stakeholders suggested that the state undertake a comprehensive, detailed cost analysis and comparison (to the extent permitted by available data) to get a fully accurate understanding of the costs associated with state adult psychiatric hospitals that could then be used for comparative purposes.

Aside from civil commitment placement needs, community capacity was also a major concern for stakeholders related to alternative placements and step-down facilities including for patients being discharged from the state hospitals. Past reports have identified numerous patients at the state hospitals that had been deemed ready for discharge but were still in the hospital due to a lack of a suitable placement to which the patient could be discharged. Stakeholders acknowledged that this issue persists and that patients with certain conditions or behaviors (e.g. violent tendencies, inappropriate sexual behavior, history of arson) will continue to be immensely difficulty to place in the community. Others indicated that the state needs to be firmer in enforcing conditions of participation with facilities such as nursing homes or adult family homes that refuse to take certain patients, suggesting that failure to do so may result in "cherry picking" of easier to handle patients by such facilities.

Another important consideration is that FIMC organizations are just beginning to acquaint themselves with the behavioral health landscape in Washington. In the Southwest region, Molina Healthcare and Community Health Plan of Washington now have over a year of experience with managing care for behavioral health patients under fully integrated managed care but the other FIMC organizations will have this introduction at some point over the next 24 months. BHO representatives suggested that building the relationships and understanding of the system essential to effective care management takes time so expectations must be set accordingly. Washington may be able to leverage lessons learned from the Southwest region's experience but only to an extent. Regional differences in population, provider landscape and geography, among other considerations, must be taken into account.

Additionally, the regional/BHO model has effectively featured a single entity responsible for managing care for behavioral health clients in a region whereas FIMC will entail at least two responsible entities and as many as five, so local and county-based providers accustomed to contracting with a single entity will likely now need to do so with multiple. BHO and FIMC organization representatives also pointed out the challenge of

managing care for clients – especially highly complex clients – when they have the option to change plans monthly as is currently the arrangement in Washington.

Commitment and Discharge Decision Making

When asked about the civil commitment process and the role of managed care entities in this process, stakeholders generally agreed that the role of the FIMC organization should be limited (as has been the case with BHOs in the current model.) Multiple stakeholders noted that the civil commitment process has been structured as is with specific intent, including to prevent monetary considerations from influencing determinations about the most appropriate course of action and placement for an individual who has recently experienced a mental health crisis. However, other stakeholders noted that the Designated Mental Health Professionals (DMHPs) dealing with individuals in crisis often do not have the knowledge of and relationship with the patient that the BHO or FIMC organization might and that allowing for their greater involvement in the process, particularly when the BHO or FIMC organization indicates that a suitable alternative placement option may be available, would be beneficial.

Regarding decision making about the discharge of civilly committed patients from the state hospitals (or other facilities in the future), stakeholders agreed that it is imperative for the FIMC organizations to proactively manage this process by working closely and effectively with hospital and community agency staff to facilitate smooth and appropriate transitions. Several stakeholders with direct knowledge of discharge activities suggested that coordination with state hospital staff had improved recently and that the process was working more efficiently than it had previously. However, other stakeholders noted the challenge of when the authorizing provider at the state hospital determines that a patient is not ready to be discharged and the entity responsible for managing care (BHO or FIMC organization) disagrees, further noting that the state hospitals tend to be particularly risk averse when faced with discharge decisions. In these instances, the state hospital director has ultimate authority over the discharge decision and it is unclear what opportunity for flexibility in this process may exist.

Contracting and Performance

Discussions with stakeholders also addressed issues around contracting and how certain contracts might be structured to best support the goal of integrating 90- and 180-day civil commitments into community settings.

Several stakeholders expressed concern about the state's contract management capabilities, both historically and forward looking. Some, including representatives from the state, noted that the contracts in place have not always been strictly enforced. Others went further and suggested that certain challenging cases (e.g. securing a stepdown placement for a hard-to-place patient) could have been resolved if the state had simply demanded that a provider abide by the terms of an existing contract. Looking ahead, HCA will be responsible for designing and managing the FIMC organization contracts but does not presently have the bandwidth or expertise to do this effectively. Building this capacity will take time and will likely require support and additional resources.

Stakeholders strongly suggested that the newly designed FIMC contracts (as well as other related contracts) must contain clear and specific provisions about expectations and be actively monitored to make sure "the state is getting what it pays for." Thus, in addition to higher level language around expectations for managing

care, the contracts also might specify particular goals for the number of bed/placement types secured, provider types with whom contracts have been executed or other elements.

In terms of the timeline for introduction and enforcement of performance-based metrics related to civil commitments, many stakeholders suggested that placing full financial risk on the FIMC organizations for the management of this population beginning in 2020 was unlikely to be successful. Part of this pertains to the previously discussed community capacity and learning curve issues, but HCA also pointed out that implementation of a risk model including financial components typically features a "zero year" during which baseline data is collected and initial performance is gauged. Based on that, meaningful decisions about financial incentives and shared risk can be made and then implemented over an additional one- to two-year period. Other stakeholders suggested that prematurely placing full risk on the FIMC organizations for management of this complex and vulnerable population, particularly in the midst of concurrent systemwide changes, could adversely impact the populations intended to be helped by the model and could exacerbate backlog at the state adult psychiatric hospitals.

Stakeholders were also asked about performance metrics including outcomes-based metrics. HCA suggested using a limited number of metrics, noting that it currently uses nine metrics tied to value in its managed care contracts. There is interest in introducing value-based purchasing into the model for inpatient psychiatric commitments but many questions need to be answered regarding how to effectively implement and measure this before it can take effect. Discussion also focused on the concept of introducing performance benchmarks at the state hospitals and while many are supportive of this, questions were raised about the likelihood and feasibility of this approach. Some stakeholders indicated that monitoring the success or failure of the state hospitals to meet established benchmarks would be difficult while others questioned how the hospitals – and by extension the state - would be held accountable for any shortcomings (e.g. quality withholds), particularly from a financial standpoint.

Stakeholders suggested a variety of specific benchmarks and performance metrics that the state might consider incorporating into the FIMC contracts, several of which are already included at least in part such as Healthcare Effectiveness Data and Information Set (HEDIS) measures. Specific measures suggested by stakeholders for possible inclusion in the contracts include both outcomes-based (e.g. recidivism and detention rates, revocations, placement) and process-based (e.g. care coordination, prescription management, data transfer, engagement, follow-up after discharge) metrics.

Populations

Stakeholders were asked about which populations to include in the risk model and whether certain populations might be considered for exclusion. While some of those interviewed suggested that the model should include all relevant civilly committed populations, others suggested that the model have a slightly narrower focus, at least in the initial implementation period.

By far, "forensic flips" were the population identified as most appropriate to be excluded from the model. Stakeholders noted that this population has been and will continue to be exceptionally difficult to manage due to the nature of how they enter the system – first as a forensic patient who has had involvement with law enforcement. Because individuals that enter the system this way may be unknown to the FIMC organizations or BHOs prior to arrest and commitment, these entities may have limited ability to manage care for them and thus potentially divert them from a crisis requiring intervention. Hence, it could be deemed unfair to hold the

FIMC organization or BHO accountable for the cost of inpatient care for these individuals when they may have had little or no opportunity to prevent the episode resulting in commitment.

Other populations identified for possible exclusion include geriatric patients and those with a diagnosis of Intellectual/Developmental Disability. Stakeholders pointed out that in some cases these individuals do not have an active behavioral health need that requires hospitalization after a period at the state hospital but are being held there due to lack of an appropriate placement for them in the community. They may also have needs such as assistance with activities of daily living that are not funded by Medicaid and must be covered by alternative funding streams, which creates complications to managing their care. These patients as well as others may also have a condition that is permanent and/or unlikely to improve such as dementia, Traumatic Brain Injury, Huntington's Disease or even chronic homelessness, suggesting that there may be little that the FIMC organization can do to improve outcomes and, depending on the condition, that the individual may not be appropriate for inclusion in a behavioral health risk model.

Finally, stakeholders were asked about whether and how American Indian/Alaska Native (AI/AN) populations might be included in this model. Overwhelmingly, stakeholders pointed to the presence of 29 tribal nations in Washington, each a sovereign government with very different priorities, resources, and needs. In light of this, meaningful engagement of the tribes in the risk model design and implementation process will require a significant investment of time and resources in order to support effective decision making. Many pointed out existing tribal distrust of the managed care system, as evidenced by the high percentage of AI/AN individuals opting out of Medicaid managed care in favor of the fee-for-service system. The pending Washington Indian Health Care Improvement Act must also be considered as it is intended to address disparities and inefficiencies in Washington's health care system related to AI/AN populations, support Indian health care providers and preserve tribal authority in decision making, so the outcome of the legislation could have significant impacts on the delivery system as well as the decision-making process related to system changes.

A final note regarding populations pertains to rate setting: for whichever populations are ultimately included in the model, established rates must be based on good, recent data that encompasses the full range of needs and services for the population. Rates may be risk adjusted for specific populations with an option to adjust rates periodically in response to the changing provider landscape, lessons learned and other considerations.

8. Disproportionate Share Funding Strategies

Institutions for Mental Disease (IMD) Exclusion

The IMD exclusion is found in section 1905(a)(B) of the Social Security Act, which prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental disease" except for "inpatient psychiatric hospital services for individuals under age 21." The law goes on to define IMDs as any "hospital, nursing hospital, 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[38]." The IMD exclusion was intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services.

The exclusion is one of the very few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21, and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services.

Because of this rule, states cannot bill traditional state plan services for inpatient psychiatric services for Medicaid eligible members in an IMD. However, the federal government does allow for Medicaid IMD-Disproportionate Share Hospital (DSH) payments to cover some of the costs of the uncompensated care provided to Medicaid and uninsured populations. Currently, Washington state adult psychiatric hospitals maximize their IMD-DSH claiming to the federal government, claiming $66,214,922 in allotment as published in the November 3, 2017 Federal Register[39].

Disproportionate Share Hospital (DSH) Hospital Funding

Washington has historically maximized the federal disproportionate share IMD-DSH claiming at Eastern and Western State Hospitals. As noted above, Washington has a 2017 IMD-DSH allotment of $66,214,922 and a total DSH allotment cap of $203,064,512. The entire IMD-DSH amount claimed by Washington is attributable to services provided at the two state adult psychiatric hospitals per Washington's regulations, which stipulate that IMD-DSH is only available to "state owned and operated psychiatric hospitals—Eastern and Western State Hospital" (WAC 182-550-5130: Institution for Mental Diseases DSH [IMDDSH.])

As with all DSH payments, IMD-DSH is currently scheduled to be reduced significantly by the Patient Protection and Affordable Care Act of 2010 (ACA), which mandated that DSH be reduced over a ten-year period to account for the millions of uninsured patients that would be covered by health plans via the Health Insurance Marketplace. If the ACA reduction is not delayed or amended, it would reduce Washington state's IMD-DSH claim from $66 million today to $18 million by 2024 (a 70 percent decrease.) CMS recently released final Medicaid DSH allotments for federal fiscal year (FFY) 2015 and preliminary DSH allotments for FFY

[38] https://www.ssa.gov/OP_Home/ssact/title19/1905.htm, IMD exclusion definition in SSA
[39] https://www.gpo.gov/fdsys/pkg/FR-2017-11-03/pdf/2017-23933.pdf, Final FY 2015 and Preliminary FY 2017 Disproportionate Share Hospital Allotments, and Final FY 2015 and Preliminary FY 2017 Institutions for Mental Diseases Disproportionate Share Hospital Limits

2017 (82 Fed. Reg. 51259) on November 3, 2017. The DSH reductions are technically in effect now as the federal fiscal year 2018 began on October 1, 2017. It is possible that legislative efforts will delay implementation of the DSH allotment reductions but whether that will occur is not known.

Maximizing IMD-DSH Funding in the Future State

When Washington starts to redirect civil commitments from ESH and WSH in 2020, the IMD-DSH payments will be impacted. Specifically, for every Medicaid and/or uninsured patient that is redirected from the state adult psychiatric hospitals, a direct impact will be felt to the DSH calculation without changes to the state regulations regarding eligible IMD-DSH hospitals. The DSH calculation is a function of cost, utilization, and reimbursement at the hospitals. As civilly committed patients shift to care in community settings, ESH and WSH will eventually see a reduction in expenses and revenue, which will impact IMD-DSH directly. Washington will have a few options to consider as they shift away from the historical reimbursement system that could include:

1. *Maintain the State Hospitals as the only IMDs eligible for IMD-DSH in Washington*. If this option is selected, the amount of IMD-DSH the state can claim will naturally be reduced when expenses are reduced for state hospital services. For example, if it cost the state $150 million a year to keep both hospitals operational and bed capacity was cut by 50 percent, we could assume a reduction of expense (in this example we'll assume a reduction to $75 million.) With less cost to claim, the IMD-DSH claim will be less and thus the state may have a reduced IMD-DSH reimbursement.
2. *Allow Non-State Hospital IMDs to claim IMD-DSH*. If civil commitments are diverted from the state hospitals, Medicaid and uninsured patients that were previously claimed at the state hospitals will now be receiving care in the community setting. The state could allow non-state hospital IMDs to claim IMD-DSH. The overall reduction in IMD-DSH claiming at the state hospital could then be applied to the non-state IMD-DSH claims.
3. *Redirect patients to non-IMD hospitals with distinct part psychiatric units and claim regular FFP for their care*. If civil commitments are redirected to acute care hospitals with distinct part psychiatric units, the hospitals could claim the full share of Medicaid FFP for eligible members since these facilities are not considered IMDs. The hospitals might also be eligible for an enhanced DSH payment under regular (non-IMD) DSH.
4. *Some Combination of All 3 Options*

Figure 8.1 below illustrates how each option could impact state finances. As you can see, with careful planning, rulemaking, and execution, Washington can continue to manage the net state cost to the same level it was prior to the shift of civil commitments from ESH and WSH. All four options result in a net state cost of $84 million in this hypothetical example.

Figure 8.1 State Budget Impact of DSH Funding Scenarios

Options	1	2	3	4
State Hospital Budget	$150,000,000	$75,000,000	$75,000,000	$75,000,000
State Hospital IMD-DSH	-$66,000,000	-$33,000,000	-$33,000,000	-$33,000,000
State Hospitals Net Cost	$84,000,000	$42,000,000	$42,000,000	$42,000,000
Non-State Hospital IMD-DSH Payments	$0	$75,000,000	$0	$37,500,000
Non-State Hospital IMD-DSH (FFP)	$0	-$33,000,000	$0	-$16,500,000
Non-State Hospital IMD Net Cost	$0	$42,000,000	$0	$21,000,000
Non-State Hospital Medicaid (Capitation) Budget	$0	$0	$75,000,000	$37,500,000
Non-State Hospital FFP	$0	$0	-$33,000,000	-$16,500,000
Non-State Hospital Net Cost	$0	$0	$42,000,000	$21,000,000
Net State Cost	$84,000,000	$84,000,000	$84,000,000	$84,000,000

Washington will need to plan for IMD-DSH claiming changes likely to emerge as the state looks to divert civil commitments from the state hospitals after 2020 and include long term civilly committed patients in the capitated risk model. There will be a dramatic change in the way that services are covered and reimbursed in the Washington mental health system. At the same time Washington will need to manage the planned federal DSH reductions over the next 10 years. A few items that will impact long term planning for Washington include the following:

- As the state hospitals focus more on forensics, the Medicaid IMD-DSH opportunity will decrease as the forensic population is not eligible for Medicaid and/or Medicaid DSH reimbursement. Reducing the eligible population will reduce the eligible DSH cost at the hospitals.
- The federal DSH reimbursement is slated to be reduced to approximately 25 percent of its current level, so depending on the speed of implementation, the scheduled DSH reduction may not have any impact on the maximum allowable DSH claim per year. Washington will need to watch this closely as the DSH reductions have been delayed by Congress for over two years.
- An IMD-DSH waiver could reduce the reliance of IMD-DSH at the state hospitals as ESH and WSH could bill regular Medicaid FFP for services provided to Medicaid patients for the 21-64 population, effectively reducing the DSH claim in future years. For this reason, **we recommend that Washington explore such a waiver to determine feasibility and potential impacts.** Essentially, the state would be claiming regular FFP instead of IMD-DSH FFP for patients that had previously been served in ESH or WSH. This would relieve pressure on the IMD-DSH cap felt at the state hospitals.

We also recommend that Washington consider legislation extending IMD-DSH payments to non-state hospitals as an option to maximize any reductions brought on by changes in the forensic vs. civil patient ratio of the state hospital population. Private hospitals (IMD and general acute) would be incentivized if targeted DSH became available. It is important to note that IMD-DSH claiming at non-state hospitals is an entirely different reimbursement process for the state. Washington currently draws federal reimbursement for the IMD-DSH claim submitted based on the Certified Public Expenditures (CPEs) at ESH and WSH. Claiming IMD-DSH at non-state hospitals would require Washington to make the full IMD-DSH payment and then draw down FFP after the payments are made - a completely different financial process than the current IMD-DSH process.

It is possible to maximize eligible claiming at ESH and WSH even as civil commitments are transitioned to the community and the ACA's DSH reductions are fully implemented. This depends on (a) if DSH reductions from the ACA are formally enacted, and (b) if the allowable IMD-DSH claim at the reduced bed state hospitals is still greater than the federal limit. In this scenario Washington will be maximizing its allotment of federal DSH funding for the state. It is also true that Washington may want to transition its strategy from a focus on maximizing federal IMD-DSH reimbursement to focusing on how to maximize federal FFP claiming for all Medicaid services (State Plan and DSH) as more services are provided outside the walls of the state adult psychiatric hospitals.

In order to maximize federal share FFP for the state, taking into account both regular FFP claiming for managed care capitation payments and FFP claiming for IMD-DSH, **we recommend that Washington continue to monitor federal activities and updates related to DSH and build models that account for the revised IMD-DSH claim, the reduced (by ACA) IMD-DSH limit, and the expected diversion of civil patients away from the state adult psychiatric hospitals.**

9. Risk Model for Inpatient Psychiatric Care

9.1 Definition of a Risk Model

The capitated risk model incorporating long term civilly committed patients was authorized in Substitute Senate Bill 5883, Section 130(9). According to the statutory language, the model must integrate civil inpatient psychiatric hospital services, including ninety and one hundred eighty-day commitments provided in state adult psychiatric hospitals or community settings into Medicaid managed care capitation rates and non-Medicaid contracts.

The risk model is needed because Washington's current interest in including all long-term, involuntary psychiatric inpatient stays (that fall into the categories of 90- and 180-day commitments) into managed care contracts has no exact precedent and raises a number of complex questions. PCG posed many of these questions in our *Washington Mental Health System Assessment: Final Alternative Options and Recommendations* report submitted in December 2016.

These questions primarily concern financial, operational and legal dimensions. Expanding managed care to all long-term civil commitments brings a substantial non-Medicaid component into a managed care model. It requires determining how to set boundaries between Medicaid and non-Medicaid program and fiscal management, how to assign roles among care managers and providers and how to ensure the model stays aligned with the emerging behavioral health delivery system being established for 2020 and beyond.

This section is structured into major categories of questions aimed at establishing a cohesive and workable approach to transitioning payment for long term-involuntary civil commitments away from direct state payments and into the hands of fully integrated managed care organizations.

9.2 Considerations in Building a Risk Model

PCG considered numerous factors that could potentially impact the success or failure of the risk model related to its design and implementation. Below are topical areas of consideration and specific issues related to each:

- Authority and clinical decision making
  - Appropriate role of FIMC organizations in the civil commitment determination process
  - Role of FIMC organizations in facilitating timely and appropriate discharge of civilly committed patients
- Oversight and monitoring
  - Contracting requirements necessary to support the integration of long term civil commitments into the community-based hospital system
  - Performance benchmarks for FIMC organizations that effectively monitor progress toward the goals of risk model implementation
  - State capacity to manage FIMC contracts and monitor performance
  - Financial or legal issues to be considered related to contract changes

- Member services
  - Populations appropriate for inclusion or exclusion in the risk model (including forensic "flips")
  - Application of risk model to tribal populations
  - Services to be included or not in the risk model
- Financing
  - Appropriate financial structure for the risk model
  - Timeline for implementation and potential phase-in options
  - Facilities to be included in the risk model
- Other
  - Existing and future capacity to serve long term civilly committed patients outside of the state adult psychiatric hospitals (including anticipated timelines and issues related to development of this capacity)
  - Ongoing transition from Behavioral Health Organization (BHO) to fully integrated managed care model statewide and potential impacts to the risk model
  - Alternative and step-down placement options available to address the needs of patients being diverted or discharged from inpatient psychiatric care

9.3 Risk Model Recommendations

9.3.1 Medicaid and non-Medicaid populations to be included in the risk model

As noted in Section 4.3, the civil inpatient population tends to be categorized into three broad sub-populations: a geropsychiatric population, characterized by high medical needs as well as behavioral health needs, and frequently with age-related forms of dementia; a small population of patients with intellectual or developmental disabilities (I/DD); and the wider civil population, which includes all other adult psychiatric patients, ages 18-50. While it is possible to identify potentially relevant sub-populations along other dimensions (for example, by diagnosis, by medical risk, or by commitment status), given that the goal of the initiative is to improve care integration and to establish clear incentives and a system of financial accountability for appropriate care, **PCG recommends that care of each of these core inpatient populations be incorporated into the risk model beginning January 1, 2020.** The transition to managed care would encompass the civil adult psychiatric, geropsychiatric, and I/DD populations on 90- and 180-day commitments, and would exclude only those civil patients who are designated "forensic flips" (described further in section 9.3.5).

PCG also recommends that the risk model apply only to new long-term civil commitments, as of January 1, 2020, which would exclude individuals already admitted prior to that time, and/or whose commitment status renewed after that point. This recommendation would allow FIMC organizations to take on risk for these care-intensive populations gradually and predictably, enabling the inevitable shifts in cost and utilization to be implemented more smoothly with less disruption within a shorter transition framework.

For reasons discussed in more detail in Section 9.3.5, PCG recommends excluding the "forensic flip" population from the risk model, due to likely barriers for FIMC organizations in providing effective care

management and continuity of care for this population, along with limited ability to manage the risk of this population, especially on account of its ongoing criminal justice involvement. In state fiscal year 2017, the "forensic flip" population constituted approximately 22 percent of the total inpatient population across Washington's state hospitals. While the size of this population is significant, PCG does not rule out the prospect of including this population in the risk model at a future date.

Finally, with regard to tribal populations, PCG recommends that tribal citizens have the choice to opt out of the risk model consistent with their options for behavioral health managed care in general. With this recommendation, we also acknowledge several factors that led to this decision: (1) Washington has 29 tribal nations, each with distinct population needs, geographic considerations, health care service models and priorities. The scope and timeline of this engagement does not support meaningful engagement with each. (2) Stakeholders suggested that many tribes are averse to managed care, noting that very few American Indian/Alaska Native individuals have chosen to "opt in" to managed care for behavioral health services, preferring instead to utilize the fee-for-service system. (3) Legislation is pending and discussions are under way that may result in significant changes to behavioral health services for tribal populations, including the possible establishment of evaluation and treatment (E&T) centers on tribal land to specifically treat tribal citizens.

9.3.2 Facilities to be included in the risk model

PCG recommends that the state include in the risk model all facilities authorized to provide 90- and 180-day civil commitment stays, including both state-operated adult psychiatric and community-based hospitals. As Washington looks to build capacity that will enable the placement of civil commitments outside of the state hospitals, it will want to cast a wide net that encompasses a variety of facilities that either possess or can attain the necessary infrastructure, resources and expertise to serve this population. At present, capacity to serve long-term psychiatric patients outside of the state hospitals is scarce due to several factors: limited capacity, licensing and facility limitations and fiscal and operational concerns about accepting long-term civil commitments. Even facilities that handle short-term involuntary commitments may be reluctant to take on longer term civil commitments in light of the complex treatment needs of this population and known challenges in securing appropriate step-down or alternative placements for certain patients once they are ready to be discharged.

Some new capacity for inpatient psychiatric care is being created and the Department of Social and Health Services (DSHS) has initiated discussions with community-based facilities to gauge interest and understand the concerns and limitations faced by these facilities related to accepting these patients. DSHS is also exploring waiving certain regulatory requirements in order to enable more facilities to accept long-term civil commitments. Currently, 13 facilities have exemptions in place that permit them to serve long-term civilly committed patients. However, the consensus among stakeholders is that building the requisite capacity to move all civilly committed patients out of the state adult psychiatric hospitals will require significant relationship building, working through regulatory and operational hurdles and capital investment by the state, all of which will require time and resources to materialize. Finally, this patient population has complex treatment needs requiring long-term stays.

State Adult Psychiatric Hospitals

In light of the considerations described above, we recommend including both Eastern and Western State Hospitals (ESH and WSH) in the risk model for long-term civil inpatient commitments. ESH and WSH are already certified to provide care to long-term civilly committed patients and thus meet the facility, staffing and other requirements associated with treating this level of care and possess the relevant experience in doing so. They also have the physical capacity to serve hundreds of psychiatric patients, something that few other facilities in Washington can offer.

Daily bed rates for ESH and WSH are currently developed based on cost centers that include Geropsych, Developmental Disabilities (DD) and all other civil cases. **In advance of Behavioral Health-Administrative Services Organizations (BH-ASOs) adopting the state rate schedule to pay these facilities on January 1, 2020, PCG recommends that DSHS implement acuity-based rates that more accurately reflect case complexity beyond and instead of these three categories.** Medicare payment rates to IMDs are currently made using an acuity-based diagnosis-related group (DRG) rate schedule.

In terms of capacity, ESH and WSH have traditionally reserved civil inpatient beds for the most medically and behaviorally challenging patients - those requiring 90- to 180-day civil inpatient commitments. As it stands, with the particular challenges of these patients, not enough capacity exists to treat long-term civil commitments outside of state-operated facilities. For this reason, it is imperative that both state adult psychiatric hospitals are included in the risk model at least for the time it takes to establish sufficient capacity to handle long-term civil commitments in alternative facilities. While predicting when such capacity will exist is challenging due to numerous variables related to how and when capacity will be developed, we recommend that Washington set a goal of ceasing new civil commitments at ESH and WSH by 2022. This will allow time for the FIMC organizations to adapt to the behavioral health landscape and build the relationships, expertise and resources necessary to facilitate the creation of new capacity for civil commitments. During this time, both the FIMC organizations and the state will be able to further engage with the provider community to better understand what is needed in terms of funding and other resources to effectively support capacity building.

Community Hospitals

We also recommend including community facilities in the risk model to the extent that facilities have the capacity and expertise to treat civilly committed patients and the ability to meet licensure, certification and/or other requirements necessary to treat long-term psychiatric commitments. As Washington is considering waiving certain facility requirements that may currently prevent facilities from accepting 90- and 180-day civil commitments, community hospitals may be more willing to consider taking on these patients. Of course, the state will need to ensure that while state requirements are waived, federal requirements are still met and that these facilities are equipped to address the full range of needs of civilly committed patients. Community hospitals can include E&T centers, psychiatric hospitals, or hospitals with psychiatric care units.

Some stakeholders questioned whether including community facilities would be beneficial considering up-front investments required, challenges in treating the long-term adult inpatient psychiatric population, and long-term cost effectiveness. However, enabling community hospitals to become certified to care for long-term civilly committed patients while incentivizing FIMC organizations to provide high quality, innovative

care management and build network capacity has the potential to limit the need for institutional care for civil patients and enable the state hospitals to shift focus to serving forensic patients.

As fully integrated managed care is rolled out, state hospitals will play a key role early on by continuing to be a resource for treating 90- and 180-day civil commitments as additional capacity is added. Community hospitals will play a vital role in transitioning state adult psychiatric hospitals away from treating long-term civil inpatient commitments and more toward forensic patients. With proper planning and resource allocation, community hospitals will be the primary placement for long-term civil commitments by 2022.

9.3.3 Regional and facility based considerations for inpatient psychiatric hospital rates

This risk model leaves the bounds of capitation rate setting for long-term inpatient psychiatric stays the same as they are today – only within Medicaid. Medicaid capitation rates are regional and based on regional utilization assumptions. To the extent that long-term civil commitments migrate out of ESH and WSH and into community hospitals, regional healthcare utilization data may change and require adjustments to regional capitation rates.

Currently HCA sets Medicaid and non-Medicaid daily bed rates for psychiatric hospitals. Payer mix is a major consideration in the financial welfare of hospitals. A significant migration of long-term involuntary commitment beds out of ESH and WSH and into the community will clearly change the payer mix for community hospitals.

Since the migrating caseload would overwhelmingly not be Medicaid eligible, non-Medicaid rates would apply. PCG anticipates significant community hospital reluctance to expand community bed capacity if payment rates and changing payer mix adversely impacts these facilities. HCA will need to work collaboratively with community hospitals to determine an approach to rate setting that incentivizes regional bed capacity development. At the same time, Washington will have to ensure that rate adjustments to build community capacity are affordable for the state.

In developing this risk model, **we recommend that the state require FIMC organizations and BH-ASOs to compensate based at a minimum on the fee-for-service per diem rates to the hospital providers** if their funding pool is based on fee-for-service. The FIMC organizations will face similar barriers to financially incentivizing community hospitals to expand bed capacity.

PCG does not foresee the risk model itself building community capacity; rather, it will be important that the state **recognize that community capacity building for long-term civil commitments is going to be driven by establishing higher per diem rates, expanding certification and direct capital investment in facility building by the state.** The lack of sufficient alternative placement options for civilly committed patients was a primary concern of stakeholders and reflects the myriad challenges associated with building this capacity: funding, facility needs, and complexity of patient needs, among other factors. The state has already taken steps to engage potential hospital-based partners in relevant discussions and can build on these relationships and acquired knowledge to determine how best to provide meaningful and effective support for capacity building.

9.3.4 Services for inclusion in the risk model

PCG recommends that the services in the risk model for civil inpatient commitments mirror those currently offered to civil inpatient commitments in the state adult psychiatric hospitals. The recommended service array includes those offered by the two state adult psychiatric hospitals as well as the services for civil inpatient commitments in Washington's Medicaid State Plan. The services offered at ESH and WSH have been developed over time and are designed to address the behavioral and physical health needs of civilly committed patients.

Particularly as the risk model will involve two different entities – FIMC organizations and BH-ASOs – responsible for managing care for civilly committed patients, maintaining currently available services will be imperative. The FIMC organizations in particular will be subject to all rules of coverage as part of their contracts with the state. Because the funds directed to the BH-ASOs to serve uninsured patients will be state-only, Washington may wish to consider allowing these entities to have greater flexibility in the use of funds to address patient needs and services not typically covered by Medicaid.

Highlights of the recommended services include: adaptive treatment programs, clinical care, cognitive assessments and behavioral therapy, dental services, individual psychotherapy, laboratory services, medical services, nursing care, occupational therapy, pharmacy services, physical therapy, recovery groups, rehabilitation screenings and services, social work, and substance abuse treatment. Details on state adult psychiatric hospital services can be found in Appendix E.

These recommended services should be available at the two state adult psychiatric hospitals as well as any community hospitals where civil inpatient commitments are served.

There are several reasons why PCG recommends the continuation of the current state adult psychiatric hospital and state plan services under the risk model.

- Continuity of Care. Expectations are that some civil commitments will still be assigned to the state adult psychiatric hospitals when the risk model is implemented on January 1, 2020. Hence, all services currently available in the two hospitals must be included.
- Same Level of Service. Washington has the stated goal of moving civil commitments from the state adult psychiatric hospitals to the community. The introduction of the risk model is intended to help facilitate meeting that goal. Placing the same services in the risk model for long-term civil inpatient psychiatric services as those that are in place at the state adult psychiatric hospitals will ensure that patients are receiving at least a baseline level of care regardless of location.
- Limit Administrative Complexity. Moving from the current system to a capitated managed care risk model will necessitate many operational changes for long-term civil inpatient commitments. Accompanying changes in the payer source with changes in services offered has the potential to upset payers, providers, and patients and will add complexity to the change management process. Maintaining the same services as they currently exist is expected to make the adjustment to a risk model smoother, from both a patient and an administrative perspective.

9.3.5 Incorporation of forensic flips

"Forensic flips" or "felony flips" are individuals who have had their felony charges dismissed because they have been found incompetent by the criminal court. Data on these status changes indicates that during fiscal year 2015 approximately eight individuals per month "flipped" from forensic to civil at WSH and three and a half flipped at ESH. On average, WSH has between 120 and 130 individuals classified as a "forensic flip" and ESH has between 20 and 30.

A flip can occur if (1) the individual has received multiple rounds of restoration services and is determined "not restorable"; or (2) the parties and court have agreed that the person is not restorable and, therefore, have dismissed the charges without completing multiple restoration periods.[40] In such instances, the charges are dismissed without prejudice and the individual may be placed in the state adult psychiatric hospital for a civil commitment evaluation.

The statute does not provide a specific timeframe for the person to be transported to the state hospital following dismissal of the charges, but state staff have indicated that the hospitals aim to transport patients as quickly as possible, generally within seven days or less. Once the patient is admitted to the state hospital, s/he must be evaluated within 72 hours for purposes of filing a civil commitment petition. If a petition is not filed, the hospital must notify the prosecutor of its intent not to file a petition. If a petition is filed, a hearing must be held within ten days. At the hearing, a court will determine whether the individual meets criteria for civil commitment and, if so, an order for up to 180 days will be entered if the grounds for commitment include the felony grounds.[41] When the patient "flips," charges are dismissed without prejudice, allowing the court to re-charge the individual in the future, if the individual is determined to have become competent.

This population poses a unique challenge to developing a risk model for civil inpatient commitments, largely because the entities responsible for paying for their care (FIMC organizations or BHOs) have no advance notice of when an individual will flip and no control over the numbers of individuals whose status will change from forensic to civil. Accordingly, if the FIMC organization or BHO had no relationship to the patient prior to the flip, they also would have had no ability to manage the patient's care in a manner conducive to preventing deterioration to the point of crisis and subsequent detention.

Arguments for and against including "forensic flips" in the risk model are provided below and are followed by PCG's recommendation.

Arguments for Inclusion of Forensic Flips in the Risk Model

- Incentivize Care Management. Some stakeholders suggested in discussions with PCG that a sizable percentage of the forensic population is enrolled in Medicaid and known to the behavioral health system at the time of arrest. This would suggest that there may be opportunities for FIMC organizations to intervene with these clients prior to detention or arrest and potentially avoid forensic commitments before they happen. Some have argued that including forensic flips in the risk model will incentivize front end treatment and attention to the at-risk population, reducing the number of flips over time.

[40] See RCW 10.77.086(1)(c) and (4).
[41] See RCW 71.05.280(3); See also Detention of R.H., 316 P.3d 535 (2013).

- Identically Classified Population. By definition a forensic flip is someone who has transitioned from a forensic status to a civil commitment. The behavioral health care needs for forensic flips are thus theoretically the same as for the population of those who enter the system as a civil commitment; the distinction is simply that each entered the system through a different door. Thus if the entire civil commitment population is included in a risk model then it can be argued that there is no justification for not including forensic flips in the risk model as well.

Arguments Against Inclusion of Forensic Flips in the Risk Model

- Criminal Justice Association. Forensic flips are closely related to the criminal justice system by their very nature. This population begins their engagement with the state adult psychiatric hospitals via criminal justice and only becomes a civil commitment upon a legal resolution. This makes forensic flips different from the general population of civil commitments despite having the same status after the flip. In addition, pursuant to RCW 10.77.086(4) charges are dismissed without prejudice for forensic flips, allowing the court to re-charge the individual in the future, if the individual is determined to have become competent. Thus the possibility exists that a forensic flip can once again become a forensic commitment. Incentives may be drawn into question if actions taken by an FIMC organization can lead to a patient being viewed as competent based on treatment received. FIMC organizations may not be equipped to deal with this additional complication and, further, it may not be cost effective to have them do so.
- Continuity of Care Management. Forensic flips enter the current state hospital system through the criminal justice system. They receive care through a fee-for-service model and, as a forensic commitment, will continue to receive care via fee-for-service after the introduction of the risk model and managed care for civil commitments. Including forensic flips in a risk model for civil commitments will add an additional layer of complexity in care management as they will need to transition from fee-for-service to managed care. The complexity of this transition is one reason why only new civil commitments are recommended for inclusion in the risk model. Excluding forensic flips from the risk model will avoid related changes in care management.
- Lack of FIMC Organization Control. Forensic flips do not enter into civil commitments through the same path as the traditional civil commitment population. Including flips in the risk model forces FIMC organizations to assume risk for individuals for whom they may not have been previously responsible. Though the suggestion has been made that some percentage of the population is known to the behavioral health system prior to interaction with the criminal justice system, this is not necessarily always the case and may be hard to track. Placing this group in the risk model may place an undue and costly burden on FIMC organizations.
- Community Concerns. Washington is considering moving all civil commitments to community-based hospitals once capacity exists. In such a scenario, it likely makes sense to have all applicable community hospitals included in the risk model. There is some concern that community hospitals may resist housing forensic flips due to safety or other concerns. These concerns may lead to increased difficultly in moving civil commitments to the community.

PCG recommends that Washington not include forensic flips in the risk model beginning January 1, 2020. This population differs from the general civil inpatient population in several significant ways detailed above. Placing forensic flips has been determined to be an unnecessary complication in the risk model.

9.3.6 State and federal laws informing the risk model

The concept of incorporating long-term civil inpatient psychiatric care into a managed care capitation model is impacted by multiple laws and rules at the state and federal level. Managed care rules, the civil commitment process and payment structures are the major factors that must be considered to understand the bounds in which to develop the risk model. Below are regulations that PCG reviewed to inform our recommendations. We identify the law and rules that apply to the risk model, provide a brief overview of each, and explain how each law or rule affects the model.

The Washington state laws and rules considered are:

- Substitute Senate Bill 5883, Sec. 130(9) authorizes the integration of civil long-term inpatient psychiatric care as defined in RCW 71.24.025 into a managed care capitation risk model. The bill states inpatient psychiatric care under the capitated model should include state hospitals or community settings and become effective January 2020. Additionally, the model must address ways that the state is able to maximize its allotment of the federal disproportionate share funding.
    - SSB 5833 affects the model as it prescribes the specific elements to be included in the model, specifically the population (civil patients requiring long-term inpatient psychiatric services), the types of facilities for consideration (state adult psychiatric hospitals and community hospitals), and the type of financial risk model (capitation.)
- RCW 71.24.025 defines the term “long-term inpatient care" as inpatient services provided for ninety days or greater to persons committed or voluntarily receiving intensive treatment under chapter RCW 71.05.
    - The model uses this definition to determine the specific population that will be covered under a capitated model.
- RCW 71.05 is the chapter of state code that addresses mental illness including the civil commitment process. The chapter includes details on the entities involved, evaluation of a person, how petitions are completed, types of court-ordered treatments and discharge determinations. This chapter provides the foundation upon which the model can be built as it defines the civil commitment process from the point in which a person enters the process to when treatment, if ordered, is complete. For example, this chapter defines the role of a designated mental health professional (DMHP,) the individual responsible for administering the civil commitment process and evaluating a person’s need for treatment. This chapter also elaborates on the role of an FIMC organization in the process. RCW 71.05.025 states the FIMC organization will establish “procedures which require timely consultation with resource management services by designated mental health professionals and evaluation and treatment facilities to assure that determinations to admit, detain, commit, treat, discharge, or release persons with mental disorders under this chapter are made only after appropriate information regarding such person's treatment history and current treatment plan has been sought from resource management services.”

  - The model is affected by this code as it clarifies the role and limitations that an FIMC organization has in determining the status of a member and the treatment decisions for civil commitments.

- RCW 71.05.320 states that someone ordered for treatment up to 180 days will be committed in a facility certified for 180 days of treatment by the department. This is relevant to understanding the reason patients needing long-term inpatient services typically go to the state hospitals and not to community-based facilities.
  - The risk model is informed by the revised code as it limits what facilities can be included in the risk model: only those certified for 180-day treatment.

- RCW 71.05.365 describes at a high level the discharge procedures for long-term commitments. The designated professional person in charge of the hospital determines when a patient no longer requires an inpatient level of care. The entity responsible for managing services for the patient must work with the hospital to develop a discharge plan and transition the patient to the community within fourteen days of determination that the patient no longer requires inpatient care.
  - The model is informed by this code in the development of FIMC organization performance metrics related to discharge measures.

- RCW 72.23.025 states the role of the state hospitals: "the intent of the legislature to improve the quality of service at state hospitals, eliminate overcrowding, and more specifically define the role of the state hospitals. The legislature intends that Eastern and Western State Hospitals shall become clinical centers for handling the most complicated long-term care needs of patients with a primary diagnosis of mental disorder."
  - This is relevant to understanding who is best served at state adult psychiatric hospitals and accordingly to develop a risk model that aligns with the state hospitals' role as intended by the legislature.

The following are laws and rules at the federal level that apply to the risk model:

- Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) relating to 42 CFR Parts 431, 438, 440, 457 and 495 provides a comprehensive set of requirements on managed care, including contracting, network adequacy, network capacity and services, and coverage. Relevant to the risk model is the new flexibility on payments for short-term stays in IMDs and details on payment structures tied to FIMC organization performance targets. Regarding IMDs, states may make monthly capitation payments to MCOs or prepaid inpatient health plans for an enrollee aged 21-64 receiving inpatient treatment in an IMD as long as the facility is a hospital or a sub-acute facility and the length of stay is for no more than 15 days during the monthly capitation payment period.
  - The recommended model considers the impact of the new IMD payment flexibility on Medicaid and non-Medicaid funding for persons requiring long-term inpatient care whose stay would exceed the 15 days in a calendar month.

- Also detailed in the Final Rule is 42 CFR 438.6: Incentive, Risk-sharing, and Withhold Arrangements. Incentive arrangements may not provide for payment in excess of 105 percent of the capitation rates. For a withhold arrangement, the capitation payment minus any portion of the withhold that is not reasonably achievable must be actuarially sound. The total withhold must be reasonable and account for the entity's operating needs taking into consideration enumerated factors.
    - These regulations inform the risk model as it relates to performance metrics and the bounds in which financial incentives can be used to monitor managed care performance.
- 42 CFR Part 438 addresses managed care, but specifically 42 CFR 438.3 and 42 CFR 438. regulate contracts and payment. 42 CFR 438.3(a) says that CMS must review and approve the contract between an MCO and the state. 42 CFR 438.3(c)(ii) states that the capitation rates under "the contract" must be based "only upon services covered under the state plan," with limited exceptions under (c)(ii) and (e) regarding mental health parity and certain additional "in lieu of" services which can be covered under the CMS Medicaid Managed Care rules. 42 CFR 438.4 states that the capitation rates must be appropriate for the populations to be covered and the services to be covered under "the contract." These would be certified by a qualified actuary. 42 CFR 438.806(a)(2), on the federal "prior approval" requirement on Medicaid FFP for most types of state Medicaid MCO contracts, states that "the contract" must meet all of the requirements of 42 CFR Part 438.
    - The combination of these requirements was analyzed to determine the mechanism in which the state could contract with FIMC organizations as federal and non-federal dollars would be used to fund the civil long-term inpatient services. The distinction of the services paid using federal and non-federal dollars must be clear in the capitation model and in contracts.

9.3.7 Performance metrics to consider for inclusion in the contracts

A capitation model places financial accountability on FIMC organizations and the inclusion of payment structures based on performance can incentivize FIMC organizations to improve care coordination and patient outcomes. Including performance metrics in contracts also allows the state to track and monitor metrics on the effectiveness of a delivery model. Below are considerations for a performance incentive structure along with the appropriate performance metrics for long-term inpatient psychiatric care.

Currently, HCA has an initiative to move from encounter-based payment to value-based payment (VBP.) This state effort aligns with national initiatives as Medicare continues to implement VBP to providers and federal legislation has authorized higher reimbursement rates to providers participating in VBP and alternative payment models (APMs.) Through legislation, HCA is also on the path to implementing widespread VBP in state-financed health care programs, Apple Health and the Public Employees Benefits program.[42] HCA's goal is to have 80 percent of provider payments under the VBP model by 2019. Washington's approved Section 1115 Medicaid Transformation Demonstration further supports HCA's efforts with a goal of having 90 percent of state-financed health care using VBP by 2021. Beginning in January 2018, HCA will withhold 1.5 percent of the capitation amount from MCOs in Apple Health with an opportunity for the MCO earn the

[42] https://www.hca.wa.gov/assets/program/vbp_roadmap.pdf

withhold back if VBP targets and quality goals are met. Additionally, HCA will reward MCOs for improvement and achievement of quality measure targets.[43]

To align with HCA's current efforts to link quality to payment, **PCG recommends that Washington require FIMC organizations and BH-ASOs to begin phasing in value-based purchasing models for long-term civil commitments in 2022**. The universe of providers in inpatient psychiatric care is smaller than for other Medicaid services, but the goal of promoting quality is just as important. Additionally, this model should be applied to both Medicaid and non-Medicaid funded contracts, FIMC organizations and BH-ASOs, as the population included in the capitation model will be covered by both entities. HCA can require the FIMC organizations to phase in VBP for inpatient psychiatric providers beginning in 2022, perhaps beginning with a certain subset or percentage of patients during the first year and raising that percentage each subsequent year.

In regard to performance and quality measures, long-term inpatient care utilization is impacted by many factors that exist along the behavioral health care continuum. Accordingly, several behavioral health performance measures are already included HCA's contracts with FIMC organizations. From the FIMC model contracts, the adult behavioral health related measures are:

- Antidepressant Medication management;
- Follow-up after hospitalization for Mental Illness;
- Diabetes Screening for people with Schizophrenia or BD who are using antipsychotics;
- Diabetes Monitoring for people with Diabetes and Schizophrenia;
- Cardiovascular Monitoring for people with Cardiovascular disease and Schizophrenia;
- Adherence to antipsychotic medications of individuals with Schizophrenia;
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;
- Use of Service – Mental Health Utilization (includes the outpatient/ED category only. Excludes: All inpatient, or intensive outpatient/partial hospitalization);
- Follow-up after ED visit for Mental Illness; and,
- Follow-up after ED visit for Alcohol and other drug dependence.

These measures are in line with those included in HEDIS and address prevention and care coordination along the continuum. PCG recommends retaining these measures as they are core standards at the national level and address stakeholders' recommendations regarding post-discharge engagement, care coordination, and prescription management. However, specific measures to monitor FIMC organization performance in managing the long-term inpatient psychiatric services should be tied to incentives. In our review of other states' contracts with behavioral health managed care entities, there were some measures relevant to inpatient psychiatric care that could be applied to this risk model. **PCG recommends Washington establish contractual performance measures and withholds for FIMC organizations as described below.**

Measures tied to financial incentives. Incentive arrangements allow states to provide payment in the amount of no more than 105 percent of the capitation rate to FIMC organizations. An FIMC organization will be rewarded for score improvement from year to year for the following measures:

[43] https://www.hca.wa.gov/assets/program/apple-health-vbp-fact-sheet.pdf

- average length of stay in psychiatric hospital;
- readmission rate;
- days per 1,000;
- admits per 1,000; and,
- community tenure (average number of days between mental health hospitalization.)

Measures tied to a withhold. A withhold arrangement allows the state to hold a portion of a capitation rate and release it upon the FIMC organization meeting specified targets. The capitation payment minus any portion of the withhold that is not reasonably achievable must be actuarially sound. The FIMC organization must meet the following established performance targets to receive their capitation withhold:

- mental health discharge plan on day of discharge for 100% of members;
- place "ready to discharge" patients once they are deemed as such within a period of 14 days;
- members discharged from inpatient psychiatric hospital and readmitted within 30 days must not exceed 15%; and,
- length of time between psychiatric hospital discharge and first mental health service that qualifies as post-discharge must not exceed seven days.

These inpatient psychiatric care-specific measures along with the behavioral health measures that HCA has established address points of care both in the community and hospitals. In combination, they promote diversion from inpatient care and recovery services in community settings. The discharge plan, average length of stay, and days per 1,000 measures encourage FIMC organizations to coordinate discharge and service planning so patients transition into the community in a timely manner and receive appropriate care. They tie financial payments to care coordination and hold FIMC organizations accountable while discouraging shifting of financial responsibility. Furthermore, readmission rates, admits per 1,000, and community tenure measures can place standards for FIMC organizations to meet low targets, thus incentivizing them to increase community-based services and focus on prevention and recovery services.

Overall, robust oversight of FIMC organization performance is first established by the state in contract requirements and then by its enforcement of the requirements. The recommended measures to include in FIMC organization contracts along with those currently in the HCA managed care contracts provide a comprehensive set of metrics for which the state can monitor FMIC organization performance. Furthermore, the recommended measures allow the state to enforce regulations such as discharge responsibilities and timing under RCW 71.05.365, discussed in Section 9.3.6 of this report. This alignment of regulations, contract language, and state monitoring is critical to enable full accountability of FIMC organizations and standards for which they are responsible for reporting. Additionally, concrete contract language on the payment structure related to performance metrics ensures that measures are not only monitored but also have clear outcomes if the FIMC organization is meeting or missing targets.

Risk Sharing at State Hospitals

Consistent with Washington's policy agenda for behavioral health, ESH and WSH will become centers of excellence for inpatient behavioral health forensic care over the next several years. For calendar years 2020

and 2021, BH-ASOs will grow as a payer source for the two hospitals; however, this growth is temporary and will phase down in 2022. This temporary relationship between the BH-ASOs and the state psychiatric hospitals is intended to facilitate the timely move to full integration while community bed capacity develops and civil commitments migrate to a regional care model.

PCG recognizes that not only is the relationship between these two parties temporary, it also does not bear the traditional features of market-based negotiations between two commercial entities. The contract relationship will be directed by HCA.

Private hospitals create an administrative infrastructure and associated business strategies for managing their contracts with health plans. We do not see a similar infrastructure emerging at ESH and WSH given the limited and directed nature of the relationship. For this reason, we see HCA's contract with BH-ASOs as being the document that also represents the interests of the state hospitals and creates protections for those entities. For example, HCA's contract may be used to set rules around protocols such as payable benefits, payment rates and criteria for ending or limiting payment.

FIMC payments to WSH and ESH will also phase down in 2022 as new civil commitments are entirely redirected to community facilities. During 2020 and 2021, FIMC payments to the state hospitals will be focused on Medicaid eligibility categories that the hospitals already navigate today; namely, individuals under the age of 21 and stays that do not exceed 15 calendar days in a month. For these services, ESH and WSH already have contract management experience with the BHOs that would convert to the FIMC organizations. PCG does not anticipate the need for state hospital capacity building to manage this payer relationship.

9.3.8 Financial and legal considerations of MCE contracts with inpatient state adult psychiatric hospitals

The managed care risk model must align with the emerging delivery system for behavioral health care services in Washington. The state is currently transitioning to full integration of behavioral health into Medicaid managed care contracts. FIMC involves two entities working collaboratively to deliver the full range of Medicaid and non-Medicaid services to consumers who are eligible for Medicaid and those who are not. This model has already been implemented in Southwest Washington and was established this year for the North Central Region. By January 1, 2020, all counties will have adopted this model.

The primary managed care entity under this model is the FIMC organization. FIMCs provide the full array of Medicaid state plan services to the Medicaid eligible population in each county. FIMCs also provide non-Medicaid funded behavioral health services to its Medicaid eligible population under a wrap-around contract.

BH-ASOs are the second entity and provide crisis services such as a 24-hour hotline, mobile crisis outreach teams and crisis coordination with providers, health plans and county agencies. BH-ASOs also provide access to non-crisis behavioral health services, such as outpatient or residential substance use disorder and mental health services to low-income individuals who are not eligible for Medicaid.

Under this delivery system model, HCA procures directly for both FIMC and BH-ASO services. The FIMC organizations are required to subcontract with the BH-ASO that has been selected by HCA for the provision of crisis services to Medicaid members. The state separately contracts with the BH-ASO for the crisis and behavioral health treatment services provided to non-Medicaid eligible individuals.

Long term civil commitments are primarily a non-Medicaid service since 21-64 year-old individuals residing in an IMD are not Medicaid eligible. A substantial majority of long term civil commitments fall into this age category. However, as noted previously, it is also true that Medicaid can be the payer for a long term civil commitment for those under the age of 21 as well as for portions of long term civil commitments that take up less than 15 days in a calendar month, consistent with the Medicaid managed care rule.

PCG recommends that Washington align managed care payment roles for long-term civil commitments consistent with this model. **We recommend that BH-ASOs be assigned the role of payer for 90- and 180-day involuntary commitments for non-Medicaid eligible individuals. Under this scenario, the FIMC organization would be assigned the role of payer for 90- and 180-day involuntary commitments for Medicaid members.**

This recommendation acknowledges that both the FIMC organizations and BH-ASOs are key and interdependent entities in administering behavioral health managed care in Washington and encourages continued collaboration among them in addressing the needs of complex behavioral health patients. At the same time, the recommendation reinforces the respective roles of the FIMC organizations as the payer for Medicaid eligible clients and the BH-ASOs for non-Medicaid indigent populations, and is designed to avoid the anticipated significant operational challenges associated with distinguishing funding streams and payment authority to non-Medicaid members across FIMC organizations and BH-ASOs in information technology systems and agency procedures.

Under this risk model, all state revenue (not Medicaid, Medicare, DSH or commercial insurance) for new 90- and 180-day admissions after January 1, 2020 will be redirected to the BH-ASOs. As patient care migrates from BH-ASOs to FIMC organizations because more patients are transitioned to non-IMD community facilities, those dollars will migrate from the BH-ASO to the FIMC organization. The total amount will depend on selected benefits, number of new admissions, and lengths of stay by the newly admitted.

Financial considerations of managed care contracts with the inpatient psychiatric hospitals that are permitted to provide long-term involuntary commitment stays are largely driven by state payment methods to the FIMC organizations and BH-ASOs for this benefit.

Currently, the FIMC organizations and BH-ASOs receive a capitated payment for long term civil commitment costs that are billable to Medicaid under federal rules. That methodology would continue after January 1, 2020, with Medicaid's actuarial vendor determining the potential impact of extending the scope of involuntary commitment benefit coverage to 90- and 180-day stays.

However, the bulk of new funding associated with the migration of long term civil commitments to managed care would be allocated to the BH-ASOs. State payments to BH-ASOs are not capitated.

State business processes and information technology that drives accurate and accountable capitation rate setting begins in the Medicaid eligibility system. These systems assign categories of eligibility and region of residence. This information then migrates to state Medicaid Management Information Systems (MMIS), where the managed care capitation rate schedule has been loaded. Rate schedules are comprised of rate "cells" based on several factors. The MMIS system uses information that has been imported from a Medicaid eligibility system to assign a member to a rate cell. This enables the MMIS system to send enrollment reports to the managed organizations and to make accurate capitation payment amounts each month.

Legally, these Medicaid capitation rates are governed by federal rules requiring them to meet actuarial soundness rules. Medicaid rules do not apply to non-Medicaid benefit costs.

It is not beyond the experience of Medicaid for single-benefit capitation rates to be set. One example is non-emergency transportation broker benefits. However, PCG is not aware of capitation methods that mix Medicaid and non-Medicaid dollars into a single capitated rate. We are also not aware of business processes supporting assignment of capitation rates (and associated membership rosters and payment files) that do not extend from the Medicaid eligibility system. Therefore, unless a process for categorizing long term civil commitments as a separate eligibility group is completed, operational capacity for capitation payments will be unsupported.

For this reason, **PCG recommends that State funding provided to BH-ASOs for 90- and 180-day civil commitments not be allocated as a capitation payment**. We do not believe a capitation payment method is the only or, in this case, the optimal method, of putting the managed care entity "at risk" of financial penalties associated with inefficient and ineffective patient care.

Performance metrics related to risk are discussed in Section 9.3.7. Health care purchasing in Washington continues to migrate toward greater adoption of value-based purchasing models. PCG believes the BH-ASOs are well-positioned to become agents of value-based purchasing for long term civil commitments in Washington.

PCG acknowledges that many adults who reside in institutions for mental diseases (IMDs) under long term civil commitments are enrolled in Medicaid prior to their commitment and will return to it following their commitment. For this reason, it is important that the risk model support the ongoing engagement of the FIMC organization in the patient's care even as the BH-ASOs become the payer for these non-Medicaid eligible individuals. **For this reason, we recommend that the state require both FIMC organizations and BH-ASOs to be represented on the hospital clinical discharge planning team.** This issue is addressed in additional detail in Section 9.3.10.

BH-ASOs will use the Medicaid fee schedule to pay eligible providers for long-term civil commitments, except that by January 1, 2020, PCG recommends five percent of total hospital payments for long-term civil commitments be tied to achievement of performance goals, increasing to ten percent on January 1, 2021 with the launch of a value-based purchasing program scheduled for January 1, 2022.

Not capitating the BH-ASO funding allocations for long term involuntary civil commitments provides the benefit of not limiting incentive payments to five percent of the actuarial rate, as is standard under federal Medicaid managed care rules. This creates greater state flexibility in designing plan incentives.

FIMC organization responsibilities and funding for long-term civil commitments would remain unchanged from today. Today, people under the age of 21 remain Medicaid eligible even while residing at an IMD. Today, IMD stays of less than 15 days in a calendar month for adults are covered by Medicaid. This will continue to remain true and funded through capitation rate setting models.

A dynamic that could possibly change the share of dollars for long term civil commitments that run through FIMC organizations is the migration of civil inpatient care to smaller, community hospitals. Such stays in facilities of less than 16 beds may be covered through Medicaid.

Health plan stakeholders we interviewed in support of this research encouraged adoption of risk corridors to the extent that their payment responsibility for long term involuntary psychiatric stays expands under a capitation model. PCG sees such a risk corridor as important to the stability of Medicaid managed care should the role of community hospitals in long term civil commitments significantly expand by 2020, and accordingly **we recommend that for the capitated portion of funds, a risk corridor is established beyond which the state supplements payment.** The risk corridor can be set up for an initial two-year term after which its continued need may be assessed in the context of the existing landscape for inpatient civil commitments.

The legal framework for implementation of these recommendations should also be codified in state administrative rules that prescribe roles and responsibilities for behavioral health managed care entities and facilities that provide care for long-term involuntary civil commitments.

PCG was also asked to consider the application of performance metrics to the state hospitals. We believe the best mechanism for doing this is through implementation of a value based purchasing model, which we recommend FIMC organizations and BH-ASOs implement beginning in 2022. The establishment of performance goals for a state hospital is not without precedent: since 2003, Texas' state hospitals have worked toward measurable performance goals related to regulatory, financial, clinical quality and access measures that have been tracked and reported in quarterly performance indicator reports. To ensure accountability with performance indicators, each state hospital has a board with individualized bylaws. Even in the absence of measures tied to finances, Washington may wish to explore introducing new or expanded performance measurement systems in the state hospitals. A list of state hospital performance metrics used in Texas is attached as Appendix F.

9.3.9 MCE role in civil commitment process

The process for executing a long-term civil commitment is legally prescribed in Washington by RCW 71.05 for adults and RCW 71.34 RCW for youth. It is a deliberately phased process under which a person undergoing a mental health crisis, and who is determined to be an imminent threat to the safety of others or him or herself, may be detained for an initial evaluation and treatment period of 72 hours.

This detention period provides a window of time under which a county-appointed DMHP may file a petition to the county circuit court for a longer period of detention, beginning at a 14-day maximum interval. If, after 14 days, the individual is still determined to be an imminent threat to his or her own safety or the safety of others, the DMHP may petition for, and the Circuit Court may grant, an involuntary detention of up to 90 days or 180 days.

Despite the IMD exclusion, there is a foundation of existing state policy related to the role of FIMC organizations in civil commitments for covered individuals. The tables on the next page provide samples of FIMC contract language involving civil commitments. The first table looks at current contract provisions in three states, while the second table examines roles defined in four other states in contracts that are recent, but not effective in 2017.

Figure 9.1 Sample Contract Language on the Role of FIMC Organizations in the Civil Commitment Process

2017 CONTRACTS	
State	Contract Language Re: Managed Care Entity (MCE) Involvement in Civil Commitment Process
Washington – FIMC	*Population*: • Under age of 18 committed on an ITA court order for 180 days *Requirements*: • MCE must be available to assess the child's needs prior to admission to the CLIP facility, including consideration of less restrictive treatment options whenever possible. • MCE must provide a designee to collaborate with CLIP Administration for children subject to court-ordered treatment and provide care coordination and assistance in the development of a less restrictive alternative treatment as appropriate. • MCE representative shall share the community and/or family recommendations for purposes of the CLIP Program assignment of committed youth. *Population:* • All enrollees *Requirements:* • Allied System Coordination Plan. MCE must coordinate with all entities below as necessary to ensure continuity of care for enrollees. This includes coordination with criminal justice.

Minnesota	*Population:*
	• All enrollees
	Requirements:
	• Assignment of a MCE Mental Health Targeted Case Manager to:
	  • Work with hospitals, pre-petition screening teams, family members or reps, current providers to assess the enrollee and develop an individual care plan that includes diversion planning and least restrictive alternatives with the Commitment Act. This may include testifying in court, and preparing and providing requested documentation.
	  • Report to the court regarding enrollee's care plan status and recommendations for continued commitment, including as needed, requests to the court for revocation for a provision discharge
	  • Provide input to court appointed independent examiners

Tennessee	*Population*: • All enrollees *Requirements:* • MCE may apply medical necessity criteria to the situation after twenty-four (24) hours of emergency services, unless there is a court order prohibiting release. • MCE must have a staff person assigned to provide legal and technical assistance for and coordination with the legal system for court ordered services.

Figure 9.2 Historical Contract Language Regarding Civil Commitments

HISTORICAL CONTRACTS - 2000		
State	Where Psychiatric Hospitalizations can Occur	Coordination between MCE and the courts
Iowa	Court-ordered hospitalization can take place either in a community hospital or in a state psychiatric hospital.	Two court liaisons employed by MCE
Colorado	No specification. Hospitalization generally occur in state hospitals.	MCE is "encouraged" to work with the judiciary
Minnesota	No specification. Most hospitalization occur in state hospitals. Through an 1115 waiver, MCE allowed to use IMDs if they were willing to pay with non-Medicaid resources.	Counties must allow MCE to participate in treatment decision if MCE is to pay
Wisconsin	No specification. There is language that MCE only has to pay for services delivered by in-network providers for court-ordered hospitalizations.	Some education of judges by MCE representative

In Washington for the past several years, BHOs (and Regional Support Networks before them) were financially incentivized to reduce long-term involuntary psychiatric commitments through "bed allocations." BHOs were allotted a specific number of beds for which they did not bear financial responsibility, but they faced financial penalties for exceeding it. Critics of this methodology believe it incentivized BHOs to utilize all of their "free" beds.

This risk model assumes that payment to the psychiatric hospital for all new 90- or 180-day civil commitments after January 1, 2020 will be made by either the FIMC organization or the BH-ASO, depending on whether the payment source is Medicaid or not. However, the FIMC organization or BH-ASO will not primarily drive the medical necessity decision of an involuntary detention. Legally, the DMHP/Designated Crisis Responder (DCR) will continue to be the originator of the detention petition, which may cause concern for FIMC organizations that believe being put at financial risk must come with a reciprocal ability to meaningfully influence the patient's care plan.

PCG believes this risk model must strike a balanced approach that preserves the existing legal framework for long-term civil detentions while enhancing the care manager's ability to influence the health plan. To do this, we recommend that **Washington adopt a new set of requirements for DMHPs and FIMCs related to civil commitments that retains the integrity of the process and DMHP independence while enabling FIMC organizations to inform the process with firsthand information about the patient and thoughtful recommendations regarding care approaches.** The suggested specific requirements are that:

- the managed care contract direct the health plan to pay for all court-ordered services even if the plan does not agree that the order meets the standards of medical necessity;
- the originator of the involuntary commitment petition must be the DMHP/DCR, independent of the MCE;
- the DMHP make facility placement decisions that promote a "regional care model." The goals of this model are to keep patients as close to their communities of residence as possible;
- the DMHP's petition must consider care and placement recommendations made by the MCE;
- the MCE be required to submit care and placement recommendations to the DMHP/DCR when a detention petition is being filed;

- the MCE be required to participate as a member of the discharge planning team. When the BH-ASO is the responsible entity, they must also be required to solicit discharge planning input from the FIMC organization, which should also be required to participate in this process.

PCG believes these recommendations bring the FIMC organization into a meaningful care management role while still preserving a line of independence between the payer and the entity legally responsible for originating detention petitions.

9.3.10 MCE role in hospital discharge decision making

FIMC organizations and BHOs play a pivotal role in facilitating the efficient and appropriate transition of civilly committed patients being discharged from inpatient care. These entities are the critical link between the hospital providers and staff attending to the patient during the period of commitment and the community providers that will address treatment, placement, medication and other issues once the patient has been released. FIMC organizations also coordinate benefits such that the patient's benefits (particularly Medicaid) are in place at the time of discharge.

Under the existing model, each FIMC organization or BHO has designated staff at the two state hospitals that focus on planning for and enabling discharge from the day the patient enters the hospital. FIMC organization contracts contain specific provisions regarding planning for patient discharge, coordinating appropriate placements and services in the community and following up with enrollees after discharge. More intensive measures must be observed for enrollees considered at high risk of re-hospitalization. The existing model has worked well and the consensus among stakeholders is that discharge planning coordination at the state hospitals operates in a relatively efficient manner.

While FIMC organizations have responsibility for coordinating discharge planning and benefits for civilly committed patients, the hospital makes the decision regarding a patient's level of need once he or she has been admitted. Further, the hospital has the ultimate authority to determine when an individual is ready to be discharged, so this decision is not within the control of the FIMC organization. However, the FIMC organization's ability to arrange for an appropriate placement and/or course of treatment for the patient upon discharge may make the authorizing representative from the hospital more likely to recommend discharge in lieu of continued commitments and may mitigate concerns about risks associated with discharge.

The role of the FIMC organizations in working with hospitals to develop discharge plans is well documented in Washington code and PCG does not recommend changes to current regulations. However, PCG does recommend that if Washington adopts the recommended model of having BH-ASOs manage care for uninsured civilly committed patients, that **the state require both FIMC organizations and BH-ASOs to be represented on the hospital clinical discharge planning team** to ensure that they have sufficient knowledge and ability to influence clinical discharge decisions to the full extent possible.

Also important to note is that shifting to a model that includes capacity for civil commitments outside of the two state adult psychiatric hospitals will create a more decentralized system in which it may be more difficult for an FIMC organization or BH-ASO to have full-time staff at each facility designated to work specifically on discharge planning. Presumably, the regular presence of staff onsite at ESH and WSH enables more frequent and impromptu interactions with hospital staff regarding discharge planning, which is conducive to a more efficient and informed process. In order to address this issue, Washington may wish to consider

developing a standard for FIMC organization or BH-ASO presence at facilities where their patients are committed; for example, the responsible entity must spend a minimum of 10 hours per month per patient onsite. This standard would be embedded in the FIMC organization or BH-ASO contract and they might be required to submit documentation of hours by facility on a monthly basis.

Appendix A

National Quality Forum: Behavioral Health Measures

Measure Title	NQF#	Measure Steward	Updated Date	Status	Type of Measure
Depression Remission at Six Months	0711	MN Community Measurement	March 06, 2015	Endorsed	Quality
Depression Remission at Twelve Months	0710	MN Community Measurement	March 06, 2015	Endorsed	Quality
Depression Utilization of the PHQ-9 Tool	0712	MN Community Measurement	March 06, 2015	Endorsed	Quality
Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)	0726	National Assoc. of State Mental Health Program Directors Research Institute, Inc. (NRI)	January 07, 2015	Endorsed	Quality
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	0418	Centers for Medicare & Medicaid Services	February 28, 2014	Endorsed	Quality
Depression Assessment Conducted	0518	Centers for Medicare & Medicaid Services	September 30, 2015	No Longer Endorsed	Quality
Antidepressant Medication Management (AMM)	0105	National Committee for Quality Assurance	March 28, 2017	Endorsed	Quality
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	0108	National Committee for Quality Assurance	June 28, 2017	Endorsed	Quality
Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	0008	Agency for Healthcare Research and Quality	September 17, 2012	Endorsed	Quality
Follow-Up After Hospitalization for Mental Illness (FUH)	0576	National Committee for Quality Assurance	June 28, 2017	Endorsed	Quality
CAC-1: Relievers for Inpatient Asthma	0143	The Joint Commission	October 02, 2014	No Longer Endorsed	Quality
HCAHPS	0166	Centers for Medicare & Medicaid Services	January 07, 2015	Endorsed	Quality
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	0104	AMA-convened Physician Consortium for Performance Improvement	March 28, 2017	Endorsed	Quality

Measure Title	NQF#	Measure Steward	Updated Date	Status	Type of Measure
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	0004	National Committee for Quality Assurance	February 08, 2016	Endorsed	Quality
Diabetes Long-Term Complications Admission Rate (PQI 03)	0274	Agency for Healthcare Research and Quality	May 12, 2016	Endorsed	Quality
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	1365	AMA-convened Physician Consortium for Performance Improvement	August 24, 2017	Endorsed	Quality
SUB-1 Alcohol Use Screening	1661	The Joint Commission	May 10, 2016	Endorsed	Quality
SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	1663	The Joint Commission	May 10, 2016	Endorsed	Quality
SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	1664	The Joint Commission	May 10, 2016	Endorsed	Quality
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1879	Centers for Medicare & Medicaid Services	December 20, 2016	Endorsed	Quality
Depression Response at Six Months- Progress Towards Remission	1884	MN Community Measurement	February 08, 2016	Endorsed	Quality
Depression Response at Twelve Months- Progress Towards Remission	1885	MN Community Measurement	October 26, 2016	Endorsed	Quality
HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed	1922	The Joint Commission	October 03, 2017	Endorsed	Quality
Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	1927	National Committee for Quality Assurance	April 05, 2017	Endorsed	Quality
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1932	National Committee for Quality Assurance	March 09, 2017	Endorsed	Quality

Measure Title	NQF#	Measure Steward	Updated Date	Status	Type of Measure
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	1933	National Committee for Quality Assurance	December 23, 2014	Endorsed	Quality
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	1934	National Committee for Quality Assurance	June 10, 2016	Endorsed	Quality
Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	1937	National Committee for Quality Assurance	April 05, 2017	Endorsed	Quality
Adult Current Smoking Prevalence	2020	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion	October 19, 2012	Endorsed	Quality
Antipsychotic Use in Persons with Dementia	2111	Pharmacy Quality Alliance	November 16, 2017	Endorsed	Quality
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2152	AMA-convened Physician Consortium for Performance Improvement	January 11, 2017	Endorsed	Quality
Antipsychotic Use in Children Under 5 Years Old	2337	Pharmacy Quality Alliance (PQA, Inc.)	November 10, 2014	Endorsed – Time-Limited	Quality
Gains in Patient Activation (PAM) Scores at 12 Months	2483	Insignia Health	April 07, 2016	Endorsed	Quality
Substance Use Screening and Intervention Composite	2597	American Society of Addiction Medicine	March 06, 2015	Approved For Trial Use	Composite
Alcohol Screening and Follow-up for People with Serious Mental Illness	2599	National Committee for Quality Assurance	May 17, 2017	Endorsed	Quality
Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	2600	National Committee for Quality Assurance	May 17, 2017	Endorsed	Quality
Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	2601	National Committee for Quality Assurance	March 06, 2015	Endorsed	Quality
Controlling High Blood Pressure for People with Serious Mental Illness	2602	National Committee for Quality Assurance	May 17, 2017	Endorsed	Quality
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing	2603	National Committee for Quality Assurance	May 17, 2017	Endorsed	Quality

Measure Title	NQF#	Measure Steward	Updated Date	Status	Type of Measure
Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	2604	National Committee for Quality Assurance	May 17, 2017	Endorsed	Quality
Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2605	National Committee for Quality Assurance	February 07, 2017	Endorsed	Quality
Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	2606	National Committee for Quality Assurance	May 17, 2017	Endorsed	Quality
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	2607	National Committee for Quality Assurance	May 17, 2017	Endorsed	Quality
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	2608	National Committee for Quality Assurance	May 17, 2017	Endorsed	Quality
Diabetes Care for People with Serious Mental Illness: Eye Exam	2609	National Committee for Quality Assurance	May 17, 2017	Endorsed	Quality
Inpatient Rehabilitation Facility (IRF) Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients	2634	Centers for Medicare & Medicaid Services	February 06, 2017	Endorsed	Quality
Metabolic Monitoring for Children and Adolescents on Antipsychotics	2800	National Committee for Quality Assurance	May 04, 2016	Endorsed	Quality
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	2801	National Committee for Quality Assurance	May 04, 2016	Endorsed	Quality
Tobacco Use and Help with Quitting Among Adolescents	2803	National Committee for Quality Assurance	May 04, 2016	Endorsed	Quality
Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department	2806	Seattle Children´s Research Institute	May 04, 2016	Endorsed	Quality
Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)	2860	Centers for Medicare & Medicaid Services	December 09, 2016	Endorsed	Quality
Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions	2888	Centers for Medicare & Medicaid Services (CMS)	December 09, 2016	Endorsed	Quality

Measure Title	NQF#	Measure Steward	Updated Date	Status	Type of Measure
Use of Opioids at High Dosage in Persons Without Cancer	2940	PQA	January 26, 2017	Endorsed	Quality
Use of Opioids from Multiple Providers in Persons Without Cancer	2950	PQA	January 26, 2017	Endorsed	Quality
Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer	2951	PQA	January 26, 2017	Endorsed	Quality
CAHPS® Home- and Community-Based Services Measures	2967	Centers for Medicare and Medicaid Services	November 14, 2017	Endorsed	Quality
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	3132	Centers for Medicare & Medicaid Services	June 28, 2017	Endorsed	Quality
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	3148	Centers for Medicare & Medicaid Services	June 28, 2017	Endorsed	Quality

Appendix B

Performance Measures in FIMC Contracts

Attachment 6 - 2017 Performance Measures
FULLY INTEGRATED MANAGED CARE
(FIMC)

All measures must be publicly reported by plan name through the Quality Compass		Notes
Prevention and Screening		
ABA	Adult BMI Assessment	Hybrid
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Hybrid
CIS	Childhood Immunization Status	Hybrid
IMA	Immunizations for Adolescents	Hybrid
LSC	Lead Screening in Children	Hybrid
BCS	Breast Cancer Screening	
CCS	Cervical Cancer Screening	Hybrid
CHL	Chlamydia Screening in Women	
Respiratory Conditions		
CWP	Appropriate Testing for Children With Pharyngitis	
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	
PCE	Pharmacotherapy Management of COPD Exacerbation	
MMA	Medication Management for People With Asthma	
AMR	Asthma Medication Ratio	
Cardiovascular		
CBP	Controlling High Blood Pressure	Hybrid
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	
SPC	Statin Therapy for Patients With Cardiovascular Disease	
Diabetes		
CDC[2]	CDC: Hemoglobin A1c (HbA1c) Testing	Hybrid
CDC[2]	CDC: HbA1c Poor Control (>9.0%)	Hybrid
CDC[2]	CDC: HbA1c Control (<8.0%)	Hybrid
CDC[2]	CDC: Eye Exam	Hybrid
CDC[2]	CDC: Medical Attention for Nephropathy	Hybrid
CDC[2]	CDC: Blood Pressure Control (<140/90 mm Hg)	Hybrid
SPD	Statin Therapy for Patients With Diabetes	
Musculoskeletal		

ART	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	

Behavioral Healthcare		
AMM	Antidepressant Medication Management	
ADD	Follow-Up Care for Children Prescribed ADHD Medication	
FUH	Follow-Up After Hospitalization for Mental Illness	NO BENEFIT*
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia	
SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
Medication Management		
MPM	Annual Monitoring for Patients on Persistent Medications	
Overuse/Appropriateness		
NCS	Non-Recommended Cervical Cancer Screening in Adolescent Females	
URI	Appropriate Treatment for Children With Upper Respiratory Infection	
AAB	Avoidance of Antibiotic Therapy for Adults With Acute Bronchitis	
LBP	Use of Imaging Studies for Low Back Pain	
APC	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	
Access/Availability of Care		
AAP	Adults' Access to Preventive/Ambulatory Health Services	
CAP	Children and Adolescents' Access to Primary Care Practitioners	
ADV	Annual Dental Visit	NO BENEFIT
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NO BENEFIT*
PPC	Prenatal and Postpartum Care	Hybrid
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	
Use of Services		
FPC	Frequency of Ongoing Prenatal Care	Hybrid
W15	Well-Child Visits in the First 15 Months of Life	Hybrid
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Hybrid
AWC	Adolescent Well-Care Visits	Hybrid
FSP	Frequency of Selected Procedures	
AMB	Ambulatory Care	
IPU	Inpatient Utilization–General Hospital/Acute Care	
IAD	Identification of Alcohol and Other Drug Services	NO BENEFIT*

MPT	Mental Health Utilization	Report the Outpatient/ED category only. Do not report the following categories: All, Inpatient, or Intensive Outpatient/ Partial Hospitalization.
ABX	Antibiotic Utilization	
Health Plan Descriptive Information		
ENPA	Enrollment by Product Line - Total	
EBS	Enrollment by State	
LDM	Language Diversity of Membership	
RDM	Race/Ethnicity Diversity of Membership	
TLM	Total Membership	
NEW MEASURES 2017		
FUM	Follow-Up After Emergency Department Visit for Mental Illness	To be reported to HCA
FUA	Follow-Up After Emergency Department Visit for Alcohol and other Drug Dependence	To be reported to HCA

* CDC[2] = Comprehensive Diabetes Care
* FUH = Benefit applies in counties with FIMC and reported at MCO level
* IET = Benefit applies in counties with FIMC and reported at MCO level
* IAD = Benefit applies in counties with FIMC

Appendix C

Discussion Questions for Stakeholder Interviews

STATE OF WASHINGTON
ANALYSIS OF INCORPORATING LONG-TERM INPATIENT CARE INTO THE PSYCHIATRIC MANAGED CARE CAPITATION RISK MODEL
STAKEHOLDER INTERVIEW QUESTIONS

The following interview questions aim to address specific policy questions that will support successful implementation of a risk model for this population.

I. General Information

1) Please describe your current role, including its relation to the operation of managed care and/or the behavioral health system in the State of Washington.

2) How long have you held your current position?

3) Do you have any general perspectives on managed care for civil inpatient psychiatric hospital services you'd like to share?

4) How do you think that incorporating a risk model including civil commitments into managed care entity (MCE) contracts will be beneficial to Washington? Please explain.

5) What do you see as the greatest areas of concern or risk related to implementation of the revised risk model?

II. Authority and Clinical Decision Making

1) How can a managed care entity (MCE) appropriately engage in care decisions that are interrelated with the legal components of a civil commitment?

2) How can an MCE best support appropriate clinical decision making when an individual is ready to be discharged from a state hospital (inclusive of court determination needs, if applicable)?

3) Does enough capacity exist today to transfer civil commitments into the community? If so, how should the financial model incorporate this capacity (state contracts with an MCE and MCE contracts with current providers). If not, how best can we build this capacity?

III. Provider Contracting

1) What contracting requirements do you believe need to be in place among MCEs, state psychiatric hospitals, state agencies and community settings to support integrating civil inpatient services, including 90 and 180-day commitments?

2) What performance metrics do you recommend for inclusion in the contracts between the state and the MCEs?

3) Do you think MCEs should be able to place performance benchmarks on the state psychiatric hospitals? If no, why not? If yes, which benchmarks would you recommend?

4) What, if any, financial or legal areas do you believe we should consider in the analysis of updating MCE contracts to include care at inpatient psychiatric hospitals?

IV. Member Services

1) What is your perspective on how commitments that start as forensic and are changed to civil (aka forensic flips) should be incorporated into managed care?

2) How do you think managed care requirements with respect to member services should be adjusted to reflect the inclusion of inpatient care?

3) Do you have suggestions for how MCEs coordinate discharge planning with community provider staff and state psychiatric hospitals?

V. Financing

1) How do you think financial risk for inpatient care should be phased into the managed care model by 2020?

2) Which Medicaid and non-Medicaid populations do you believe should be included in a risk model for long-term civil inpatient psychiatric services? Conversely, are there specific populations that you believe should be excluded from such a model?

3) How should tribal populations be incorporated into this model?

4) Which services should be included in a financial risk model for long-term civil inpatient psychiatric services? Are there any services you believe should be excluded?

VI. Additional Perspectives

1) Is there any other input you'd like to provide as it relates to this initiative?

Appendix D

Matrix of Key Stakeholder Issues and Concerns

Ref. #	Issue/Concern	Associated Risks	Possible Solution
Authority and Clinical Decision Making			
1.	MCE role in the civil commitment process must not interfere with the integrity of the process	The civil commitment process is structured to enable independent decision-making regarding an individual's course of treatment; any real or perceived MCE influence on commitment decisions based on financial considerations must be avoided	Ensure that the integrity of the civil commitment process remains in place by preserving the current structure but allow for MCEs to provide clinical information that may serve to better inform the decisions of the court and DMHPs
2.	Fully Integrated Managed Care is still in the implementation phase and has not been adopted statewide	With only two MCEs currently managing behavioral health services in Washington, it is expected that there will be a sharp learning curve for the others as they enter this arena over the next two years. Additionally, the MCEs will need time to build relationships with behavioral health providers, hospitals and other involved stakeholders in each new region that they support	Continue to document, publicize and incorporate lessons learned from the early adopter regions to support a smoother transition for MCEs and related parties in each region. Ensure that the risk model timeline accounts for the need for time to learn the landscape and establish the relationships essential to effective care management for complex populations
3.	Sustainment of crisis services in the shift to Fully Integrated Managed Care	Local/county-run crisis services managed outside of BHO contracts may be challenging to sustain under an FIMC model because of the lack of a single entity managing behavioral health services in a region. The loss or reduction of these services may result in individuals experiencing a BH crisis not getting timely or appropriate access to assistance when needed	The state must support the ongoing presence of existing crisis services by addressing, either through BH-ASO funds for this purpose and/or contracting requirements with the MCEs, that sufficient funding is made available and appropriate contracts are executed to ensure that these services remain in place
4.	Shift from regional to FIMC model of care will create system overlap and confusion	Under the BHO model, a single entity in each region has primary responsibility for contracting with behavioral health service providers, including crisis responders, in that region. Under FIMC, each region will have multiple entities responsible for contracting, in some cases as many as five, which may create timing challenges, confusion and complications in executing contracts and ensuring sufficient capacity and a strong continuum of care for patients with behavioral health needs	Similar to the model in the Southwest region, ensure that crisis services are contracted for in a manner that preserves the resources in place, at least while FIMC is still in implementation mode and system issues are being identified and addressed. Use lessons learned from the early adopter regions to inform the approach used in other regions.
Oversight and Monitoring			
5.	MCE contracts must be structured to ensure that the necessary capacity is built to support the aims of the risk model	If MCEs are given a pool of money to use without sufficient parameters for how it will be spent (e.g. building community capacity to accept civilly committed patients,) the state risks spending significant funds without generating the kinds of resources that are needed to support the treatment of complex psychiatric patients	Include specific metrics in the MCE contracts regarding network adequacy for various facility and provider types

Ref. #	Issue/Concern	Associated Risks	Possible Solution
6.	MCE contracts must contain benchmarks that effectively gauge performance and ensure high quality care	MCEs need to be held accountable to specific performance standards in order to verify that they are providing quality, appropriate care to complex behavioral health patients	Examine national and state best practice models and accepted metrics to inform development of performance measures for the risk model and incorporate appropriate metrics into the model
7.	HCA capacity to provide sufficient oversight of managed care contracts	The introduction of a capitated risk model to manage a highly complex population and benefit, and the associated contract provisions and performance measures, will require substantial contract oversight capacity and expertise that does not currently exist within HCA	Hire additional staff with contract and performance oversight expertise to supplement HCA's existing resources. Ensure that the risk model allows sufficient time to collect and incorporate baseline data that can inform future requirements, metrics, incentives and structural issues regarding contracts to ensure achievement of the stated goals of the risk model
8.	The state is not effectively managing or enforcing its existing contracts with providers of residential services	Individuals not appropriate for continued placement in the state hospitals remain there in some cases due to a lack of alternative placement providers being willing to accept them, typically because of behavior-related challenges. Thus, facilities are considered to be choosing to accept those individuals easiest to serve	The state must required providers to take on patients in accordance with the terms of their contracts with the state. If providers refuse to do so, the state can apply financial or contract-related pressure to ensure that the state "gets what it is paying for"
Populations and Member Services			
9.	Need to ensure access to and continuity of services for long term civilly committed patients	State hospitals are designed to address the needs of long-term civilly committed patients in a manner that few other facilities are. Hence, the shift to serving long-term civilly committed patients in community facilities carries some risk that not all required services will be readily available to a patient	Include in the risk model all services currently available to long term civilly committed patients at the state hospitals
10.	Forensic flips are exceptionally difficult to manage	Forensically flipped patients can have a significant and adverse effect on MCE/BHO budgets and these entities typically have no opportunity to intervene with the individual prior to criminal justice involvement. Further, even active planning on behalf of the patient during the time of the civil commitment stay does not guarantee successful outcomes since the patient may flip back to forensic status if they are re-charged for their crimes	Do not include forensic flips in the capitated risk model, at least in its first phase. Allow MCEs and BHOs to tackle care management for other populations before including this particularly challenging patient population in the caseload
11.	Tribes in Washington have unique needs and priorities that must be considered related to the risk model	Requiring that tribal populations be included in the risk model without conducting sufficient outreach and engaging in discussions with each of the 29 sovereign nations will yield a model that does not work for tribes and may generate backlash that will impede implementation of the model	Enable tribal citizens to continue to opt out of behavioral health managed care and thus the risk model. In line with existing current efforts and legislation to address the needs of tribal nations, engaged in sustained and meaningful discussions with tribes to understand and address specific concerns related to behavioral health including long term inpatient psychiatric care
12.	Patients in state hospitals that have conditions that will not improve (e.g. dementia, Huntington's, Traumatic Brain Injury)	These patients have little or no opportunity for their conditions to improve and therefore should be served in specialized settings and may not be appropriate for a risk-based managed care model	Increase state funding for long term care specialized housing that can address the needs of these individuals outside of the state hospital system

Ref. #	Issue/Concern	Associated Risks	Possible Solution
Financing			
13.	Rate setting must be fully reflective of the full range of needs for patients included in the risk model	Actuarial rates are sometimes set using outdated or incomplete data, resulting in a rate that does not fully reflect the cost of caring for patients and is insufficient to do so effectively. Time intervals for rate adjustments may also not enable timely updates to account for changes in patient needs or related capacity issues	When developing rates, use good, recent data and consider all elements that will need to be incorporated into the rate to address all patient needs. Adjust rates to reflect variations by region and for patient complexity. Consider more frequent rate reviews and allow for more timely updates to reflect landscape or other changes that drive up costs of care
14.	Bed allocation model has created incentives to overutilize inpatient care at the state hospitals	The existing bed allocation model for BHOs and early adopter MCEs may create financial incentives for these entities to rely too heavily on inpatient care at the state hospitals because these are considered “free” days when the state is assuming the costs for providing this care. This may also discourage active and efficient discharge planning on behalf of civilly committed patients	Replace the bed allocation model with a model that places the cost burden for care at the state hospitals on the entity responsible for managing the patient’s care
Community Capacity			
15.	Sufficient capacity to serve long term civilly committed patients outside of the state hospitals does not currently exist	The placement of long-term civilly committed patients in non-state hospital facilities requires that such capacity exists; without it, managed care entities will have options for placing patients, putting their health and safety at risk	Allow a reasonable timeline for placement of all civilly committed patients outside of the hospitals and establish a target date by which the state hospitals will no longer accept civil commitments
16.	The facility requirements and costs associated with accepting long-term civilly committed patients will discourage many hospitals from pursuing the ability to accept these patients	If hospitals are unwilling to participate in accepting civilly committed patients, the effort to relocate such commitments from the state hospitals will fail and the risk model will not achieve its intended outcomes	Commence and continue active engagement with hospitals to understand and address concerns associated with taking on this population. Work with and through MCEs to negotiate contracts with the hospitals that allow for the necessary placements in a cost-effective manner

Appendix E

State Hospitals Services Inventory

Western State Hospital Services Inventory

Direct Services
Adaptive Treatment Program (specialized treatment for patients with borderline intellectual functioning)
Behavioral Modification/Token economy systems
Care for Individuals with Dementia
Clinical Care Services
Cognitive Assessment
Cognitive Behavioral Therapy
Dental Services
Diagnostic Radiology
Dialectical Behavioral Therapy
Dietary
Forensic Risk Assessments
Habilitative Mental Health (DD Services)
Individual Psychotherapy
Inpatient Competency Evaluation and Restoration Treatment
Medical Services
Medication Management
Not Guilty by Reason of Insanity Treatment
Nursing Care
Occupational Therapy
Optometry
Pharmacy Services
Physical Therapy
Podiatry
Psychiatric Care
Psychological Assessment
Psychological Services
Recovery Groups/Treatment Malls
Recreational Therapy
Rehabilitation Screening and Services
Specialized treatment for individuals with traumatic brain injury
Substance Abuse Group Treatment
Suicide Risk Assessment and Treatment
Vocational Rehabilitation/Greenhouse
Direct Support Services
Adult Basic Education Classes/GED Preparation
Art Therapy
Assistance with Guardianship/Advance Directives
Beautician Services
Chaplain Services
Civil Commitment Evaluation and Testimony
Clinical Case Consultation
Discharge Planning: Community Outreach
Discharge Planning: Coordination with Behavioral Health Organizations
End of Sentence Review Hearings for Individuals with History of Sexual Offenses
Environmental/Custodial Services

Evening and Weekend Recreational Programming
Facilities and Environment of Care
Direct Support Services
Forensic Risk Review Board (reviews NGRI clients for discharge readiness and works with Public Safety Review Panel [PSRP])
Infection Control Services and Program
Jail Competency Evaluation Services
Lab Services (Limited, Reference lab for tests not completed onsite)
Motivational Interviewing Treatment
NGRI Forensic Community Program
Outpatient Case Management to NGRI Patients on Conditional Release
Patient Family Education/First Aid Mental Health Training
Patient Illness and Life Skills Education
Relapse Prevention Plan Assistance
Sanity and Diminished Capacity Evaluation and Testimony
Social Work Services

Eastern State Hospital Services Inventory

Direct Services
Active Treatment/Recovery Mall
Care/treatment of physical illness
Competency Evaluation (forensic)
Competency Restoration (forensic)
Dental Services
Diagnostic Radiology (portable radiology – no radiology department at ESH)
Laboratory Services
Medical Intervention
Medication Management/Education
Nutrition Services provided by registered dieticians
Occupational Therapy
Pharmacy
Physical Therapy
Psychiatric Services
Psychiatric Stabilization (civil – Adult and Geriatric Units; and Habilitative Mental Health {HMH} for patients with a developmental disability and a mental illness)
Psychology Services
Recreational Therapy
Speech Therapy
Direct Support Services
Accounting (onsite banking system for patients, Financial Benefits Coordinator, Part D Coordinator)
Discharge planning
Individual/Group/Family treatment and education
Medical Records
Pastoral
Referrals for CDP if necessary
Social Work
Treatment planning

Appendix F

Texas State Hospital Performance Indicators[44]

Performance Indicators Category	Indicator(s)/Measurement(s)
Regulatory Indicators	• CMS & Joint Commission Surveys/Complaints
Financial Indicators	• Quarterly Charges and Collections
Financial Measures	• Average Cost per Unique Patient Served • Medicaid Value of Service Charged on GR Patients • Revenue Versus Budget • Outside Medical Cost • Percent MCO Patients Days Authorized for Current Week • Average Cost per Bed Day
Clinical Quality Indicators	• Patient Satisfaction • Patient Complaints & Grievances • Medication Errors • Workers Compensation Cost • Patient Injured During Restraint or Seclusion • Falls Injuries • Rate for Unauthorized Departures • Facility Support Performance Indicators
Clinical Quality Measures	• Potentially Preventable Readmissions (15 Days) • Employee Injuries • Patient Restraints • Patient to Patient Aggression • Abuse & Neglect Allegations • Staff Competency • Staff Turnover Rates for Critical Shortage Staff • Vacancies for Critical Shortage Staff • Staff Utilizing Education Leave • Data on Healthcare Associated Infections • Receiving New Generation Medications • Cost of New Generation Medications • TCID Cost of Tuberculosis Medications
Access Measures	• Average Length of Stay • Percent of Admissions Discharged in 15 Days by Week of Admission • Unique to Hospital System Patients Admission for the Week • Average Daily Census/Capacity • Patients Hospitalized Over 365 Days • Admissions/Discharges/New to System • TCID Admissions, Inpatient Days & ALOS

[44] Health and Human Services Commission, Department of State Health Services, *State Hospital Section*, 2017 Management Plan, 3rd Quarter FY 2017

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