Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Services in Institutions of Mental Diseases

Status of 1115 IMD Waiver Application

Engrossed Substitute House Bill 1109; Section 215(29); Chapter 415; Laws of 2019

December 1, 2019

Services in Institutions of Mental Diseases

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Executive summary

This report provides the status of the HCA's application for a Section 1115 waiver; "*for full federal participation for medicaid clients in mental health facilities classified as institutions of mental diseases,*" per ESHB 1109, see below:

"1109- Section 215 (29) $24,819,000 of the general fund—state appropriation for fiscal year 2020 is provided solely to assist behavioral health entities with the costs of providing services to medicaid clients receiving services in psychiatric facilities classified as institutions of mental diseases. The authority must distribute these amounts proportionate to the number of bed days for medicaid clients in institutions for mental diseases that were excluded from behavioral health organization calendar year 2019 capitation rates because they exceeded the amounts allowed under federal regulations. The authority must also use these amounts to directly pay for costs that are ineligible for medicaid reimbursement in institutions of mental disease facilities for American Indian and Alaska Natives who opt to receive behavioral health services on a fee-for-service basis. The amounts used for these individuals must be reduced from the allocation of the behavioral health organization where the individual resides. If a behavioral health organization receives more funding through this subsection than is needed to pay for the cost of their medicaid clients in institutions for mental diseases, they must use the remainder of the amounts to provide other services not covered under the medicaid program. ***The authority must submit an application for a waiver to allow, by July 1, 2020, for full federal participation for medicaid clients in mental health facilities classified as institutions of mental diseases. The authority must submit a report on the status of the waiver to the office of financial management and the appropriate committees of the legislature by December 1, 2019."***

Federal financial participation (FFP)[1] is not available for Medicaid services for individuals between the ages of 21 and 64 who reside in an Institute for Mental Disease (IMD). The IMD exclusion is a component of Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act.

The Centers for Medicare and Medicaid Services (CMS) provided new guidance via a State Medicaid Director Letter, SMD#18–011 on November 13, 2018, to allow states to apply for waivers to receive FFP for services provided to exclusion-aged individuals residing in IMDs under 1115 demonstration waiver authority. This opportunity would allow states to use FFP in participating IMDs with a 30-day or less state wide average length of stay.

Funding is conditioned upon receiving the state's commitment to improving community-based care according to specific milestones. CMS outlined extensive requirements for states to maintain outpatient mental health services, including crisis stabilization, with additional requirements for several clinical, system, and information technology milestones and measures. The additional requirements from CMS require further review and documentation by HCA to complete the application and supplementary resources to implement the requirements. To meet these

[1] FFP is assumed to be defined as Federal Financial Participation, not Full Federal Participation.

requirements, HCA has submitted a Decision Package for additional funding to ensure adequate resources to meet the measures, as required.

HCA anticipates completing the waiver application with a March submission target date to allow for the implementation of the waiver by July 1, 2020.

Background

Since the Social Security Act's passage in 1965, the "IMD exclusion" has barred use of federal financial participation (FFP) medical assistance under title XIX for services provided to individuals under age 65 residing in an IMD. In 1972 an exception to the exclusion was passed allowing FFP for inpatient psychiatric services for individuals under age 21. The IMD exclusion was intended to ensure that states pay for long-term inpatient psychiatric services in institutions such as state hospitals. Under the exclusion, no Medicaid payment can be made for services provided either in or outside the facility when a person between the ages of 21-65 resides in an IMD.

42 CFR §435.1010 defines an IMD as:

Institution for mental diseases means 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. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

While the IMD exclusion strictly limits use of FFP for Medicaid fee-for-service payments, Medicaid managed care plans were allowed to purchase services at IMDs as an "in lieu of" service for stays of 30 days up until CMS revised 42 CFR §438.6e in May of 2016. Once contracts active at the time of the rule change expired, Medicaid managed care entities could only purchase up to 15 days of IMD services in a calendar month in lieu of non-IMD inpatient psychiatric services. However, if a patient requires more than 15 days of such care, the individual must be dis-enrolled and the capitation payment recouped from the plan. The 15 calendar day limit has resulted in cumbersome processes to reconcile claims and plan capitation payments.

CMS has issued guidance to states via State Medicaid Director's Letters announcing opportunities for states to fund greater than 15-day stays in IMDs by way of 1115 demonstration waivers—subject to reporting, milestone requirements and a state wide average length of stay of 30 days or less.

The first such letter provided opportunities for Substance Use Disorder (SUD) services in an IMD. Washington State is approved for the SUD demonstration waiver.

The IMD SUD letter is available at the following link:

https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

The SMI/SED (Mental Health) letter is available here:

https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

Approval of this waiver application will allow Washington State to maintain and expand access to inpatient short-term care and have salutary effects on the availability of long-term residential mental health treatment. In 42 C.F.R. 438.6(e), as amended in July 2016, FFP for IMD stays of over 15 days in a calendar month for Medicaid beneficiaries aged 21-64 is prohibited. Federal rules also prohibit the use of FFP for capitated payments to managed care entities during any month where the individual has a stay of longer than 15 days in an IMD.

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

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

Washington State currently has 543 staffed inpatient mental health beds in eleven facilities that meet the definition of an IMD. Because the 2016 Managed Care Final Rule prohibits use of FFP in these facilities when the stay lasts longer than 15 days in a calendar month, the state and the managed care entities it contracts with must use limited state dollars to pay for treatment of excluded services. Use of state dollars to pay for services in IMD settings reduces the ability to focus state funding on other vital services.

Recently, CMS has issued guidance to states via State Medicaid Director's Letters announcing opportunities for states to fund greater than 15-day stays in IMDs by way of 1115 demonstration waivers, subject to reporting, milestone requirements and a state wide average length of stay of 30 days or less.

Goals of waiver acceptance, required by CMS

Per CMS approval, a waiver granted per the "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance" (SMI/SME) State Medicaid Director letter, will allow states to receive FFP for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as IMDs. This only applies if those states also take action to ensure good quality of care in IMDs and to improve access to community-based services. This "SMI/SED demonstration opportunity" is comparable to the recent section 1115 SUD waiver to improve treatment for SUDs, including opioid use disorder (OUD). However, through these demonstrations,

states will focus on improving care for individuals with serious mental health conditions in inpatient or residential settings that qualify as IMDs, as well as strengthening community-based mental health care.[2]

States participating in the SMI/SED demonstration opportunity must commit to taking a number of actions to improve community-based mental health care. These commitments are linked to a set of goals for the SMI/SED demonstration opportunity:

- Include actions or milestones to ensure good quality of care in IMDs, to improve connections to community-based care following stays in acute care settings.
- Ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries with SMI or SED, to provide a full array of crisis stabilization services.
- Engage beneficiaries with SMI or SED in treatment as soon as possible. States are encouraged to build on the opportunities for innovative service delivery reforms.

Through this demonstration opportunity, federal Medicaid reimbursement for services will be limited to beneficiaries who are short-term residents in IMDs primarily to receive mental health treatment. CMS will not approve a demonstration project unless the project is expected to be budget neutral to the federal government.

CMS goals of the SMI/SED demonstration opportunity include:

- Reduced utilization and lengths of stay in Emergency Departments among Medicaid beneficiaries with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) awaiting mental health treatment in specialized settings.
- Reduced preventable readmissions to acute care hospitals and residential settings.
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Details of the application

Washington State will request waiver authority to allow FFP for payment of services to Medicaid beneficiaries receiving treatment in a mental health IMD. As with the current 1115 waiver for SUD services, Washington State will request that it apply to Medicaid beneficiaries enrolled in managed

[2] Note, consistent with the SUD demonstration opportunity, states will be expected to achieve a statewide average length of stay of 30 days for beneficiaries receiving care in participating IMDs pursuant to this SMI/SED demonstration opportunity.

care or the fee-for-service (FFS) system. The state will also seek the authority to make capitation payments to state contracted managed care entities to pay for services to Medicaid beneficiaries regardless of the length of stay in an IMD, recognizing that an average length of stay of 30 days is required within the waiver.

In addition, Washington State will be requesting that the waiver authorities described in this amendment apply to Medicaid beneficiaries in both the managed care and fee-for-service (FFS) systems. Application of the waiver to both systems would ensure equal access to this benefit for all Medicaid beneficiaries. Specifically, HCA seeks a waiver of the following requirements:

Implementation plan

The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments. The table below outlines the high level project work plan to develop the waiver application.

Table 1 - Projected plan

Date	Project Plan
4/01/2019	Project Start
5/01/2019	Determine subject matter experts
5/15/2019	Information Gathering/Draft Application/ Implementation Plan
6/15/2019	Develop Budget for Contractors (RDA, Mercer, Independent Evaluator) – develop budget decision package and submit to OFM 9/19
9/01/2019	Complete Draft Application/Implementation Plan
10/01/2019	Internal Review of Application/Implementation Plan
11/15/2019	Complete Draft HIT Plan
11/30/2019	Executive Review of Application/ Implementation Plan/HIT Plan
12/01/2019	Tribal Notice, Public Notice, Begin Tribal Roundtables
2/01/2020	Tribal Consultation
3/01/2020	Submit Application to CMS
7/01/2020	CMS Approval/Begin FFP
8/01/2020	Monitoring Plan Negotiation
9/01/2020	Begin Implementing Milestones
12/31/2020	Request Extension: Attached to Main 1115 Waiver

Table 2 - Waiver application and implementation policy authorities

Policy	Waiver/Expenditure Authority	Statutory and Regulatory Citation
Allow the state to make capitated payments to managed care entities for individuals in a MH IMD for more than 15 days in a calendar month regardless of the length of stay and regardless of the age of the individual. The capitated payments may be used to pay for treatment in IMD settings and services provided before or after discharge from the facility during the calendar month. Any in lieu of services provided in an IMD would meet the requirements of 42 CFR 438.3(e).	Waivers of all IMD payment restrictions Expenditure authority for IMD payments	42 CFR 438.6(e)
To allow for FFP in expenditures for services provided to managed care and fee-for-service (FFS) Medicaid beneficiaries in MH IMD facilities, including IMD facilities that are public institutions.	Expenditure authority for IMD payments	§1905(a)(29) paragraphs A and B

Required milestones

Ensuring quality of care in psychiatric hospitals and residential settings

- Participating hospitals and residential settings are licensed or otherwise authorized by the state to primarily provide treatment for mental illness and are accredited by a nationally recognized accreditation entity including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) prior to receiving FPP for services provided to beneficiaries.
- Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements.
- A utilization review entity (e.g., a managed care organization or administrative service organization) ensures beneficiaries have access to the appropriate levels and types of care.

Provides oversight to ensure lengths of stay are limited to what is medically necessary and that only those receiving treatment in psychiatric hospitals and residential treatment settings have a clinical need. Participating psychiatric hospitals and residential treatment settings must meet federal program integrity requirements. The state has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers. Specifically, under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers (42 CFR Part 455 Subparts B and E), ensure treatment providers have entered into Medicaid provider agreements (42 CFR 431.107), and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues.

- Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in these treatments settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

Improving care coordination and transitions to community-based care

- Implementation of a process to ensure that psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services as well as requirements that community-based providers participate in these transition efforts.
- Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available.
- Require psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge. Ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to.
- Implementation of strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers).
- Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers with the goal of enhancing care coordination.

Increasing access to continuum of care including crisis stabilization services

- Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability.

- Commitment to a financing plan approved by CMS to be implemented by the end of the demonstration to increase availability of:
    - Non-hospital, non-residential crisis stabilization services
    - Including services made available through crisis call centers
    - Mobile crisis units
    - Coordinated community crisis response that involves law enforcement and other first responders
    - Observation/assessment centers as well as on-going community-based services.
- Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible.
- Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association, e.g., LOCUS or CALOCUS to help determine appropriate level of care and length of stay.

Earlier identification and engagement in treatment including through increased integration

- Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions in treatment sooner, including through supported employment and supported education programs.
- Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers.
- Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

Health information technology requirements

Waiver approval is also conditioned on commitments from the state to improve health information technology (HIT) capabilities to support mental health service system improvements and monitoring, as below:

- Closed loop referrals and e-referrals
- Interoperable care plans
- Interoperable assessment/screening tools
- Medical record transmissions
- Service and data compilation and analytics to determine risk

Fiscal impacts

The table below details the fiscal impact of the application as provided by Mercer actuaries. This information informed the state budget and details state saving expectations for service provision in

facilities. This table does not include the anticipated costs of administrative elements, implementation costs, data gathering and reporting or continuation of the waiver and the required elements. The table below includes the assumed savings in the fiscal year 2021 budget, not including implementation costs.

Table 3 - Fiscal impacts table (savings for the cost of stays)

No Waiver	GF-S				Federal				Total			
IMD Unallowable	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
Inpatient	$ 22,934	$ 22,934	$ 22,934	$ 22,934	0	0	0	0	$ 22,934	$ 22,934	$ 22,934	$ 22,934
Residential	$ 7,683	$ 7,683	$ 7,683	$ 7,683	0	0	0	0	$ 7,683	$ 7,683	$ 7,683	$ 7,683
Other	$ 1,945	$ 1,945	$ 1,945	$ 1,945	0	0	0	0	$ 1,945	$ 1,945	$ 1,945	$ 1,945
Total	**$ 32,562**	**$ 32,562**	**$ 32,562**	**$ 32,562**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 32,562**	**$ 32,562**	**$ 32,562**	**$ 32,562**
Waiver FMAP												
Inpatient	29.7%	30.4%	30.4%	30.4%	70.3%	69.6%	69.6%	69.6%	100.0%	100.0%	100.0%	100.0%
Residential	1	1	1	1	0	0	0	0	1	1	1	1
Other	85.9%	86.1%	86.1%	86.1%	14.1%	13.9%	13.9%	13.9%	14.1%	13.9%	13.9%	13.9%
Costs Under Waiver												
Inpatient	$ 22,934	$ 6,967	$ 6,967	$ 6,967	$ -	$ 15,967	$ 15,967	$ 15,967	$ 22,934	$ 22,934	$ 22,934	$ 22,934
Residential	$ 7,683	$ 7,683	$ 7,683	$ 7,683	$ -	$ -	$ -	$ -	$ 7,683	$ 7,683	$ 7,683	$ 7,683
Other	$ 1,945	$ 1,674	$ 1,674	$ 1,674	$ -	$ 271	$ 271	$ 271	$ 1,945	$ 1,945	$ 1,945	$ 1,945
Total	**$ 32,562**	**$ 16,324**	**$ 16,324**	**$ 16,324**	**$ -**	**$ 16,238**	**$ 16,238**	**$ 16,238**	**$ 32,562**	**$ 32,562**	**$ 32,562**	**$ 32,562**
Savings	$ -	$ (16,238)	$ (16,238)	$ (16,238)	$ -	$ 16,238	$ 16,238	$ 16,238	$ -	$ -	$ -	$ -
Inpatient FMAP Calc	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
Non-Med	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Med	74%	73%	73%	73%	74%	73%	73%	73%	74%	73%	73%	73%
Blended Inpatient	70.3%	69.6%	69.6%	69.6%	70.3%	69.6%	69.6%	69.6%	70.3%	69.6%	69.6%	69.6%
Blended Other	14.1%	13.9%	13.9%	13.9%	14.1%	13.9%	13.9%	13.9%	14.1%	13.9%	13.9%	13.9%
For Blended other, assume 20% of these are for medicaid inpatient clients												

Conclusion

The 1115 MH IMD waiver allowing use of FFP presents opportunities to improve services and is essential if we are to narrow the access and funding gaps between the outpatient system and more acute levels of care for inpatient mental health treatment. These opportunities come with requirements that will necessitate investments in health information technology and administration that have the potential to broadly improve care and reduce utilization.

Individuals experiencing serious mental illness often require higher levels of care. Approval of the waiver will allow federal funding for an average of thirty days of inpatient stays in an IMD, allowing those individuals access to the required care.

Washington State remains committed to funding mental health, substance use, and crisis services - as demonstrated by recent budget increases outlined in the Governor's plan and enacted by the legislature. This waiver application may allow the state to continue to use state funds to maintain and expand this continuum of care. The waiver approval process and acceptance contains

additional implementation strategies that will impact the entire system in ways beneficial to the state and all systems of care.

The Health Care Authority remains steadfast and on target in the waiver application process, recognizing that long term inpatient bed accessibility and funding are integral to the recovery of a person experiencing mental illness.