Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Rate Methodology for 90- and 180-Day Civil Commitment Beds

Engrossed Substitute House Bill 1109; Section 215(24); Chapter 415; Laws of 2019

December 1, 2019

Rate Methodology for 90- and 180-Day Civil Commitment Beds

Washington State Health Care Authority

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Executive Summary

Access to the full array of mental health treatment options is vital to recovery for individuals experiencing mental illness. A continuum of treatment is imperative to ensure safe, healthy communities and quality outcomes. As a leader in providing innovative medical and behavioral health treatment, Washington State invests $24.3 billion[i] annually at all levels of care. Included in these treatment modalities are inpatient psychiatric care, hospital diversion programs, peer services, crisis stabilization, housing support, and many other evidence-based practices to promote recovery for persons experiencing mental illness.

Despite these efforts, access to inpatient psychiatric treatment remains a challenge.

> "A severe shortage of inpatient care for people with mental illness is amounting to a public health crisis, as the number of individuals struggling with a range of psychiatric problems continues to rise. The disappearance of long-term-care facilities and psychiatric beds has escalated over the past decade, sparked by a trend toward deinstitutionalization of psychiatric patients in the 1950s and '60s, states Dominic Sisti, director of the Scattergood Program for Applied Ethics of Behavioral Health Care at the University of Pennsylvania."[ii]
>
> Washington State has attempted to address the challenge of funding long-term psychiatric beds with two specific provisos, Bill 6032 Section 204 (p), which funds up to 48 long-term beds, and Bill 1109 Section 215 (24), which funds up to 71 community beds in State Fiscal Year 2020, increasing to 119 beds funded by State Fiscal Year 2021. The intention is to fund 227 long-term civil commitment beds by State Fiscal Year 2023, under these provisos.
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> This report is prepared in compliance with ESHB 1109 (2019), section 215(24), which reads, "$27,917,000 of the general fund—state appropriation for fiscal year 2020, $36,095,000 of the general fund—state appropriation for fiscal year 2021, and $60,644,000 of the general fund—federal appropriation are provided solely for the department to contract with community hospitals or freestanding evaluation and treatment centers to provide long-term inpatient care beds as defined in RCW 71.24.025. Within these amounts, the authority must meet the requirements for reimbursing counties for the judicial services for patients being served in these settings in accordance with RCW 71.05.730. The authority must coordinate with the department of social and health services in developing the contract requirements, selecting contractors, and establishing processes for identifying patients that will be admitted to these facilities. Sufficient amounts are provided in fiscal year 2020 for the authority to reimburse community hospitals serving Medicaid clients in long-term inpatient care beds as defined in RCW 71.24.025 at a rate of $1,171 per day, or the hospital's current psychiatric inpatient per diem rate, whichever is higher. The rate paid to hospitals in this subsection cannot exceed one-hundred percent of the hospitals eligible costs based on their most recently completed Medicare cost

report. The authority in collaboration with the Washington state hospital association must convene a work group to develop a methodology for reimbursing community hospitals serving these clients. In developing this methodology, the authority must account for cost structure differences between teaching hospitals and other hospital types. The authority must provide a report to the appropriate committees of the legislature by December 1, 2019. The report must: (a) Describe the methodology developed by the work group; (b) Identify cost differences between teaching hospitals and other hospital types; (c) Provide options for incentivizing community hospitals to offer long-term inpatient care beds day beds including a rate recommendation; (d) Identify the cost associated with any recommended changes in rates or rate setting methodology; and (e) Outline an implementation plan."

Definitions

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

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

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

Freestanding evaluation and treatment center (residential evaluation and treatment center): A residential evaluation and treatment center may be referred to as RTF throughout this report as they are licensed and certified by the Washington State Department of Health (DOH) as residential treatment facilities (RTF). Treatment in a freestanding evaluation and treatment center

means services provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self, due to the onset or exacerbation of a psychiatric disorder. Services are provided in freestanding inpatient residential (non-hospital/non-institute for mental disease [IMD] facilities) to provide medically necessary evaluation and treatment to the consumer who would otherwise meet hospital admission criteria. At a minimum, services include evaluation, stabilization, and treatment provided by or under the direction of licensed psychiatrists, nurses, and other mental health professionals, and discharge planning to ensure continuity of mental health care.[vi]

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

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

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

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

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

Background

The proviso language reflects the intent by the Legislature's intent to ensure that long-term psychiatric inpatient stays were compensated at a level that enabled the facilities to sustain these services. The directive was to develop a methodology to reimburse community hospitals for the costs specific to the population served, recognizing that long-term needs of individuals may vary from those who are on a short-term stay. To that end, a workgroup was convened to ensure that stakeholders were offered the opportunity to discuss methodologies that will ultimately be recommended by HCA's Financial Services Division to the Legislature.

Workgroup Participants			
Ann Christian, Washington Council for Behavioral Health	Abigail Cole, HCA	Ian Goodhew, University of Washington	Natalia Kohler, MultiCare
Dwane Liuska, University of Washington	Catrina Lucero, HCA	Dennis Martin, HCA	Len McComb, Washington State Hospital Association
Margo Miller, HCA	Devon Nichols, Office of Financial Management	Kara Panek, HCA	Shirley Prasad, Washington State Hospital Association
Beckie Shauinger, Fairfax Behavioral Health	Grant Stromsdorfer, HCA	Gary Swan, HCA	Andy Toulon, participating as an observer (Washington State Legislature)
Christy Vaughn, HCA	Keri Waterland, HCA	Chelene Whiteaker, Washington State Hospital Association	Michele Wilsie, HCA

The following table identifies a current list of facilities willing to care for individuals on 90- and 180-day civil commitment orders. These facilities were identified because: 1) the facility volunteered to provide long-term bed capacity, and 2) the facility is a Department of Commerce grant recipient.[x]

Current and Anticipated Community Hospitals Providing 90- and 180-Day Civil Commitment Beds				
Facility	**Location**	**Number of Beds**	**Online Date**	**Facility Type**
Astria Hospital	Toppenish	14	January 2019	Non-IMD
Cascade Behavioral Health	Tukwila	18	Early 2020	IMD
Fairfax Behavioral Health	Seattle	20	Early 2020	IMD
MultiCare Health Systems	Auburn	TBD	TBD	TBD
Navos Behavioral Health	Burien	TBD	TBD	IMD
Providence Health & Services, Northwest	Everett	6	February 2021	Non-IMD
PeaceHealth St. John	Longview	2	May 2019	Non-IMD
PeaceHealth Southwest	Vancouver	TBD	TBD	TBD
Skagit Valley Hospital	Everett	2	November 2019	Non-IMD
UW Medicine Behavioral Health Teaching Hospital	Seattle	Fifty (50) 90- and 180-day long-term involuntary commitment beds, up to 40 geriatric psychiatric beds and 50 beds that will serve psychiatric patients with acute medical/ surgical needs	FY 2023	Non-IMD (TBD)
Virginia Mason Memorial	Yakima	6 10	November 2018 First quarter 2020	Non-IMD

Current and Anticipated Evaluation and Treatment Facilities Providing 90- and 180-Day Civil Commitment Beds				
Facility	**Location**	**Number of Beds**	**Online Date**	**Facility Type**
Cascade Mental Health Care	Centralia	4	September 2018	RTF
Kitsap Mental Health Services	Bremerton	4	December 2018	RTF
Telecare North Sound	Sedro-Woolley	3	October 2018	RTF
RI International	Olympia	16	Late 2019	RTF
Mark Reed E&T	McCleary	TBD	TBD	RTF
Compass Health	Everett	16	TBD	RTF

Methodology for Establishing Inpatient Psychiatric Payment Rates

Currently, community hospitals receive one per diem payment rate for inpatient psychiatric services. There is no distinction between the payment rate for short-term and long-term inpatient psychiatric care. Community hospitals' per diem payment rate for inpatient psychiatric care is established as follows:

1. For community hospitals that before 2017 did not have an existing inpatient psychiatric rate and did not have more than 200 psychiatric bed days, their initial rate was set at the statewide average per diem rate. The lowest rate was set at $711.55 per day.
2. For community hospitals with an existing inpatient psychiatric rate in 2017, the HCA conducted a rate rebase. According to the Medicaid State Plan Amendment 17-0040, each hospital's rebased rate is the higher of:
    a. Existing inpatient psychiatric per diem rate as of 2017; or
    b. Adjusted cost per day (which was reduced to 78.41 percent for acute care hospitals and 68.15 percent for freestanding psychiatric hospitals); or
    c. Statewide average cost per day (which was reduced to 78.41 percent for acute care hospitals and to 68.15 percent for freestanding psychiatric hospitals).
3. For new inpatient psychiatric services after 2017, when the hospital did not have an existing psychiatric per diem rate, the facility is paid the statewide average. When the hospital has a full year cost report filed, the facility-specific cost report is used to determine the percentage of hospital costs for a new per diem rate. After calculating a base per diem

rate, factors such as a Medicare wage index for the hospital's geographic location and any indirect medical education costs are applied to arrive at a per diem rate.

4. After 2017, if a hospital has more than 200 psychiatric bed days, they receive an increase in the reimbursement rate as directed by the Legislature to be in line with the percentage of cost other hospitals are paid as a result of the 2017 rebase.

Residential E&T rates are set through the actuarial process. Managed care organizations (MCO), behavioral health administrative services only (BH-ASO), and behavioral health organizations (BHO) currently contract for these beds outside of the HCA fee for service methodology.

More information can be found at WAC 182-550-3800 and the Washington Medicaid State Plan Attachment 4.19-A, Part 1, page 32.

Additional Costs: Caring for 90- and 180-Day Civil Commitment Stays

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

Professional Services Fees and Costs: Long-Term Psychiatric Stays at Community Hospitals

A key component for caring for this patient population is professional services. The professional services fees for psychiatrists, psychologists, and other mental health professionals caring for psychiatric patients are captured in the Medicare cost report but not included in the per diem rate calculation. Hospitals must bill these services separately from the inpatient claim. Other costs included in the cost report but billed separately from the inpatient claim include occupational or other additional therapies.

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

Involuntary Treatment Act Costs

There are cost considerations related to the legal process itself, such as court fees, transportation, attorney costs, security costs, and costs for the documentation of the process. Also, community hospitals have costs associated with either onsite Involuntary Treatment Act (ITA) court or infrastructure for remote access to ITA court. There are also discharge planning and continuum of care coordination costs that must be considered. All of these costs are not captured on the Medicare cost report.

Freestanding Psychiatric Hospitals

Freestanding psychiatric hospitals face other cost challenges in caring for long-term civil commitment patients. As illustrated, the current statewide average rate paid to freestanding psychiatric hospitals only covers about 68 percent of the statewide average costs. Acute care hospitals that provide non-psychiatric services are able to cost shift from higher paying non-psychiatric services to lower paying psychiatric services. However, freestanding psychiatric hospitals only provide these lower paying psychiatric services and are unable to cost shift. Also, freestanding psychiatric hospitals care for a significant number of Medicaid and Medicare patients. Based on 2018 hospital discharge data (CHARS), the overall Medicare/Medicaid payer mix for freestanding psychiatric hospitals was 72 percent. As such, these hospitals do not have significant commercial claims to offset lower paying Medicare and Medicaid claims, posing a challenge to freestanding psychiatric hospitals to be sustainable.

Rate Setting Methodology Recommendations

To help address the mental health crisis in our state, the Legislature has embarked on an ambitious five-year plan to move most individuals on long-term civil commitment stays out of Eastern and Western State Hospitals and into community facilities such as community hospitals and residential E&T facilities.

The workgroup recommends that all costs be analyzed to ensure willing providers. In addition, the workgroup recommends that an incentive structure be developed. Providers may face a decision when accepting long-term stays to receive fewer short-term stays, which may impact their communities. Important takeaways include:

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

Basis for Determining Cost

HCA will need a standardized source of information to determine the cost of providing services to individuals on 90- and 180-day civil commitments.

Acute Care Hospitals

Medicare cost reports are used to inform Medicare and Medicaid rates. Acute care hospitals and HCA are familiar with the data contained in the Medicare cost report. Thus, the workgroup recommends using Medicare cost reports as the basis for determining the cost for acute care hospitals.

Freestanding Psychiatric Hospitals

Medicare cost reports are also used to inform the payment methodology. The current inpatient psychiatric rate for freestanding psychiatric hospitals is based on a percentage of the statewide average costs for all hospitals providing these services. Given this existing rate methodology, the rate for 90- and 180-day civil commitment services should be based on an increased percentage of the existing statewide average costs.

Residential E&T Facilities

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

Recommendation

The workgroup recommends using the Medicare cost report as the basis for determining cost for acute care hospitals and the current statewide average rate as the foundation for determining the rate for freestanding psychiatric hospitals. The workgroup recommends updating the Medicaid per diem rate as the basis for determining cost for the residential E&T facilities.

Basis for Determining Costs		
	Pros	**Cons**
Acute care hospitals: Medicare cost reports	Standard process both the HCA and the hospitals are familiar with Utilizes and existing process Audited body of work	Large data set Based on prior year costs causing information to be somewhat dated Does not include ITA court costs, professional services such as psychiatric and psychological services that

		are required to be billed separately, transportation costs
Freestanding psychiatric hospitals: the current statewide average rate as the foundation	The statewide average rate has already been established by the HCA during the 2017 rebase. The new payment rate for 90- and 180-day civil commitment services will be an increased percentage of the statewide average rate to reflect increased cost of caring for long-term psychiatric patients Simple calculation of the rate for the initial and subsequent years Adjusts for the benefit the state is receiving when hospitals serve lower acuity patients, which reduces the overall "Medicaid" cost being reported	Large data set Average amounts derived from the cost reports are dated Does not include ITA court costs, professional services such as psychiatric and psychological services that are required to be billed separately, transportation costs
Residential E&T facilities: actuarial data in conjunction with reported costs	No standardized cost reporting Consideration must be given to additional non-Medicaid costs for room and board and the necessary state general funds to cover this portion of a per diem rate Consistent with past actuarial work augmented with provider specific cost information	Currently does not include room and board costs which are excluded in RTF settings but incorporated into community hospital costs

Calculating Initial Base Rate

It will be 12 to 18 months before the actual cost of providing long-term psychiatric inpatient care is reported to the Centers for Medicare and Medicaid Services (CMS) and analyzed in the Medicare or other cost reports. HCA will require a method to calculate an adequate rate for this interim period for:

1. Providers serving 90- and 180-day civil commitment clients in fiscal year (FY) 2021, and
2. New providers that begin serving 90- and 180-day civil commitment clients in future years but do not yet have a cost report that reflects that experience.

The workgroup has identified several options.

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

This option would use an inpatient fixed-weight index to update payments and cost limits. The workgroup recommends using CMS's annually updated 2012-based inpatient psychiatric facilities market basket for this purpose. For example, the market basket for inpatient psychiatric facilities in FY 2019 is 2.9 percent.

Option 2: Use the average facility-specific inpatient psychiatric per diem rate for providers who have indicated an interest in providing 90- and 180-day beds

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

Option 3: Use the current ($1,171 for acute care hospitals and $900 for RFTs) rate and then apply a retroactive cost-based rate adjustment

This option would pay providers at the rates established in the 2019-21 operating budget until the provider has an updated cost report on file. The rate would be retroactively adjusted to reflect cost report information. If the provider's current per diem rate is higher than the rates assumed in the 2019-21 operating budget, that higher rate would be their initial base rate. In accordance with ESHB 1109, the rate established and assigned shall not exceed 100 percent of the specific hospital's costs for providing these services.

The initial base rate for freestanding psychiatric hospitals would be set at $995. This rate is based on the following:

- In the 2017 rebase, HCA calculated the "estimated average cost per day," which is $1,216.88. This is a result of the "estimated 2018 total cost" divided by the "total psych bed days in 2016."
- In 2017, HCA calculated the statewide average rate for freestanding psychiatric hospitals, which is $829.30. This is calculated by multiplying $1,216.88 by 68.15 percent. Currently, this is the rate for freestanding psychiatric hospitals for all inpatient psychiatric services.

For FY 2021, a new statewide average rate for freestanding psychiatric hospitals for 90- and 180-day civil commitment beds will be $995.16. This is calculated by multiplying $1,216.88 by 81.78 percent. This higher percentage will reflect the increased cost of caring for long-term psychiatric patients.

For freestanding residential E&T facilities, the intent is to establish a focused workgroup comprised of HCA, RTF providers, the Washington Council for Behavioral Health, and Medicaid actuaries, to develop a standardized approach to determining cost and apply retroactively.

Recommendation

The workgroup recommends Option 3 for providers serving clients in FY 2021. The workgroup recommends a variation of Option 2 for "new" providers. The statewide average rate should be updated annually to include providers serving clients in the prior year. For example, the FY 2022 statewide average rate would be based on providers serving clients in FY 2021.

Calculating an Initial Base Rate		
	Pros	**Cons**
Option 1: FY 2020 Base adjusted	Simple	Not tied to changes in cost or individual hospital costs May be difficult to justify to CMS For some hospitals, this rate is too low to serve this population
Option 2: New provider average	Recognizes current mix of providers Can be updated annually	Not directly tied to a facility's specific costs
Option 3: Retrospective rate adjustment	Ensures that providers are paid cost Encourages providers to serve clients as they will be made whole for year 1 of service	

Calculating an Acuity Adjustment

Clients on 90- and 180-day civil commitment orders may have higher levels of acuity than short-term psychiatric patients. The workgroup discussed two options for calculating an acuity adjustment.

Option 1: Use a flat percentage increase

Increase base rates by 20 percent

Option 2: Calculate an acuity factor based on severity of illness indicators

Submitted inpatient claims information contains the severity of illness indicators, not the Medicare cost reports. This option would examine the difference between high- and low-acuity claims and adjust the base rate by a factor informed by the percentage difference in claims between the two. For example, if high-acuity claims have an average cost that is 20 percent above claims with a low-acuity indicator, the base rate would increase by that percentage.

Calculating and Acuity Adjustment		
	Pros	**Cons**
Option 1: Increase base by 20%	Simple/easy to implement Minimal administrative burden.	Not tied to actual cost or data Difficult to defend to CMS
Option 2: Calculate an acuity factor based on severity of illness indicators	Tied to actual costs and data Justifiable to CMS Could be updated annually Incentivizes hospitals to take more complex patients	Would require additional work to calculate

Recommendation

The workgroup recommends Option 2. This should be applied to both acute care freestanding psychiatric hospitals and E&T facilities. The workgroup identified that this recommendation will need further refinement before it can be implemented.

Calculating Initial Teaching Hospital Enhancement

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

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

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

The budget proviso directing this workgroup requires that the report identify cost differences between teaching hospitals and other hospital types. The workgroup has identified a methodology for a payment supplement to cover the teaching costs of the hospital.

Teaching hospitals incur additional costs associated with faculty salaries and reduced efficiency inherent to student training. Most of the additional cost related to teaching comes from reduced

productivity of health care professionals (doctors, nurses, social workers, physician assistant and nurse practitioners) who redirect time from patient care to observe and teach trainees from diverse disciplines. In the case of physicians, time that would be billable patient visits is used. The time required to conduct a patient visit with a medical student is two to three times greater, due to the teaching aspect. The ratio is similar for other professional staff.

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

The Legislature directed the workgroup to consider these additional costs.

Recommendation

The workgroup recommends including a $244 enhancement in the base rates for these facilities. The rate was developed using a formula similar to the Medicare teaching education adjustment factor (IME) which is based on the ratio of residents to the average daily census of the inpatient unit.

University of Washington Medical Center (UWMC) FY 2018 Medicare cost report data suggests a 15 percent teaching factor add-on. Applying the 15 percent teaching factor to FY 2018 costs expressed as a per diem yields a rate of $214. This rate was adjusted by a Medicare inflation rate through to the expected opening of the teaching hospital (mid-FY 2022-23) resulting in a final enhancement rate of $244.

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

Calculating Teaching Hospital Enhancement Factor		
	Pros	**Cons**
$244 enhancement rate	Based on a formula similar to the Medicare teaching education adjustment factor	

Adjusting Rates After an Initial Base Period

HCA will need a method to adjust rates once the cost of providing long-term psychiatric inpatient care is reflected in Medicare or other cost reports. The workgroup has identified several options.

Option 1: Annual rebase

This option would have HCA perform a targeted annual rebase to update provider-specific rates every year based on the most recent cost reports for participating hospitals by type. Annual rebase for this purpose means updating a provider's rate every year to match their most recent cost report.

Option 2: Adjusting the initial base rate by a Medicare inflation rate

This option would use an inpatient fixed-weight index to update base rates each year. The workgroup recommends using CMS's annually updated 2012-based inpatient psychiatric facilities market basket for this purpose. The market basket for inpatient psychiatric facilities in FY 2019 is 2.9 percent.

Recommendation

The workgroup recommends Option 1 for acute care hospitals, and 2 for freestanding psychiatric hospitals.

Adjusting Base Rates		
	Pros	**Cons**
Option 1: Annual Rebase	Standard process both the HCA and the hospitals are familiar with Utilizes and existing process Directly ties payment rates to cost Justifiable to CMS	Will require additional work by the HCA
Option 2: Initial base rate adjusted	Simple Low administrative burden	Not tied to changes in cost but more generally inflation May be difficult to justify to CMS

Quality Performance

HCA is moving toward a goal of paying for value to achieve better health, better care, and lower costs. This effort includes shifting health care payments away from a system that pays for volume to one that recognizes quality and outcomes. As this work progresses, the workgroup encourages HCA and the Legislature to recognize that long-term, involuntarily civil commitment patients are a high-acuity population, usually with co-morbidities and significant social needs.

The workgroup recommends that further data collection and analysis be done to better understand the gaps in the continuum of care, and how community hospitals, residential E&T facilities, HCA, and the Legislature can address these gaps and improve outcomes for long-term psychiatric patients. This is not an easy problem to address and it has not been solved by the current mental health infrastructure.

Community hospitals and residential E&T facilities will not be able to find a solution without better data and information. The first step in this will involve collecting and analyzing data from Western and Eastern State Hospitals; this will provide a baseline. As we have more experience with this vulnerable patient population in community settings, data on certain key metrics (as compared to baseline information from the state psychiatric hospitals) may help us understand where community hospitals, residential E&T facilities, HCA, and the Legislature can make changes or investments to both define and achieve quality measures.

Legislative Implementation

The workgroup requests that the information contained in this report be used to determine the payment rates for facilities outlined in the report. Although outcomes may vary, long-term treatment is seen as a step in recovery for many individuals experiencing mental illness. Consistent care with treatment goals, structure, and services designed to transition people back to a stable environment are needed for recovery, healing, and lasting change.

Other Considerations

The state has identified a potential trend of shorter long-term inpatient care for facilities currently contracted to provide bed capacity for individuals on 90- and 180-day civil commitment orders. Should this trend be actualized, treatment in facilities willing to provide bed capacity for this population could prove more cost-effective than when individuals are cared for in state-operated beds. The trend for the 185 individuals who were served during the period of September 2018 through August 2019 points to a shorter inpatient stay.

Bed Stay Trends				
Facility	**Shortest Stay**	**Longest Stay**	**Mean Length of Stay**	**Median Length of Stay**
Astria Hospital	48 days	148 days	81 days	69 days
Cascade Mental Health Care	3 days	149 days	43 days	22.5 days
Kitsap Mental Health Services	2 days	92 days	18 days	14 days
TeleCare E&T (Clark County)	1 day	147 days	24 days	14 days
TeleCare E&T (Skagit County)	19 days	257 days	64 days	38 days
Virginia Mason Memorial	7 days	102 days	37 days	30.5 days

Additional Information

Hospital rates used to calculate the original $1,171 average are located in the Hospital Rate Table. It is the average of the "Current Psych Per Diem Rates" of all the hospitals in the following table. This rate was originally calculated by the Office of Financial Management.

Provider Name	2016 FYE Cost Report Used	Current Psych Per Diem Rates	200+ Psych Bed Days in SFY 2016?
BHC Fairfax Hospital - Kirkland	8/31/2016	$829.30	Yes
Cascade Behavioral Health Hospital	12/31/2016	$829.30	Yes
Lourdes Counseling Center	6/30/2016	$829.30	Yes
Navos - West Seattle Campus	12/31/2016	$829.30	Yes
Central Washington Hospital	12/31/2016	$1,350.22	Yes
Multicare Auburn Medical Center	12/31/2016	$1,080.18	Yes
Northwest Hospital & Medical Center	6/30/2016	$1,299.14	Yes

Overlake Hospital Medical Center	6/30/2016	$1,050.53	Yes
PeaceHealth Southwest Medical Center	6/30/2016	$1,424.71	Yes
PeaceHealth St. John Medical Center	6/30/2016	$1,524.61	Yes
PeaceHealth St. Joseph Medical Center	6/30/2016	$1,011.58	Yes
Providence Sacred Heart Medical Center & Children's Hospital	12/31/2016	$1,087.58	Yes
Providence St. Peter Hospital	12/31/2016	$1,190.69	Yes
St. Joseph Medical Center	6/30/2016	$1,451.33	Yes
Swedish Edmonds Campus	12/31/2016	$1,440.15	Yes
Swedish First Hill Campus	12/31/2016	$1,389.33	Yes
Yakima Valley Memorial Hospital	10/31/2016	$1,020.65	Yes
Harborview Medical Center	6/30/2016	$1,294.15	Yes
Skagit Valley Hospital	12/31/2016	$1,162.03	Yes
University of Washington Medical Center	6/30/2016	$1,325.19	Yes

While freestanding E&Ts are licensed by the Department of Health (DOH) as RTFs (facility licensure), they may be licensed by DOH as a behavioral health agency and certified to provide evaluation and treatment services (treatment licensure). This is an important distinction, as RTFs are used for many purposes, depending on what services they are licensed and certified to provide. The generic term RTF could be confusing going forward.

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[i] Usgovernmentspending.com/Washington_state_spending_pie-chart
[ii] https://www.npr.org/2017/11/30/567477160/how-the-loss-of-u-s-psychiatric-hospitals-led-to-a-mental-health-crisis, accessed October 5, 2019
[iii] American Hospital Association
[iv] American Hospital Association
[v] RCW 71.05.745
[vi] Lawinsider.com/dictionary/freestanding evaluation and treatment, accessed 10-7-19
[vii] RCW 71.41.020
[viii] Legal Information Institute (July 12, 2006). 42 CFR 435.1009 - Institutionalized individuals. Cornell University Law School.
[ix] Centers for Medicare and Medicaid Services
[x] https://content.govdelivery.com/accounts/WADOC/bulletins/1ff584e