

Behavioral Health Finance

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Financing Overview Behavioral Health Administration

State Hospital Funding

DSHS
 DSH Federal \$66.35M
 DSH-State Match \$66.35M
 Medicaid Federal \$16.71M
 Medicaid-State Match \$16.81M
 Medicare/Private Insurance \$26.47M
 GF-S \$103.52M

Child Study and Treatment Center for children 5-17 years old, \$11.80M, 47 beds

 Eastern State Hospital for civil and forensic treatment for adults, \$76.93M, 307 beds

 Western State Hospital for civil and forensic treatment for adults, \$196.50M, 845 beds

 Yakima contracted competency restoration treatment, \$2.20M, 24 beds

 Maple Lane contracted/state employee model competency restoration treatment, \$2.70M, 30 beds

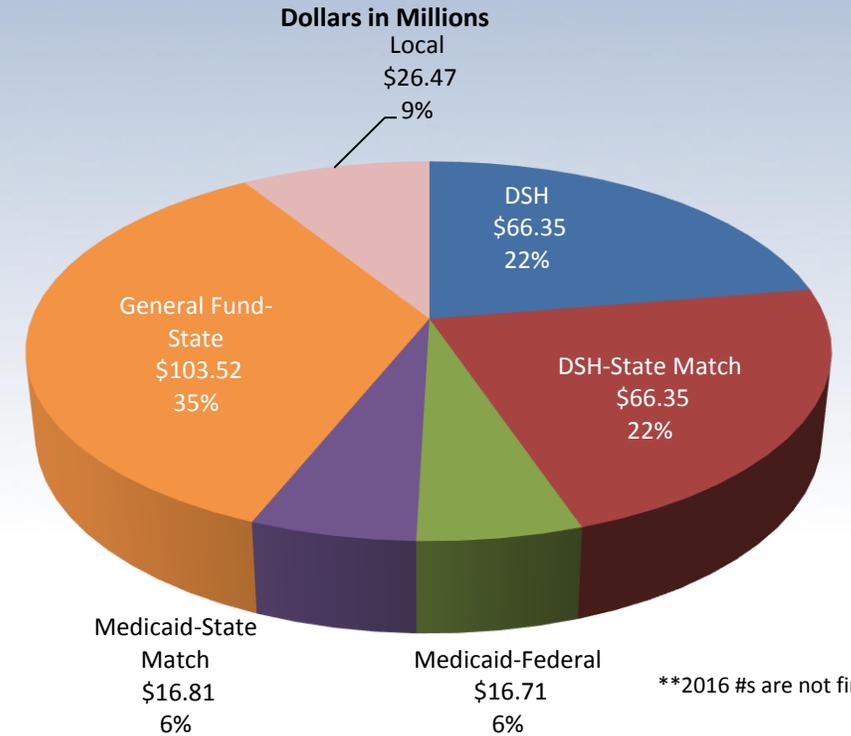
Civil Services

- RCW 71.05 (adults); RCW 71.34 (children)
- Treatment for individuals civilly committed as a result of being a danger to themselves or others or “gravely disabled”
- Primarily for individuals who have already been detained for initial detention and a 14-day commitment in the community
 - Exception: ESH does use a small number of beds to serve individuals being initially detained or for 14-day commitments

Forensic Services

- RCW 10.77
- Evaluations for individuals who have been charged with a crime but may be incompetent to stand trial (done in jails and inpatient settings)
- Competency restoration for individuals determined to be incompetent so they can proceed through the legal process
- Treatment for individuals acquitted as “not guilty by reason of insanity”

FY2016 Institution Expenditures by Fund Source



**2016 #s are not final

**Includes Competency Restoration Treatment Operations at Yakima and Maple Lane

Medicaid Disproportionate Share Hospital Payments (DSH)

What is it?

- The United States government provides funding to hospitals that treat indigent patients through the **Disproportionate Share Hospital (DSH)** programs, under which facilities are able to receive at least partial compensation.
- **Disproportionate Share Hospitals** serve a significantly **disproportionate** number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured or underinsured patients.
- **Proposed DSH Rule: Treatment of Third Party Payers in Calculating Uncompensated Care Costs:** On August 12, 2016, CMS issued a proposed rule regarding Medicaid DSH payments. Comment period closed September 14, 2016

Medicaid Disproportionate Share Hospital Payments (DSH)

How can we claim it?

- DSH is available for uninsured patients who are being served on a certified ward and are considered a certified patient (receiving active treatment) as determined by a physician
- For our State Hospitals the DSH claim is made for all patients ages 22-64 years old

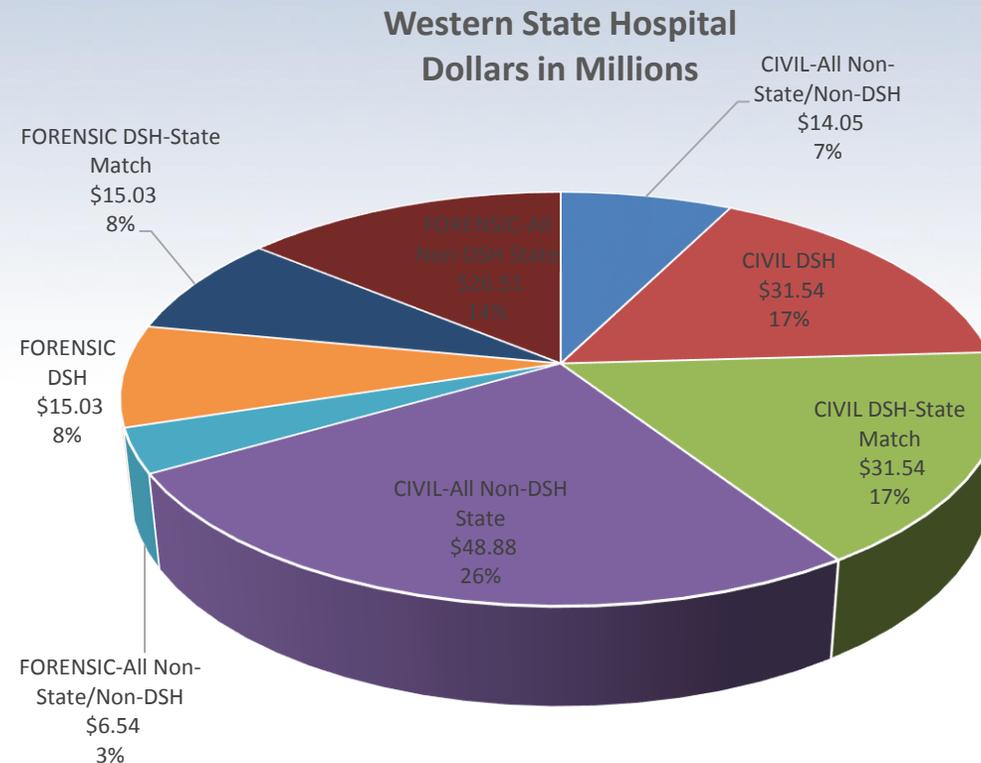
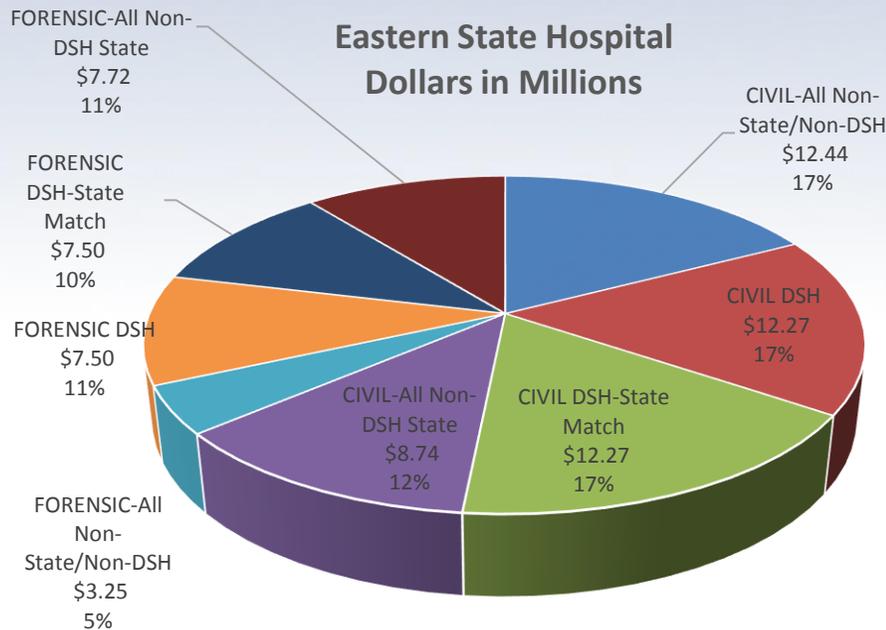
How can we lose it?

- If the hospital becomes decertified
- If a ward becomes decertified
- If a client becomes decertified
- Further, the Affordable Care Act requires phased reductions in DSH beginning in FY2018 from \$12 billion to \$4 billion by FY 2025
- For Washington's State Hospitals this means a loss of about \$11.1 million in FY2018 up to a loss of about \$44.5 million in FY2025 (or a drop from \$66.9 million federal DSH funds to \$22.4 million federal funds)

Medicaid Disproportionate Share Hospital Payments (DSH)

How is it distributed between the hospitals?

- Below illustrates the distribution of funds between hospitals by civil and forensic
- Note: This is how the state has chosen to distribute, it is not mandated how we distribute only that it must be toward qualified claims, if the state chose, it could apply all of the DSH to forensic uncompensated care



Medicaid Disproportionate Share Hospital Payments (DSH)

How is it distributed between the hospitals?

REVENUE/EXPENDITURE ALLOCATIONS FY 2016

REVENUE SOURCE	ESH			WSH		
	CIVIL	FORENSIC	TOTAL	CIVIL	FORENSIC	TOTAL
LOCAL						
MEDICARE	\$5,744,755	\$1,534,457	\$7,279,212	\$5,403,247	\$4,768,529	\$10,171,776
INSURANCE	\$1,975,630	\$129,239	\$2,104,869	\$1,468,700	\$195,926	\$1,664,626
PRIVATE PAY	\$358,854	\$72,046	\$430,900	\$1,634,373	\$175,564	\$1,809,937
PART D	\$677,335	\$384,985.00	\$1,062,320	\$1,172,439	\$587,187	\$1,759,626
TOTAL LOCAL	\$8,756,574	\$2,120,727	\$10,877,301	\$9,678,759	\$5,727,206	\$15,405,965

FEDERAL						
MEDICAID	\$3,683,709	\$1,127,627	\$4,811,336	\$4,374,724	\$812,286	\$5,187,010
MEDICAID STATE MATCH	\$3,683,709	\$1,127,627	\$4,811,336	\$4,374,724	\$812,286	\$5,187,010
DSH	\$12,266,928	\$7,504,835	\$19,771,763	\$31,543,208	\$15,033,228	\$46,576,436
DSH STATE MATCH	\$12,266,928	\$7,504,835	\$19,771,763	\$31,543,208	\$15,033,228	\$46,576,436
TOTAL FEDERAL	\$31,901,274	\$17,264,924	\$49,166,198	\$71,835,864	\$31,691,028	\$103,526,892
GF-S	\$5,058,554	\$6,596,042	\$11,654,596	\$44,503,478	\$25,699,582	\$70,203,060
TOTAL EXPENDITURES	\$45,716,402	\$25,981,693	\$71,698,095	\$126,018,101	\$63,117,816	\$189,135,917

POTENTIAL DSH CLAIM AMOUNTS

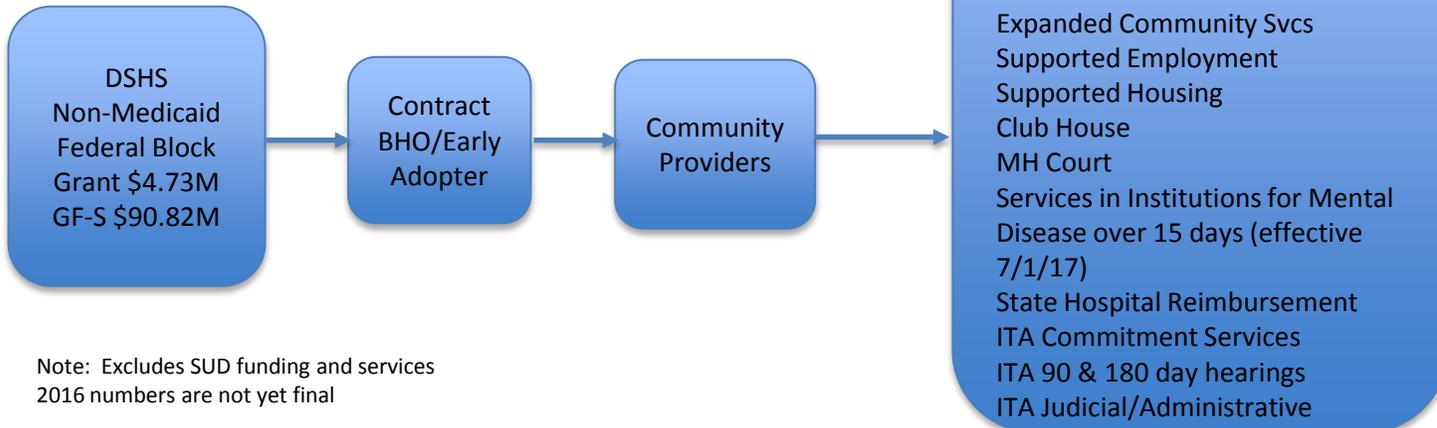
HOSPITAL	WARD TYPE	PAYER	2016
ESH	CIVIL	DSH	15,794,482.62
	FORENSIC	DSH	9,662,971.59
	TOTAL		25,457,454.21
WSH	CIVIL	DSH	41,037,707.07
	FORENSIC	DSH	19,558,226.82
	TOTAL		60,595,933.89

Medicaid Disproportionate Share Hospital Payments (DSH)

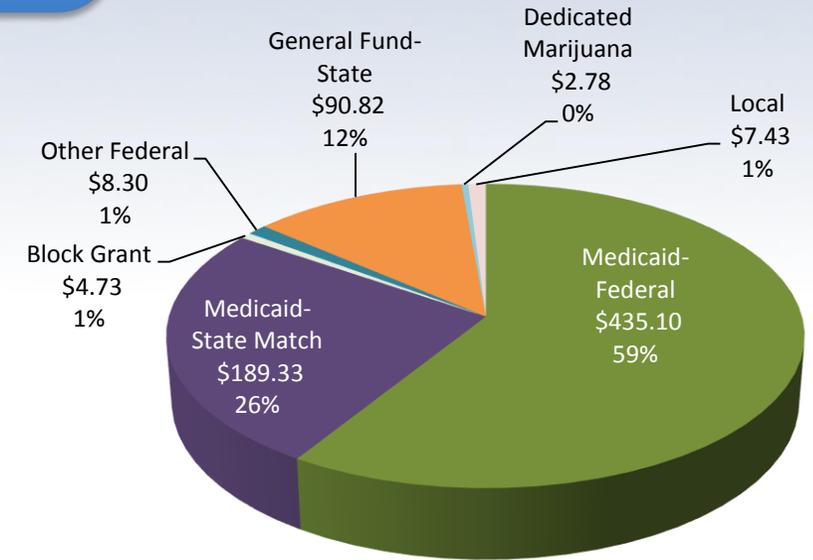
How might it affect how we think about refinancing?

- The Proposed rule addresses the hospital-specific limitation on Medicaid disproportionate share hospital (DSH) payments under section 1923(g)(1)(A) of the Social Security Act (Act). Specifically, this rule would make clearer in the text of the regulation an existing interpretation that uncompensated care costs include only those costs for Medicaid eligible individuals that remain after accounting for payments received by hospitals by or on behalf of Medicaid eligible individuals, including Medicare and other third party payments that compensate the hospitals for care furnished to such individuals. As a result, the hospital-specific limit calculation would reflect only the costs for Medicaid eligible individuals for which the hospital has not received payment from any source
- More research/guidance will need to be pursued to understand if the BHO/MCOs would be considered a third party payer, if so it is likely the hospitals could not claim DSH
- Further, state hospital claims would need to be built into the BHO/MCOs utilization for rates, but with the new ruling on IMD stay limits over 15 days not being eligible for FFP, likely these would need to be Non-Medicaid or state only payments as well

Community Mental Health Services — Managed Care



FY2016 BHO Expenditures by Fund Source
Dollars in Millions



Note: Excludes SUD funding and services
2016 numbers are not yet final

Behavioral Health Organizations' Contractual Obligations Medicaid Contract

Who is Eligible for Services?

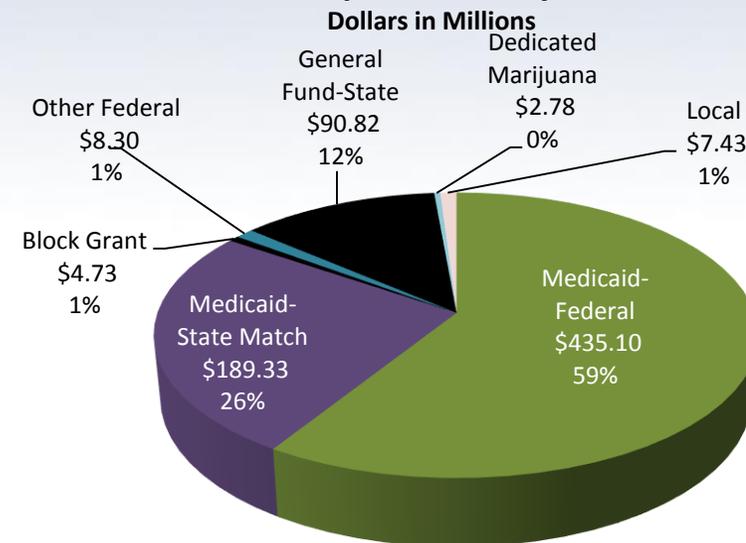
- All individuals who are Medicaid Eligible are entitled to the following State Plan Services that are required in the BHO Medicaid Contract.
 - Crisis and Stabilization Services
 - Intake Assessment
 - Rehabilitation Case Management

Medical Necessity for Evaluation and Treatment Facilities and Community Inpatient Psychiatric Services is determined by the facility admitting staff or through an involuntary treatment determination by a DMHP or Court.

What Services are BHO's Required to Provide those meeting access to care standards/criteria

- Access to Care Standards are used to determine medical necessity for outpatient mental health services that are required by the Medicaid state plan (see previous slide for services)

FY2016 BHO Expenditures by Fund Source



(General Fund-State and Block Grant are showing as black to illustrate they are not part of the Medicaid Contract)

Behavioral Health Organizations' Contractual Obligations

Non-Medicaid Contract

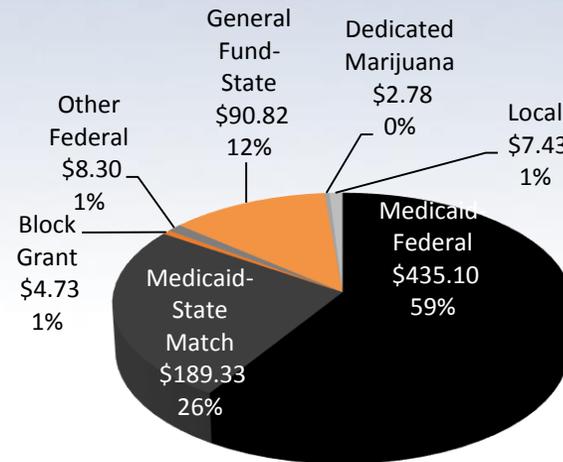
BHO Obligations

- Crisis and Stabilization Services to all people within the boundaries of the Region
- Perform all aspects of the Involuntary Treatment Act including
 - Evaluations for ITA
 - Payment for ITA E&T stays for non-Medicaid individuals
 - Court Costs
 - Monitoring of Less Restrictive Treatment Orders
- Hospital Liaison Services
 - Individuals admitted to State Hospital or CLIP facility.

What Services are Required if Medically Necessary?

- Crisis and ITA are the only required services.

FY2016 BHO Expenditures by Fund Source
Dollars in Millions



(General Fund-State and Block Grant are showing as orange to illustrate they are part of the Non-Medicaid Contract)

Services to be provided within available resources

BHO establishes the financial and clinical eligibility. Clinical criteria can be more restrictive than Access to Care Standards for Medicaid. These include:

- Outpatient mental health services for non Medicaid individuals.
- Residential Services and Housing Supports
- Other programs funded directly by the Budget Act
 - Housing and Recovery through Peer Services (HARPS)
 - WA – Program for Assertive Community Tx (PACT)
 - Expanded Community Services
 - Jail Services
 - Peer Bridger Program

Behavioral Health Patient Case Study #1: Individual is transported to Hospital ED/ER for medical treatment after serious suicide attempt. While being treated at ED/ER, the individual continues to express suicidal intent. DMHPs are called and evaluate individual. No less restrictive alternative can be found and individual is detained to E&T. Individual has had no prior contact with mental health system.



No services were provided in this scenario prior to suicide attempt. If individual or family had requested services or contacted crisis system: BHO crisis and outpatient services could have been provided to manage depression and suicidal ideation.

Evaluation and Treatment provided in either Community Inpatient or E&T Facility. BHO is payer. May be Medicaid or State Funds.

State Hospital provides all clinical and custodial services.

BHO Provides Hospital Liaison to work with hospital and individual on discharge planning. Liaison is funded with State Funds.

If Medicaid Eligible BHO provides all state plan services with Medicaid funds. State or local funds may be used for non-Medicaid services.

Behavioral Health Patient Case Study #2: 25 y/o, Axis 1 & Axis 2 diagnosis, meets DDA eligibility, determined to be imminent danger to themselves and others evidenced by assaultive, violent, predatory, or self-injurious behavior. Refuses or unable to voluntarily participate in diversion or community-based services offered by the DDA.



DDA Services:

- Case Management
- In-home
- Residential

(Funding through State-Plan and HCBS waivers)

BHA Services

- Case management
- Medication Management
- Mental Health Therapies

(Funding through Medicaid)

HCA Services

- Primary Care, dental & Vision

(Funding through Medicaid)

BHA Services

- Evaluation and Treatment provided in either Community Inpatient or E&T Facility.

(BHO is payer. May be Medicaid or State Funds.)

BHA State Hospital Services

- Psychiatric Care
- Medications
- Medical
- Dental
- Vocational
- Psychiatric social work

(Typically not eligible for Medicaid funding as client may be determined to have reached maximum benefit of treatment)

DDA Services:

- Case Management

(Funded through State Plan)

BHA State Hospital Services

- Discharge Planning

DDA Services:

- Case Management
- Determine if person meets definition of individual with community protection issues;
- Resource Management for service provider referrals

(Funded through State-Plan)

Discharge Challenges:

- Client refuses to voluntarily participate in DDA service programs;
- Service providers unable or unwilling to support client

DDA Services:

- Case Management
- Residential
- Supported Employment Services
- Behavioral Therapies
- Community Protection Program

(Funding through State-Plan and HCBS Waivers)

BHA Services

- Case management
- Medication Management
- Mental Health Therapies

(Funding through Medicaid)

HCA Services

- Primary Care, dental & Vision

(Funding through Medicaid)

Behavioral Health Patient Case Study #1: Age 57, Schizoaffective Disorder, placed in hospital due to danger to self or others; upon referral from WSH ALTSA determines eligible: needs medication reminders and cuing for activities of daily living; behaviors interfere with residential placement and sustaining community integration



Payer by Contractual Obligation

Client	Nursing Home	Adult Family Home	Assisted Living	Enhanced Services Facility	In-home	Supported Living (DD)	State Operated Alternative Living (DD)	MH Outpatient	MH Inpatient	MH Crisis	State Hospital	Healthy Options
Mental Health Only								BHO	BHO	BHO	MH	MCO
Mental Health and Developmental Disabilities		DDA	DDA		DDA	DDA	DDA	BHO	BHO	BHO	MH	MCO
Mental Health with LTC/Personal Care Needs	ALTSA	ALTSA	ALTSA	ALTSA	ALTSA			BHO	BHO	BHO	MH	MCO
BHO's provide crisis and involuntary treatment for individuals who do not qualify for Medicaid												
Healthy Options - is for clients who do not meet the access to care standards for Mental Health Services												

Institution for Mental Disease (IMD)

- The Medicaid statute prohibits federal financial participation (FFP) for services for people under age 65 in Institutions for Mental Disease (IMD) (42CFR435.1009 and 435.1010).
- An IMD is defined as an institution with more than 16 beds, primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (definition includes substance use/abuse diagnoses).
- There is an exception to the exclusion for individuals under age 21 receiving inpatient psychiatric services in hospitals and Psychiatric Residential Treatment Facilities. The exception does not apply to youth residential substance abuse treatment facilities.

Payment for Services In IMDs

- In July of 2014 the State received CMS approval of a waiver that allowed for payment for services in IMDs in lieu of more expensive full service hospital payments. This change was included in the mental health managed care waiver. When SUD was added on April 1, 2016 the same waiver was included and approved.
- The waiver did not include state hospitals.
- The major effect of the waiver was an increase in federal match for patient stays in community psychiatric hospitals, SUD residential facilities and some large group homes.

New federal IMD Regulations

- On May 6th 2016, CMS released new federal regulations that result in a partial loss of the State's authority to receive FFP for services provided in IMDs.
- Medicaid payment for services in an IMD will be limited to 15 days per month under the new regulations and states can no longer use 'in lieu of' authority for these services.
- If a stay in an IMD exceeds 15 days in a calendar month, the person is ineligible for all Medicaid services retroactive to the first day of the month.
- While the new regulation is in effect now, CMS is phasing in compliance. Our projected date for Washington to be in full compliance is July 1, 2017 when the state completes a new rate rebase process.

Questions?