Intensive Outpatient Services report

Engrossed Substitute Senate Bill 5092; Section 215(39)(e); Chapter 334; Laws of 2021

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Summary

Senate Bill (SB) 5092 (2021) Section 215(39)(e), and SB 6168 (2020) Section 215(76)(f) (referred to in this report as proviso 76), require the Health Care Authority (HCA) to implement two pilot sites, one on each side of the Cascade Mountains, for children and youth-centered intensive outpatient services and partial hospitalization services. The pilot sites are **Providence Sacred Heart Hospital** (eastside) and **Seattle Children's Hospital** (westside).

The Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP) began January 1, 2021. Startup of direct services began spring of 2021. As required by SB 5092, the sites are based in psychiatric hospitals serving children and adolescents. HCA established minimum standards, eligibility criteria, authorization and utilization review processes, and payment methodologies for the pilot programs. The requirements include:

- Meeting the needs of an individual referred to the program. Children and adolescents discharged from an inpatient hospital treatment program who require the level of services offered by the pilot programs in lieu of continued inpatient treatment.
- Children and adolescents who require the level of services offered by the pilot programs to avoid inpatient hospitalization.

Services may not be offered if there are less costly, alternative community-based services that can effectively meet the needs of children and youth referred to the program.

SB 5092 requires HCA to collect data from the pilot sites, and work with the actuaries who are responsible for establishing managed care rates for Medicaid enrollees. This preliminary report contains specific data from the pilot sites and efforts with HCA's contracted actuary, Mercer Government Human Services Consulting (Mercer).

Impacts to timeline

The timeline for starting the pilots was impacted by the COVID-19 pandemic. Resources were redirected to support the pandemic response. With a later start date, the data collection period was reduced. The services shared in this preliminary report are from March 1 through June 30, 2021. HCA expects the data for the final report to be more robust.

Findings

HCA worked closely with Seattle Children's Hospital, Providence Sacred Heart, and Mercer. See the Mercer report in Appendix A for a description of the methodology and assumptions used in developing the fees and fiscal impact for the pilot programs, and considerations for potential Medicaid coverage of these two services in the future.

Youth served

PHPs and IOPs served 39 youth from March 1–June 30, 2021.

- BEST at Providence Sacred Heart Hospital served 18 youth.
- Seattle Children's Hospital's 3 programs and RISE at Providence Sacred Heart Hospital served 21 youth.

Demographics data

Age

- PHPs served youth, ages 8- to 13-years-old, with an average age of 10.
- IOPs served youth, ages 13- to 18-years-old, with an average age of 15.

Gender and transgender identity

Of the 39 served by IOPs and PHPs, 38 percent identified as male, and 61 percent identified as female. This data included transgender youth.

Race

Most youth served by BEST, RISE, and Seattle Children's Hospital were Caucasian/White. The programs also served African American, Asian, Native American, and Pacific Islander youth.

Ethnicity

RISE and Seattle Children's Hospital served Hispanic and Non-Hispanic youth.

Co-occurring disorders

Providence and Seattle Children's Hospital served youth with co-occurring mental health and intellectual or developmental disorders, or mental health and co-occurring substance use disorders.

Referrals

Some youth served by BEST and RISE programs were referred by an emergency department.

Services provided

Program descriptions and components will be provided later in this report. Generally, children and youth served by PHPs moved into a lower level of care after an average of 12 days of treatment. Children and youth served by IOPs received an average of 14 days of treatment.

Impact and outcomes

Prevented inpatient stays

BEST prevented a total of 220 inpatient stays and RISE prevented a total of 54 inpatient stays, for a total of 274 inpatient stays prevented across both programs.

Next Steps/Conclusion

HCA will submit a final report to the Office of Financial Management and the appropriate committees of the Washington State Legislature by December 1, 2022.

Appendix A

Proviso 76—Pilot Programs for Intensive Outpatient Services and Partial Hospitalization Services for Children and Adolescents

HCA contracted with Mercer, part of Mercer Health & Benefits LLC, to develop fees and determine fiscal impact for the pilot programs in response to proviso 76.

Per the proviso, the Legislature provided $1,801,000 of the general state appropriation to HCA to implement two pilot IOP and PHP programs for certain children and adolescents. The following Mercer report describes the methodology and assumptions used in developing the fees and fiscal impact for the pilot programs, effective January 1, 2021. The report also includes considerations for potential Medicaid coverage of these two services in the future.

Mercer

Government Human Services Consulting

Proviso 76 — Pilot Programs for Intensive Outpatient Services and Partial Hospitalization Services for Children and Adolescents

Washington State Health Care Authority

February 25, 2021 – UPDATED December 3, 2021

Contents

1 Introduction

The State of Washington (State or Washington) Health Care Authority (HCA) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop fees and fiscal impact for the pilot Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) for mental health in response to Proviso 76. Per the Proviso, $1,801,000 of the general state appropriation for fiscal year 2021 is provided for the authority to implement two pilot programs for IOP and PHP, for certain children and adolescents. This document describes the methodology and assumptions used in developing the fees and fiscal impact for the pilot PHP and IOP programs effective January 1, 2021. The document also includes considerations for potential Medicaid coverage of these two services in the future.

In November 2021, HCA requested Mercer update the Proviso 76 report to align with final program expectations. Mercer utilized Schedule A from of the contracts for the IOP and PHP Programs between HCA and Seattle Children's Hospital (K5190) and between HCA and Providence (K5191). Both contracts were provided by HCA. **Mercer's rate development approach, six-month revenues of each program, fiscal impact, and per diem rates remain unchanged at this time.** Updates related to eligibility criteria, data collection and program standards are outlined in Section 3.

Mercer identified the following fiscal impact detailed in Table 1. Please see Appendix A for more detailed cost information.

Table 1: Fiscal Impact Summary

Category	Maximum Pilot Funds (All facility fees covered with State-Only Funds)	Best Estimate (Estimated facility fees likely to be covered with State-Only Funds)	Minimum Pilot Funds (No facility fees covered with State-Only Funds)
Assumed Coverage of Facility Fees Using State-Only Funds	100.0%	37.8%	0.0%
Total Estimated Annual Cost – Base Per Diem	$ 1,001,464	$ 1,001,464	$ 1,001,464
Total Estimated Annual Cost – Facility Fee	$ 1,922,468	$ 720,542	$ 0
Total Estimated Annual Cost – Direct Billing Per Diem	$ 1,029,891	$ 1,029,891	$ 1,029,891

Table 2a: Per Diem Summary

Per Diem	Providence RISE	Providence BEST	Seattle Obsessive-Compulsive Disorder (OCD) IOP	Seattle Anxiety IOP	Seattle Dialectical Behavior Therapy (DBT) IOP
Base Per Diem	$ 54.73	$ 134.50	$ 96.98	$ 202.70	$ 215.74
Facility Fee Per Diem	$ 247.00	$ 247.00	$ 168.00	$ 168.00	$ 168.00
Direct Billing Per Diem	$ 79.47	$ 143.71	$ 145.59	$ 121.33	$ 136.49

Table 2b: Estimated Six-Month Revenues to Each Program (Assuming 100% State Coverage of Facility Fees)

Per Diem	Providence RISE	Providence BEST	Seattle OCD IOP	Seattle Anxiety IOP	Seattle DBT IOP
Base Per Diem	$ 95,164	$ 130,473	$ 76,655	$ 96,128	$ 102,311
Facility Fee Per Diem	$ 429,503	$ 239,599	$ 132,787	$ 79,672	$ 79,672
Direct Billing Per Diem	$ 138,192	$ 139,407	$ 115,077	$ 57,539	$ 64,731

In Tables 1, 2a, and 2b, the fiscal impact:

- Includes direct billing of professional services by the physician, Advanced Registered Nurse Practitioner (ARNP), or psychologist only on the Direct Billing rows of each table. Direct billing of professional services should be reimbursed through the existing Medicaid reimbursement for Medicaid-eligible clients. For children with commercial insurance, physician, ARNP, and psychologist services should be reimbursed by commercial insurance.
- Is reliant on the draft staffing and capacity provided by each of the programs listed above. If expectations around capacity or staffing change, cost estimates are subject to change.
- Assumes that all providers participating in the pilot will be hospitals compliant with Medicaid hospital conditions of participation including physician direction and the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation certification.

- Assumes that the State will need to provide billing guidance to avoid potential risks of duplicate payments of the facility fee. The facility should not bill two facility fees for a single child on dates when a service covered under the Outpatient Prospective Pricing System (OPPS) approach and pilot IOP/PHP unit are billed. Instead, the facility would be permitted to bill the OPPS unit and professional fees ***or*** a pilot IOP/PHP unit and professional fees.
- Is expected to only be applicable to the State-funded Pilot program authorized under Proviso 76. Fiscal impacts and costs for PHP and IOP, if adopted in the future, under Medicaid managed care will vary from the summarized information.

Background

Mercer participated in program discussions with HCA to gather information on the PHP and IOP structure. On September 11 and September 25, 2020, Mercer participated in meetings with Seattle Children's Hospital and Providence Health Care — Spokane to learn about the goals of the pilot program including but not limited to the issue(s) the pilot is trying to solve, target population, number of children per pilot program, average length of stay per child, cost per child, clinical staffing of the program, telemedicine, and transportation. As follow-up to the meetings, each hospital provided Mercer and HCA with IOP and PHP program design proposals, which served as the primary source of data to support rate development and rate assumptions. Seattle Children's Hospital and Providence Health Care — Spokane are expected to operate five distinct PHP and IOP programs in this pilot. HCA expects to directly contract with the two providers to establish reimbursement on a fee-for-service basis for these programs outside of the Medicaid program for the pilot.

2 Methodology

Fees were developed using a market-based pricing methodology for each program. Under this approach, assumptions were established for key cost components based on the service description to calculate the modeled fee. The key steps in the process are highlighted below:

1. Identify key clinical and policy cost components.
2. Conduct a wage study for the State of Washington.
3. Develop cost component assumptions.
4. Develop utilization assumptions.

Each of these steps is described in further detail below:

Step 1: Identify Key Clinical and Policy Cost Components

To develop the modeled fees, Mercer reviewed program design proposals and service definitions for each service to understand the key requirements of the services, including provider qualifications, licensing, requirements and other general information related to delivery of service under each program. Based on this review, the key cost components were identified to account for costs that were reasonable, necessary and related to the delivery of the service.

The major cost components considered for each service were:

- Direct Care Costs — Salary expenses for the required staffing (i.e., the different full-time equivalent direct staff positions, educational and experience requirements and time requirements) at prevailing state urban wages, adjusted to include consideration for Employee-Related Expenses (EREs) and productivity.
- Training and certification costs
- Administrative expenses
- Facility fees for hospital providers

Step 2: Conduct a Wage Study for the State of Washington

Based on the service definitions and clinical reviews, appropriate staffing levels and positions for each service were determined. Compensation data was compiled from the US Bureau of Labor Statistics (BLS) data published in May 2019 and trended to midpoint of calendar year (CY) 2021.[1] The salary data reflects Seattle/Tacoma/Bellevue regional data. The data is representative of urban wages for areas similar those of the new programs and was used to develop an annual wage range for each staffing position, as outlined below:

Table 3: Salary Ranges

Staff Position	Annual Salary Range for CY 2021
Psychiatrist	$254,000–$344,000
ARNP	$118,000–$156,000
Practice Manager	$81,000–$149,000
Psychologist	$88,000–$124,000
Post-Doctoral Psychology Fellow	$63,000–$104,000
Registered Nurse (RN)	$79,000–$113,000
Licensed Mental Health Professional (LMHP)/Mental Health Therapist (MHT)	$56,000–$85,000
Unlicensed Bachelor's or Master's Practitioner (BA/MA)	$45,000–$70,000

Step 3: Develop Cost Component Assumptions

Direct Care Costs

Staff Wages

Staff wages are calculated as a result of matching salary ranges from the wage study to expected staffing assumptions for each individual PHP and IOP programs expected to operate in the pilot program. Staffing assumptions reflect program design information shared by the providers with considerations for avoiding duplicate reimbursement with administrative expenses and facility fees. Staffing assumptions for physicians, ARNPs, and psychologists reflect a reduction, as these providers are expected to bill professional fees for direct services. The staffing assumptions in Table 4 list the full time equivalents (FTEs) built into the modeled market rates or assumed to bill the State directly outside of the rate.

[1] *Occupational Employment Statistics*. U.S. Bureau of Labor Statistics. (2019). Retrieved from https://www.bls.gov/oes/#data.

Table 4: Staffing Assumptions

FTE Category	Providence RISE	Providence BEST	Seattle OCD IOP	Seattle Anxiety IOP	Seattle DBT IOP
Psychiatrist	0.10	0.10	0.10	0.10	0.10
ARNP	0.10	0.00	0.00	0.00	0.00
Psychologist	0.00	0.00	0.40	0.20	0.20
Postdoctoral Fellow	0.00	0.00	0.50	0.00	0.00
RN	0.00	1.00	0.00	0.00	0.00
LMHP/MHT	1.00	1.00	0.00	0.50	0.55
Unlicensed BA/MA	0.50	0.00	0.00	1.00	1.10
Total in Base Fee	**1.70**	**2.10**	**1.00**	**1.80**	**1.95**
Allowing for Direct Billing of Professional Services:					
FTEs of Licensed Practitioners omitted who bill professional fees directly	1.05	0.70	1.60	0.80	0.90
Total FTEs (incl. Direct Billing)	**2.75**	**2.80**	**2.60**	**2.60**	**2.85**

Employee Related Expenses

ERE is assumed to be 20% of wages, which is in the range of ERE assumptions observed for similar programs. These expenses include considerations for health insurance, unemployment taxes (Federal and State), worker's compensation, Federal Insurance Contribution Act (FICA) tax, contributions for other benefits (e.g., short-term disability, long-term disability, retirement). The amounts included in the fees represent the employer's share of the costs for these items.

Non-Billable Time (Productivity)

Mercer considered adjustments to account for non-billable staff time. Non-billable staff time includes time for training, paid time off, and a portion of each workday that is spent on usual and required non-billable activities. Consideration for this non-billable time was included in the fee through a productivity adjustment. The staffing cost was adjusted by a factor that accounted for total billable time relative to total staff time.

Training and Certification Costs

Consideration was included for expenses related to training requirements outlined in the national certification requirements and service descriptions were reflected in fee development. These are assumed to be approximately 5% of the total costs.

Administrative Expenses

Costs not covered by the facility fees but associated with general administrative expenses such as program management, equipment and supplies, and other indirect costs necessary for program operations were also considered. The assumption of 5% was based on past experience, interactions with program designs, interaction with facility fees and discussions with HCA.

Facility Fees

In accordance with Revised Code of Washington (RCW) 70.01.040, hospital owned provider-based clinics may bill a facility fee in addition to professional fees for physician services. The facility fee covers costs associated with the building, electronic medical systems, billing, and other administrative and operational expenses.[2] Facility fees for providers participating in the pilot programs were sourced from publicly available Facility Fee Reporting data from the Department of Health.[3] State funding for the pilot program is expected to cover the facility fee as part of each program's per diem rate. (Note: non-hospital providers would have an indirect cost consideration consistent with federal regulations at 2 CFR 200 et al[4]).

Step 4: Develop Utilization Assumptions

Provider Capacity and Average Contacts per Week

Provider capacity is measured as the maximum number of individuals that can be supported under the individual programs. Program design proposals included an expected provider capacity and these served as the basis for developing the expected utilization of services. Program design proposals also included the expected service delivery structure, which was expressed as the average billable contacts per week in the rate development process.

Absentee Factor

An absentee factor includes consideration for the percentage of time that appointments are missed. Although missed appointments reduce the units of service that are delivered, the provider still needs to pay their direct care staff for their hours on the job. This model is hospital-based and serves vulnerable populations that are likely have a higher absentee factor. Mercer assumed a 20% absentee factor.

[2] *RCW 70.01.040: Provider-based clinics that charge a facility fee—Posting of required notice—Reporting requirements*. Washington State Legislature. Retrieved from https://app.leg.wa.gov/rcw/default.aspx?cite=70.01.040.

[3] *Facility Fee Reporting*. Washington State Department of Health. Retrieved from https://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalFinancialData/HospitalFacilityFees. See Hospital Facility Fees section for reported amounts by year.

[4] Retrieved from https://ecfr.federalregister.gov/current/title-2/subtitle-A/chapter-II/part-200.

Vacancy/Occupancy

The vacancy/occupancy factor includes consideration for the level of expected provider capacity under which each program will operate. Mercer has assumed that these programs will be running at 95% of the expected provider capacity. As a result, Mercer assumed a 5% vacancy/occupancy factor and reduced the expected utilization accordingly.

Annual Units of Service

Table 5 below shows the expected number of units of service for each program. If the number of units provided is less than expected, then the revenues to the program would potentially not cover the cost of the program. However, if the number of units provided is higher than expected, then the revenues to the program would potentially exceed the cost of the program.

Table 5: Annual Units of Service

Assumption Category	Providence RISE	Providence BEST	Seattle OCD IOP	Seattle Anxiety IOP	Seattle DBT IOP
Capacity (# of individuals)	24	12	10	6	6
Average Daily Billable Contacts per Week	3.67	4.09	4	4	4
Weeks per year	52	52	52	52	52
Absentee Factor	20%	20%	20%	20%	20%
Vacancy/Occupancy	5%	5%	5%	5%	5%
Annual Service Units	3,478	1,940	1,581	948	948
Hours Per Service Unit	4	4	3	3	3.5
Total Annual Hours	13,911	7,760	4,742	2,845	3,320

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Additional Program Considerations

In addition to payment methodologies, HCA requested that Mercer recommend eligibility criteria, data collection, minimum program standards and billing guidance including authorization and utilization review processes for the pilot program for the State's consideration. Regardless of the outcome of this pilot, Mercer recommends that Washington State Institute for Public Policy (WSIPP) conduct a cost-benefit analysis of IOP/PHP programs for treating children with mental health conditions. Eligibility Criteria, Data Collection, and Minimum Program Standards have been updated as of November 2021 to reflect provider contracts.

Eligibility Criteria

It is anticipated that the pilot will fund Medicaid eligible children using the allotment from the legislature and will include youth under age 21 meeting the eligibility of criteria (a) or (b) below and criteria (c):

a. Serve youth, based on the IOP/PHP age requirements, who have been discharged from an inpatient hospital treatment program and who require the level of services offered by the pilot program in lieu of continued inpatient treatment, or

b. Youth who require the level of services offered by the pilot program to avoid inpatient hospitalization, and

c. Services may not be offered if there are less costly alternatives community-based services that can more effectively meet the needs of an individual referred to the program.

Each program also has its own target population, which must be met for the child to be admitted to the program.

Data Collection

Mercer originally recommended the following data be collected from the pilot sites in order to determine the effectiveness of the pilots.

- Data commonly associated with encounter submissions (client ID, admit date, discharge date, et similar to data submitted to ProviderOne.
- A narrative description of the services provided at each pilot site and identification of any specific gaps, which the sites were able to fill in the current continuum of care.
- Clinical outcomes associated with the treatment provided to each child, including:

  - Pre- and post- program participation assessment using a nationally validated tool such as CALOCUS, CANS, CAFAS or GAIN.
  - Average Length of Stay.
  - Number of completed treatment regimes.
  - Number of emergency room visits and inpatient admissions occurring during treatment regimes.
- Estimated reductions in psychiatric inpatient costs associated with each of the pilot sites including:
  - Number of days of inpatient stays averted due to early discharge and treatment in a pilot consistent with the language of the Proviso.
  - Number of inpatient admissions diverted due to treatment in the pilots.
  - Services that the pilots replaced at a lower cost for each child.

Data Collection

Per the final contracts between HCA and Seattle Children's Hospital, and HCA and Providence, the following data is required to be submitted to HCA help determine the effectiveness of the pilot program.

The data listed below will be submitted no later than August 15, 2021 for youth who have been discharged from the program. For youth still enrolled in services and actively receiving treatment past this date, the data will be submitted to HCA no later than five days post discharge. Absent the information requested in this section, HCA will accrue up to the remaining unspent funding level. Payments can still be made, but not if the requested payment exceeds the budgeted funding totals.

The data will be utilized to determine the effectiveness of the pilot program, and will include the following:

- Facility name (tax identification number [Tax ID#] or National Provider Identification [NPI])
- Client's first and last name
- Client's age
- County of residence
- Date of admission
- Admission Diagnosis
- Race/ethnicity
- Gender

- Gender at birth
- Current gender identification
- Length of treatment (days of treatment)
- Guardianship status (parent(s), legal guardian, Department of Children, Youth and Families [DCYF] case worker, etc.)
- Insurance type (Medicaid, private, etc.)
  - How many additional youth were served above what the pilot program paid for?
- Presence of developmental disability/intellectual disability/ autism spectrum disorder.
- Presence of co-occurring substance use disorder.
- Number of mental health Emergency Department (ED) visits in prior 12 months.
- Number of inpatient psychiatric hospitalizations in prior 12 months.
- Assessments completed at admission and discharge using a nationally validated tool.
- Estimated reductions in psychiatric inpatient costs associated with each of the pilot sites including:
  - Number of days of inpatient stays diverted due to early discharge and treatment in a pilot consistent with the language of the Proviso.
  - Number of inpatient admissions diverted due to treatment in the pilots.
  - Services that the pilots replaced at a lower cost for each youth.
- Discharge plan:
  - Discharged placement (home, foster home, residential treatment, etc.)
  - Treatment after discharge (individual/group therapy, family therapy, medication management, etc.)

The Data to be shared and listed above, will be sent to HCA, no later than August 15, 2021, using the Secure File Transfer (SFT) process, created and supported by HCA.

The information being submitted through the SFT process is considered category 4 Protected Health Information (PHI), which is considered the most sensitive, so it is vital that the process is followed. The Contractor will consult with the HCA Contract Manager on this process, as needed.

Medicare Standards for Partial Hospitalization

The table below summarizes the Medicare program standards for Partial Hospitalization in a Community Mental Health Center (CMHC) or hospital, including the most recent Medicare

reimbursement rates dependent on the type of program. These are included for future consideration in the event that IOP/PHP are incorporated into the Medicaid program. Consistent with federal regulations at 42 CFR 440.20[5], outpatient hospital services must be furnished under the direction of a physician and furnished by an institution that is formally approved as a hospital and meets the requirements for participation in Medicare as a hospital. In addition, consistent with regulations at 42 CFR 447.321[6], services provided within outpatient hospitals and clinics are subject to the Medicaid upper payment limit.

Table 6: Medicare Standards for Partial Hospitalization in a CMHC or Hospital

Service	Unit, Coding, and Assumed Duration	Practitioner(s) and Rates[7]
Medicare Partial Hospitalization in a CMHC or Hospital	Per diem Use of Medicare coding to verify three activities provided daily Assume four hours per session (five sessions per week)	• 2021 CMHC Rate APC 5853 (three or more services per day) — $136.14 • 2021 Hospital-based Rate APC 5863 (three or more services per day) — $253.76 *Note: Physician, Physician Assistant, Nurse Practitioner and Clinical Nurse Specialist services, and Clinical Psychologist services are billed separately. The services of Licensed Clinical Social Workers and Occupational Therapists are included in the payment for partial hospitalization.* *Note: Licensed Professional Counselors can be utilized in Medicaid.* Medicare enrolled CMHC or outpatient hospital providers with physician direction with a minimum of 20 hours/week of therapeutic services. The services must be medically supervised, coordinated, comprehensive, structured, and multimodal treatment. The PHP must provide three or more of the following services each session:
		• Individual or group psychotherapy with a licensed/authorized mental health professional

[5] Centers for Medicare & Medicaid Services, HHS. *CMS*. Retrieved from https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec440-20.pdf

[6] 42 CFR Ch. IV (10-1-10 Edition). *CMS*. Retrieved from https://www.govinfo.gov/content/pkg/CFR-2010-title42-vol4/pdf/CFR-2010-title42-vol4-sec447-321.pdf

[7] Centers for Medicare & Medicaid Services, HHS. *CMS*. Retrieved from https://www.cms.gov/files/document/12220-opps-final-rule-cms-1736-fc.pdf

Service	Unit, Coding, and Assumed Duration	Practitioner(s) and Rates[7]
		• Occupational Therapy • Services of other staff trained to work with psychiatric patients • Drugs and biologicals that cannot be self-administered • Individualized activity therapies that are not primarily recreational or diversionary • Family counseling for treatment of the patient's condition • Patient training and education • Medically necessary diagnostic services Payment equals Conversion Factory (CF) * Ambulatory Payment Classifications (APC) * Geographic adjustment (based on hospital wage index). *Note: The manual states that the APC is a per diem.* *Note: Hospitals in urban areas may have indexes approaching 1 such as 0.99. However, rural areas may have a wage indexes closer to 0.90.*

Minimum Program Standards

All providers participating in the pilot are hospitals compliant with Medicaid hospital conditions of participation including CMS certification and physician direction. All care must be directed by a physician.

Each program is expected to maintain the staffing, staffing ratios and capacity provided by each of the programs listed below. If expectations around capacity or staffing change, cost estimates are subject to change (e.g., an increase in capacity, change in staffing pattern/hiring of additional unlicensed staff, and change in group sizes is not permitted without HCA determining that the cost and quality of services provided are not altered).

Table 7a includes the minimum program standards that align with the rates developed by Mercer. Please note that administrative staffing is assumed to be covered in the administrative factor and facility fee. Table 7b includes the staffing in Section 5.3.1 of Seattle Children's Hospital contract with HCA. Table 7c includes the staffing in Section 5.3.1 of Providence's contract with HCA. Changes between the Mercer minimum standards (Table 7a) and provider staffing assumptions (Tables 7b and 7c) are illustrated with a double asterisk ('**').

Table 7a: Minimum Programmatic Staffing Standards

FTE Category	Providence RISE	Providence BEST	Seattle OCD IOP	Seattle Anxiety IOP	Seattle DBT IOP
Psychiatrist (supervision of staff)	0.10	0.10	0.10	0.10	0.10
ARNP	0.10	0.00	0.00	0.00	0.00
Psychologist (supervision of staff)	0.00	0.00	0.40	0.20	0.20
Postdoctoral Fellow	0.00	0.00	0.50	0.00	0.00
RN	0.00	1.00	0.00	0.00	0.00
LMHP/MHT	1.00	1.00	0.00	0.50	0.55
Unlicensed BA/MA	0.50	0.00	0.00	1.00	1.10
Total in Base Fee	**1.70**	**2.10**	**1.00**	**1.80**	**1.95**
FTEs of Licensed Practitioners omitted who bill professional fees directly	1.05	0.70	1.60	0.80	0.90
Total FTEs (incl. Direct Billing)	**2.75**	**2.80**	**2.60**	**2.60**	**2.85**

**Note: Additional direct psychiatrist, ARNP, and psychologist direct service time is necessary to maintain each program for direct services billed outside of the per diem.*

Table 7b: Seattle Children's Contracted Programmatic Staffing Assumptions

FTE Category	Seattle OCD IOP	Seattle Anxiety IOP	Seattle DBT IOP
Psychiatrist (supervision of staff)	0.10	0.10	0.10
ARNP	0.00	0.00	0.00
Psychologist (supervision of staff)	2.40**	1.00**	1.20**
Postdoctoral Fellow	0.80**	0.00	0.20**
RN	0.00	0.00	0.00
LMHP/MHT	0.00	0.50	0.20**
Unlicensed BA/MA	0.00	1.00	1.05**

**Note: Positions of Manager and Admin/insurance processing coordinator are expected to be reimbursed via the administrative factor and/or facility fee. Mercer assumed the Behavioral Health Specialist and Family Advocate/Case Manager positions align with the Unlicensed BA/MA FTE Category.*

Table 7c: Providence Contracted Staffing Assumptions

FTE Category	Providence RISE	Providence BEST
Psychiatrist (supervision of staff)	0.30**	0.50**
ARNP	0.75**	0.00
Psychologist (supervision of staff)	0.00	0.00
Postdoctoral Fellow	0.00	0.00
RN	0.00	1.00
LMHP/MHT	4.00**	4.00**
Unlicensed BA/MA	1.50**	1.00**

**Note: Positions of Practice Manager and Patient Services Representative are expected to be reimbursed via the administrative factor and/or facility fee. Mercer assumed the Patient Care Coordinator position aligns with the Unlicensed BA/MA FTE Category.*

The following standards are recommended from the State Medicaid Manual 4221 Outpatient Psychiatric Services.[8]

Each IOP/PHP program is required to have an outpatient program entry. This includes an intake evaluation performed for each recipient being considered for entry into the outpatient psychiatric treatment program. The evaluation is a written assessment that evaluates the recipient's mental condition and, based on the patient's diagnosis, determines whether treatment in the outpatient program would be appropriate.

The evaluation team should include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified). For each recipient who enters the program, the assessment should include a certification by the evaluation team that the program is appropriate to meet the recipient's treatment needs. The assessment should be made a part of the patient records.

Each IOP/PHP program is required to have Treatment Planning. For each recipient who enters the outpatient program, the evaluation team should develop an individual Plan of Care (PoC). This consists of a written, individualized plan to improve the patient's condition to the point where the patient's continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The PoC is included in the patient records and contains a written description of the treatment objectives for that patient. It also describes:

[8] State Medicaid Manual 4221, Chapter Four. Retrieved from https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927

- The treatment regimen — the specific medical and remedial services, therapies and activities that will be used to meet the treatment objectives.
- A projected schedule for service delivery — this includes the expected frequency and duration of each type of planned therapeutic session or encounter.
- The type of personnel that will be furnishing the services.
- A projected schedule for completing reevaluations of the patient's condition and updating the PoC.

Documentation. The outpatient program should develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity or session for which billing is made. This documentation, at a minimum, should consist of material, which includes:

- The specific services rendered.
- The date and actual time the services were rendered.
- Who rendered the services.
- The setting in which the services were rendered.
- The amount of time it took to deliver the services.
- The relationship of the services to the treatment regimen described in the PoC.
- Updates describing the patient's progress.

For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC should be submitted with bills. Similarly, a detailed explanation should accompany bills for a medical or remedial therapy, session or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

Periodic Review. The evaluation team should periodically review the recipient's PoC in order to determine the recipient's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the recipient's continued participation in the program. The evaluation team should perform such reviews on a regular basis (i.e., at least every 90 days) and the reviews should be documented in detail in the patient records, kept on file and made available as requested for State or Federal assessment purposes

Pilot programs standards in the table below have been updated to reflect standards consistent with provider contracts as of November 2021.

Table 8: Program Standards

Assumption Category	Providence RISE	Providence BEST	Seattle OCD IOP	Seattle Anxiety IOP	Seattle DBT IOP
Maximum Capacity (# of individuals)	28	12	10	8	8
Maximum Group Size	9	4	5	8	8
Staffing Present During Group Sessions			2	2	2
Days per Week	2–4 for IOP 5 for PHP	2–4 for IOP 5 for PHP	4	4	4
Hours of Service in Per diem	4	4	3	3	3.5
Average Length of Program	22 average visits in an episode: 10 PHP and 12 IOP	20 average visits: 15 PHP and 5 IOP	8 to 12 weeks, with an average of 40 days of IOP	4 to 6 weeks, with an average of 20 days of IOP	8 to 12 weeks, with an average of 40 days of IOP
Interventions included in Per Diem	• Psychiatrist and ARNP oversight • Licensed/unlicensed therapists conduct group therapy sessions twice per day • Licensed Therapist individual therapy once per week (IOP) and twice per week (PHP)	• Psychiatrist and ARNP oversight • Licensed/unlicensed therapists conduct group therapy sessions twice per day • Licensed Therapist individual therapy once per week (IOP) and twice per week (PHP)	• Psychiatrist oversight • 2–3 hours of daily group patient skills • Twice a week parent training groups	• Psychiatrist oversight • 2–3 hours of daily group patient skills • Twice a week parent training groups	• Psychiatrist oversight • 2–3 hours of daily group patient skills • Twice a week parent training groups

Assumption Category	Providence RISE	Providence BEST	Seattle OCD IOP	Seattle Anxiety IOP	Seattle DBT IOP
Case Management included in Per Diem	• Connect to resources; facilitate stepdown to community services; discharge planning	• Connect to resources; facilitate stepdown to community services; discharge planning	• Connect to resources; facilitate stepdown to community services; discharge planning	• Connect to resources; facilitate stepdown to community services; discharge planning	• Connect to resources; facilitate stepdown to community services; discharge planning
Interventions Required of Program and Billed Separately	• Psychiatrist at least one contact (IOP) and two contacts (PHP) for evaluation and management services • ARNP direct services	• Psychiatrist at least two contacts for evaluation and management services • ARNP direct services	• Up to one group session and up to one individual therapy or family therapy session per day is billed to the Medicaid Managed Care Organization plans while the program remains delivered via telehealth. • All other services including additional group sessions and extended group time fall under the per diem.	• Up to one group session and up to one individual therapy or family therapy session per day is billed to the Medicaid Managed Care Organization plans while the program remains delivered via telehealth. • All other services including additional group sessions and extended group time fall under the per diem.	• Up to one group session and up to one individual therapy or family therapy session per day is billed to the Medicaid Managed Care Organization plans while the program remains delivered via telehealth. • All other services including additional group sessions and extended group time fall under the per diem.

In addition to the staffing and standards described above, the final contract between HCA and Providence (K5191) included information about service area and service hours, staffing ratios, access and outcome measures:

The service area and service hours were to be at least the following:

- Eastern WA catchment area
- Primary service area Spokane
- Daily treatment services for PHP (5 days a week to total 20 or more service hours) and for IOP (9–19 hours in treatment services) each week (Monday–Friday)

Staffing ratios for the Providence programs were to maintain the following minimums:

- Psychiatrist 1:12
- Licensed therapist 1:3 (PHP) and 1:4 (IOP)
- Registered Nurse 1:12
- Social Worker 1:12

Access to the program was projected to be from four sources:

- Direct admission from ED
- Referrals from school's programs
- Referrals from Community Providers
- Parent referrals

Two sources were projected to be used for outcome measures:

- Admit and discharge comparison for:
  - Ohio youth problem, functioning and satisfaction scale
  - Patient/Family satisfaction

Suggested Considerations for Billing

Only one per diem, per patient, per day may be billed. For a per diem to be generated, a contact that meets all program standards and billing guidance outlined in the contract must occur. Licensed direct care staff must provide services within the scope of practice for their license under State law.

Direct individual and group services by the physician, ARNP, or psychologist should be billed to Medicaid or the child's commercial insurance. Direct billing of professional services should be reimbursed through the existing Medicaid reimbursement for Medicaid-eligible clients. For children with commercial insurance, physician, ARNP, and psychologist services should be reimbursed by commercial insurance.

HCA must provide detailed billing guidance to avoid any duplicate payments of the facility fee. Mercer expects that any service for which the hospital bills via the OPPS approach directly to the Medicaid program is inclusive of a facility fee. As a result, Mercer recommends that a facility fee is paid using State-only funds (via a per diem inclusive of the facility fee) whenever an IOP/PHP unit is billed without an OPPS-qualifying outpatient service being provided on the same day for a patient. The facility should not bill two facility fees on a day when IOP/PHP units are billed for a patient.

The per diem should only be billed if the individual attends for the minimum needed to bill the unit. The service is billed in whole units only. If the individual does not meet the minimum attendance, group therapy or individual therapy from hospital is billed instead of IOP/PHP. IOP/PHP can only be billed if the individual attends a group session, which does not exceed the practitioner to client ratio and all other minimum service standards are met.

The following activities may not be billed or considered the activity for which the per diem unit is billed:

- Contacts that are not medically necessary.
- Time spent doing, attending or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide or an academic tutor. *Note: Children must receive education consistent with state and federal education requirements.* However, Medicaid is prohibited from reimbursing for formal educational services including training in traditional academic subjects (42 CFR 441.13(b)[9]).
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.

[9] Regulations. *GOVREGS*. Retrieved from https://www.govregs.com/regulations/expand/title42_chapterIV-i2_part441_subpartA_section441.20#regulation_3

- Respite care.
- Transportation for the individual or family; services provided in the car are considered Transportation.
- Covered services that have not been rendered.
- Services rendered that are not in accordance with approved program standards.
- Services not identified on the youth's treatment plan.
- Services not in compliance with the contract or program standards or hospital conditions of participation.
- Services provided to spouse, parents, or siblings of the eligible youth under treatment or others in the eligible youth's life to address problems not directly related to the eligible youth's issues and not listed on the eligible youth's treatment plan.
- Services provided that are not within the licensed staff's scope of practice.
- Anything not included in the approved service description.
- Changes made to the service that do not follow the requirements outlined in the provider contract, service manual or program standards.
- Vocational training, employment of an individual, employment assessments and ongoing support to maintain employment.

4

Disclosures and Limitations

This report is intended to support HCA efforts to respond to Proviso 76 developed by Washington State Legislature as part of ongoing budget planning. This report is intended to be relied upon solely by HCA and other State stakeholders and is not intended to be distributed broadly. Mercer disclaims any use beyond the intended purpose. The analyses presented in this report are based on publicly available information and Mercer's experience in other state programs.

This report relies on data and program expectations provided by the potential participants of the Pilot program. Mercer acknowledges that the suppliers of data are solely responsible for its validity and completeness. Mercer has reviewed the data and information for internal consistency and reasonableness, but did not audit it.

All estimates are based upon the information and data available as of the date of this report and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely and potentially wide range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. To the extent additional information becomes available that may impact the anticipated structure of the programs, the recommendations and accompanying fiscal analyses may need to be revised accordingly.

The State understands that Mercer is not engaged in the practice of law or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that the State secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

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To the best of Mercer's knowledge, there are no conflicts of interest in performing this work. Mercer expressly disclaims responsibility, liability or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Appendix A
Fiscal Analysis

Proviso 76 - PHP/IOP Pilot: Fiscal Analysis (Maximum Pilot Funds)

Cost Category	Providence RISE	Providence BEST	Seattle OCD IOP	Seattle Anxiety IOP	Seattle DBT IOP	Total
Capacity (Number Of Individuals)	24.0	12.0	10.0	6.0	6.0	58.0
Average Days Per Week	3.7	4.1	4.0	4.0	4.0	3.9
Unit of Service	Per Diem	Per Diem	Per Diem	Per Diem	Per Diem	Per Diem
Hours Per Unit of Service	4.0	4.0	3.0	3.0	3.5	3.7
Annual Units Of Service	3,478	1,940	1,581	948	948	8,896
Staff Wages and Employee Related Expenses	$ 171,295	$ 234,852	$ 137,980	$ 173,031	$ 184,160	$ 901,318
Training and Certification Expenses	$ 9,516	$ 13,047	$ 7,666	$ 9,613	$ 10,231	$ 50,073
Administrative Expenses	$ 9,516	$ 13,047	$ 7,666	$ 9,613	$ 10,231	$ 50,073
Base Per Diem[1]	**$ 54.73**	**$ 134.50**	**$ 96.98**	**$ 202.70**	**$ 215.74**	**$ 112.58**
Base Hourly Cost[1]	**$ 13.68**	**$ 33.63**	**$ 32.33**	**$ 67.57**	**$ 61.64**	**$ 30.74**
Estimated Annual Cost - Base Per Diem[1]	**$ 190,328**	**$ 260,947**	**$ 153,311**	**$ 192,256**	**$ 204,622**	**$ 1,001,464**
Estimated 6-Month Cost - Base Per Diem[1]	**$ 95,164**	**$ 130,473**	**$ 76,655**	**$ 96,128**	**$ 102,311**	**$ 500,732**
State-Only Pilot Funds Facility Fee Coverage %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Facility Fee Per Diem	**$ 247.00**	**$ 247.00**	**$ 168.00**	**$ 168.00**	**$ 168.00**	**N/A**
Estimated Annual Cost - Facility Fee Per Diem[1]	**$ 859,007**	**$ 479,198**	**$ 265,574**	**$ 159,345**	**$ 159,345**	**$ 1,922,468**
Estimated 6-Month Cost - Facility Fee Per Diem[1]	**$ 429,503**	**$ 239,599**	**$ 132,787**	**$ 79,672**	**$ 79,672**	**$ 961,234**
Direct Billing FTEs Omitted	1.1	0.7	1.6	0.8	0.9	5.1
Direct Billing Per Diem	**$ 79.47**	**$ 143.71**	**$ 145.59**	**$ 121.33**	**$ 136.49**	**$ 115.78**
Estimated Annual Cost - Direct Billing Per Diem[1]	**$ 276,385**	**$ 278,814**	**$ 230,154**	**$ 115,077**	**$ 129,462**	**$ 1,029,891**
Estimated 6-Month Cost - Direct Billing Per Diem[1]	**$ 138,192**	**$ 139,407**	**$ 115,077**	**$ 57,539**	**$ 64,731**	**$ 514,946**

[1] This fiscal estimate is reliant on the draft staffing and capacity provided by each of the programs listed above. If expectations around capacity or staffing change, cost estimates are subject to change.

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