



Adding Behavioral Health Services to the State Plan

Actuarial Estimates of Fiscal Impact

Engrossed Substitute Senate Bill 6032; Section 213(5)(vv);

Chapter 299; Laws of 2018

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Washington State
Health Care Authority 

Christy Vaughn

Financial Services

P.O. Box 45502

Olympia, WA 98504

Phone: (360) 725-0468

Fax: (360) 586-9551

<http://hca.wa.gov>



Legislative Reference

The Health Care Authority (HCA) is submitting this report in response to Engrossed Substitute Senate Bill 6032 (2018):

“(vv) \$150,000 of the general fund—state appropriation for fiscal year 2019 is provided solely for the authority to contract with actuaries to develop estimates for the cost of implementing new behavioral health service types in the Medicaid state plan. The authority must coordinate with behavioral health organizations to identify: (i) Eligible behavioral health service types that are currently provided to Medicaid enrollees without federal funding and are dependent on state, local, or other funds; and (ii) eligible behavioral health service types that are not currently available to Medicaid enrollees due to the lack of federal funding. The authority must contract with the actuaries responsible for certifying state behavioral health capitation rates to develop estimates for the cost of implementing each of these services. The estimates must identify the cost of implementing each service statewide, the estimated state and federal Medicaid cost, and any estimated offset in state non-Medicaid spending. The authority must submit a report to the office of financial management and the appropriate committees of the legislature identifying the services and costs estimates by November 1, 2018.”

Follow-Up Report

This is a follow-up report from the original report, submitted to the Legislature on November 1, 2018. In that report we indicated that analysis data from consulting firm Mercer were not available. In this report we include Mercer’s analysis.

Adding Behavioral Health Services to State Plan

HCA’s Division of Behavioral Health and Recovery (DBHR) coordinated with the Behavioral Health Organizations (BHOs) to develop a list of behavioral health services that could potentially be eligible to be added to the Medicaid State Plan Amendment (SPA).



Behavioral Health Services Considered

The BHOs proposed that the following behavioral health service types be considered for addition to the allowable services in the Medicaid SPA:

Services to Be Analyzed for Addition to the Medicaid SPA

- Clubhouse Services
 - Emphasizes community, participation, work, and wellness. Offers people living with mental illness opportunities for friendship, employment, housing, education, and access to medical and psychiatric services — all in a caring and safe environment that facilitates recovery and full participation in society.
 - Not included in the current state plan. This service was previously Medicaid-eligible in Washington under B3 waiver authority. However, that waiver expired and was not renewed because the projects allowable under the B3 waiver were not being implemented statewide.
- Substance Use Disorder (SUD) Peer Services
 - Peer services provide a wide range of activities to assist an individual in exercising control over their own life and recovery process. Activities include developing self-advocacy skills, maintaining community living skills, and promoting socialization. Also, peer counselors share their life experiences, which builds alliances with the person in recovery that enhances the individual's ability to function. While mental health peer services are included in the current state plan, SUD peer services are not.
 - The Legislature, through the operating budget, directed DBHR to pursue peer support. The HCA's September 2018 budget submittal included a decision package detailing multiple strategies being developed to add this service.
- Partial Hospitalization Programs (PHPs)
 - PHPs serve people with chronic mental illness which leads to repeated hospitalization when their symptoms interfere with daily responsibilities and lead to impaired functioning in the community. Services resemble a highly-structured, short-term hospital inpatient program except that participants return home each evening; there is no 24-hour care. However, PHPs provide more intense treatment than outpatient day treatment or psychosocial rehabilitation. Coordinated, interdisciplinary services are offered for more than 20 hours per week. Participation is relatively brief (measured in days — not weeks or months) and is intended to improve the individual's functioning to prevent relapse and hospitalization. PHPs may be appropriate as a time-limited response to stabilize acute or gradually deteriorating symptoms, or to transition from inpatient care.
 - In some other states' Medicaid programs, PHPs are exclusively hospital based. However Medicare regulations appear to allow them to be offered by either hospitals or community mental health centers.



Additional Services Identified by BHOs

- Eating Disorder Services (outpatient and residential)
 - Treatment can include family-based approaches, cognitive behavioral therapy, nutritional evaluation, and counseling to address both the eating disorder and underlying conditions such as substance use, depression, and anxiety.
 - Eating disorder diagnoses are already covered under BHO and Managed Care Organization behavioral health benefits. Therefore, this service would not be new to the state plan.
 - Although this service is already in the state plan, it is not offered statewide. Currently, BHOs must negotiate rates with the two current state-certified providers on a case-by-case basis to provide the service.
 - If HCA contracted for the service and standardized the rates for the three most common modalities (residential, intensive outpatient, and outpatient), the services could be offered statewide.
- Substance Use Disorder Outpatient Day Treatment (in lieu of residential treatment)
 - Substance Use Disorder Outpatient Day Treatment is the SUD equivalent to mental health day support for people who need more intensive services than routine outpatient treatment can provide. These services help individuals learn life, adaptive coping, and socialization skills and to retain or improve their current functioning.
- Co-Occurring Disorder (COD) Services
 - COD services became available through the Service Encounter Reporting Instructions (SERI) coding practices as of April 2018. SERI is a statewide reporting guide for behavioral health services.
- Substance Use Disorder Urinalysis
 - SUD urinalysis is available when medically necessary.
 - Drug screenings/urinalysis for Opiate Substitution Treatment clients and pregnant women are included in current BHO rates. The state plan explicitly mentions that this service should be done as screening for medical test fitness or for monitoring these populations during substance use treatment.
- Drop-In Services
 - Provides social support, organized and informal recreational activities, and education about accessing community resources. Drop-in services are less intensive and focused than day support or peer support.
 - Not included in the current state plan. However, fully-integrated managed care and the 1115 demonstration waiver have provided coverage for these services.
 - These services are already available to Medicaid clients through SUD center prescribers (the SUD center contracts with HCA).
 - HCA may need to provide technical assistance to help BHOs properly process encounters.



Actuarial Estimates of Fiscal Impact

HCA contracted with Mercer, the actuarial firm responsible for certifying state behavioral health capitation rates, to estimate implementation costs to add the additional services. The analysis focused on Clubhouse services, SUD peer support services, and PHPs. As of the original date of this report, the actuarial analysis was not available.

The fiscal impact analyses have now been completed. Mercer's analysis specific to adding SUD peer support and Clubhouse services to the state plan shows that:

- The total (state and federal) cost impact of adding SUD peer support services to the state plan ranges from approximately \$6.6 million to \$8.8 million. To meet the anticipated need for this service, it would require between 440 and 590 SUD peer support staff members, assuming a case load of 20 per staff member.
- The total (state and federal) cost impact of adding Clubhouse services to the state plan ranges from approximately \$12.0 million and \$16.0 million. To meet the anticipated need for this service within each BHO/Fully Integrated Managed Care region, an estimated 18 to 30 Clubhouse facilities would be necessary. This range of necessary facilities is influenced by the potential mix of both small (100-member capacity) and large (200-member capacity) Clubhouses.

The detailed analysis is included in this report.

HCA will continue to gather information about eating disorder services, SUD outpatient day treatment, COD services, SUD urinalysis, and drop-in services. We will direct Mercer to perform detailed analysis for those services found to be feasible to add to the Medicaid SPA.

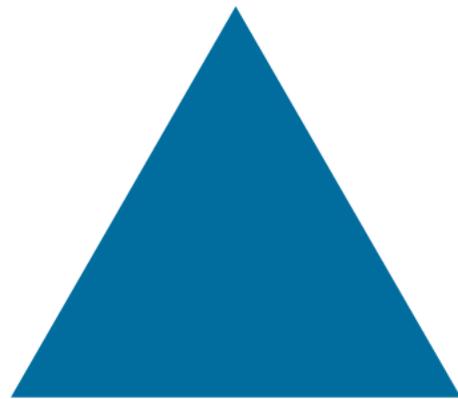


HEALTH WEALTH CAREER

STATE PLAN AMENDMENT REVIEW

DECEMBER 20, 2018

State of Washington



MAKE TOMORROW, TODAY



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EXECUTIVE SUMMARY

The State of Washington (State) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop estimates for the cost of implementing new behavioral health service types in the Medicaid State Plan. Based on discussions and information provided by the Health Care Authority (HCA), Mercer focused the research and analyses to three priority service areas: Substance Use Disorder (SUD) Peer Support, Clubhouse and Partial Hospitalization. This document presents an overview of the methodologies, assumptions and considerations regarding adding these three priority services to the Washington State Plan. If subsequent discussions with Legislative partners and HCA result in a desire to explore additional focus areas, Mercer can conduct additional focused analyses and amend the report as necessary.

Mercer conducted fiscal impact analyses specific to adding SUD Peer Support and Clubhouse services to the Washington State Plan with the following results:

- The total (state and federal) cost impact of adding SUD Peer Support services to the State Plan ranges from approximately \$6.6 million to \$8.8 million. To meet the anticipated need for this service, it would require between 440 and 590 SUD Peer Support staff members, assuming a case load of 20 per staff member.
- The total (state and federal) cost impact of adding Clubhouse services to the State Plan ranges from approximately \$12.0 million and \$16.0 million. To meet the anticipated need for this service within each Behavioral Health Organization/Fully Integrated Managed Care (BHO/FIMC) region within the State, an estimated 18 to 30 Clubhouse facilities would be necessary. The range of necessary clubhouses is influenced by the potential mix of both small (100-member capacity) and large (200-member capacity) Clubhouse facilities.

This document also includes a summary of selected states' descriptions of mental health (MH) Partial Hospitalization Program (PHP) services as well as options for the State to consider for potentially adding PHP as a Medicaid State Plan benefit. While initial discussions with HCA focused on both SUD and MH PHP services, further review of existing State Plan SUD services indicated that HCA covers SUD Intensive Outpatient (IOP) services, which is similar to SUD Partial Hospitalization. As such, Mercer limited our focus to MH PHP services with the understanding that this level of care may be necessary to more clearly articulate the breadth of Washington's MH continuum of care and define step-up/step-down service options, particularly for certain sub-populations such as children with eating disorders. Mercer included sample descriptions of MH PHP

services to highlight similarities and differences between selected states' Medicaid MH PHP services and level-set understanding about the service. Descriptions were also intended to help HCA understand where the service could fit within the existing MH continuum as well as provide context regarding PHP coverage options.

Please note that the annual fiscal impact estimates included in this document represent the total estimated medical cost, split between state versus federal funding, associated with the anticipated Medicaid eligible users of these proposed services. These estimated costs do not reflect consideration for any facility or program start-up costs or current funding for these services through other state-only funding streams.

The information contained within this document should be considered proprietary and confidential. All estimates are based upon the information and data available at a point in time, 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.

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SUD PEER SUPPORT SERVICES

Research defines a SUD Peer Support Specialist as an individual who provides a set of activities that engage, educate and support individuals to successfully make behavioral changes necessary to recover from SUD. This service is often used in conjunction with and in support of clinical interventions. Services include outreach, mentoring and peer support at all stages of recovery from addiction, including assisting the individual in developing self-management strategies, conducting one-on-one support sessions, organizing structured social activities, developing goals and recovery/wellness plans, and providing crisis support and linkage to natural supports in the workplace and other environments.¹ SUD Peer Support Specialists can play an important role in supporting long-term recovery from SUD while decreasing utilization of higher levels of care such as emergency departments (ED), inpatient (IP) hospitals and residential settings.

Generally, to provide SUD Peer Support under the State Plan, states must ensure:

- Peers have adequate clinical supervision by a competent behavioral health professional as defined by the State.
- Peer support is coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals developed using person-centered planning and promoting participant ownership of the plan of care.
- Peer support providers are adequately trained and certified. The general requirements for initial training and certification, as well as continuing education requirements must be included in the State Plan.

In recent years, numerous states have added SUD Peer Support services to their State Plans, including Delaware² and Kentucky³, which used the Rehabilitation Option of their State Plans. Similar to State of Washington's intent, both Delaware and Kentucky covered SUD Peer Support

¹ The National Association of State Alcohol and Drug Abuse Directors, Inc., State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide, September 24, 2014, p. 34; SAMHSA Financing Center for Excellence, Recovery Support Services: Peer Recovery Support Coaching, 2011.

² Delaware's SPA was #13-0018 approved on September 18, 2014.

³ Kentucky's SPA was #14-006 approved on October 8, 2014.

services for both outpatient and residential addiction services. The sections that follow summarize the assumptions, supporting research and estimated fiscal impact for the State to add this new benefit to the Apple Health program.

FISCAL ANALYSIS AND CONSIDERATIONS

To calculate the estimated annual fiscal impact of adding SUD Peer Support services to the State Plan, Mercer estimated the number of anticipated annual users of SUD Peer Support as well as the average annual SUD Peer Support cost per user.

Annual Medicaid Users Estimate

The users of SUD Peer Support are anticipated to be a sub-set of those who have historically utilized Detoxification/Withdrawal Management (Detox), SUD Short Term/Long Term Residential (Residential) and/or those who had at least 20 SUD Outpatient claims in a year (inclusive of Group and Individual SUD Outpatient services as well as Opiate Substitution Treatment services). Mercer included individuals of all ages within this calculation as well as users of institution for mental diseases (IMD) Detox and SUD Residential facilities. Individuals using Residential and/or more intensive SUD Outpatient services are thought to represent those with more chronic, disabling SUD conditions. These populations demonstrate some level of engagement in treatment and represent the type of client SUD peer support staff typically work with (in conjunction with other clinical interventions) to provide mentoring, assistance with self-management strategies, access to social activities, and linkage to natural supports. On the other hand, those using Detox services represent individuals who may be more difficult or reluctant to engage in SUD treatment. In this case, SUD peer support staff can often be more effective in motivating these individuals into taking the necessary steps to engage in treatment, and SUD peer support staff are often used in this manner (e.g., visit individuals in EDs, homeless shelters, inpatient settings). For these reasons, individuals in Detox, Residential and intensive Outpatient were determined to be the most likely candidates for referral to and utilization of SUD Peer Support services.

Based on review of historical Calendar Year (CY) 2017 Washington utilization, about 29,600 Medicaid eligible individuals statewide met the above service utilization criteria on an annual basis. Please note that we applied overall penetration rates (percentage of eligibles who utilize services) for each of the above service criteria from the CY 2017 BHO data to CY 2017 Southwest (SW) eligibility data in order to estimate SW users and get to a statewide estimated user count.

Mercer assumed that, overall, between 30%–40% of those 29,600 identified potential users would engage in SUD Peer Support services, resulting in a range of about 8,900 and 11,800 users on an annual basis. As a direct comparison point in other state programs was not readily available, this range of 30%–40% was informed by clinical expectations from Mercer's work in other programs as well as general expectations on SUD penetration. Individuals accessing SUD Detox that are also anticipated to utilize SUD Peer Support could be fairly low, possibly in the range of 10%–15%. It is not unusual for individuals in Detox level of care to be more difficult to engage. They may be experiencing uncomfortable or painful symptoms and/or be extremely fatigued or irritable due to the

withdrawal itself and not interested in talking with anyone. Further, there can be minimal readiness to change behavior, denial about the extent of the addiction, and lack of willingness to engage in SUD treatment or recovery support services. It is not uncommon for these individuals to leave against medical advice as cravings recur. Essentially, at this stage, there can be low interest and/or appreciation for what peer support can potentially offer.

Based on discussions with HCA, it is also anticipated that SUD peers will not likely, at this time, be going into the community (e.g., EDs, IP hospital settings) to engage members into ongoing SUD treatment. HCA indicated that the majority of SUD peers will likely be working within SUD clinic/residential programs. Utilization of SUD Peer Support in these settings will likely be higher, and expected to be in the range of 50%–60%, presumably because these members are already engaged in treatment and SUD Peer Support would be an added service/benefit readily available.

The range of 30%–40% was selected to balance these two assumptions.

Annual Medical Cost per User Estimate

Mercer determined that the average MH Peer Support medical cost per user would be a reasonable proxy for the SUD Peer Support cost per user. Both MH Peer Support and SUD Peer Support services are typically targeted to individuals with higher needs, more chronic conditions, and/or more challenging social situations. As with MH Peer Support, some users of SUD Peer Support will access this service extensively, while others will only access it a few times over the course of a year. There will likely be broad variability between individual users of SUD Peer Support services.

In researching other states, when MH Peer Support services and SUD Peer Support services were identified as separate and distinct services, Mercer found that unit costs were typically the same for both. For this reason, Mercer was comfortable in using the average MH Peer Support unit cost.

Mercer utilized the average MH Peer Support hourly unit cost from the CY 2017 BHO Data Book (\$74.63) as well as the average annual CY 2017 MH Peer Support units per user (approximately 8.7 hours) to calculate an average annual CY 2017 cost per user of about \$648. This value was trended 3 years from a CY 2017 basis to a CY 2020 basis at an annual trend rate of 4.8%, consistent with the trend applied to MH Peer Support services in the CY 2019 BHO rate development process resulting in a CY 2020 estimated annual cost per user of about \$745 for SUD Peer Support services.

Additional Outpatient (OP)/Offsetting Costs

Based on discussion with HCA and Mercer's clinical review, the expectation is that any offsets to SUD services such as Detox, SUD Residential or other higher levels of care would be offset by increases in other Outpatient services (across SUD, MH and physical health (PH)) as a result of adding SUD Peer Support services to the State Plan. For example, as peers successfully engage members in ongoing SUD treatment and person-centered planning activities, members are more likely to follow up with other recommended whole-person-oriented treatment recommendations,

such as behavioral health counseling, primary care and necessary specialist appointments, preventative screening activities and supported employment. They may also demonstrate improved adherence to any prescribed medications for MH, SUD, and/or PH conditions. As such, no expected offsetting costs were included within the fiscal estimate calculation.

Fiscal Estimate Range

Based on the estimated annual medical cost per user (on a CY 2020 basis) as well as the range of estimated Medicaid users calculated using the engagement rate assumptions of 30% and 40%, Mercer has developed an estimated annual fiscal impact of adding SUD Peer Support services to the State Plan ranging from about **\$6.6 million to \$8.8 million**, in total. This estimate does not reflect consideration for any program start-up costs or current funding for this service through other state-only funding streams.

Based on the historical split within the anticipated population between Legacy (non-Newly Eligible populations) and Newly Eligible individuals, we have estimated that about 36% of the anticipated SUD Peer Support users will be Legacy and 64% will be Newly Eligible. Using that distribution as well as a 50% Federal Medical Assistance Percentage (FMAP) for Legacy and the CY 2020 FMAP of 90% for Newly Eligible, Mercer has estimated the split between State and Federal funding. The results are further illustrated in the below table.

	CALCULATIONS	LOW RANGE	HIGH RANGE
Expected SUD Peer Support Medicaid Users	(A)	8,900	11,800
Assumed Medical Cost per User — CY 2020 Basis	(B)	\$746	\$746
Medical Cost of SUD Peer Support Services	(C) = (A) x (B)	\$6.6 million	\$8.8 million
Additional OP/Offsetting Costs	(D)	\$0	\$0
Total Fiscal Impact — CY 2020 Basis	(E) = (C) – (D)	\$6.6 million	\$8.8 million
Federal Share — CY 2020 Basis	(F) = (E) x [(36% x 50%) + (64% x 90%)]	\$5.0 million	\$6.7 million
State Share — CY 2020 Basis	(G) = (E) x [(36% x 50%) + (64% x 10%)]	\$1.6 million	\$2.1 million

Assuming a case load of 20 individuals per SUD Peer Support staff member, which is consistent with caseload information found in other states, the number of SUD Peer Support staff needed to serve the anticipated users ranges from about 440 (assuming a 30% engagement rate and about 8,900 users) to about 590 (assuming a 40% engagement rate and about 11,800 users).

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CLUBHOUSE SERVICES

Clubhouses refer to a community intentionally organized to support individuals living with the effects of mental illness. Clubhouses demonstrate positive clinical and social outcomes. Based on the core principles of peer support, self-empowerment and functionality within a community setting, Clubhouses strive to help members:

- Participate in mainstream employment and educational opportunities
- Find community-based housing
- Join health and wellness activities
- Reduce hospitalizations
- Reduce involvement with the criminal justice system
- Improve social relationships, satisfaction and quality of life.⁴

Dating back to the late 1940s, Clubhouses have now emerged around the world and are successfully demonstrating that individuals with mental illness can successfully participate in their communities through education, employment and other social activities. An increasing body of research provides evidence that Clubhouses provide a holistic, inspiring and cost-effective solution for people living with mental illness.⁵ HCA has made a commitment to implement Clubhouse programs statewide to support Apple Health members struggling with mental illness in their recovery.

FISCAL ANALYSIS AND CONSIDERATIONS

Mercer calculated the estimated annual fiscal impact of adding Clubhouse services to the State Plan by estimating the number of anticipated annual users of these services, the number of Clubhouses needed to provide services to those users and the estimated annual service cost per Clubhouse.

⁴ <https://www.hca.wa.gov/assets/essb-6032-clubhouse-programs-12-01-18.pdf>; accessed December 12, 2018.

⁵ <https://clubhouse-intl.org/our-impact/clubhouse-outcomes/>, accessed December 12, 2018

Annual Medicaid Users Estimate

Mercer determined that the top 20% of adult⁶ Medicaid users of Day Support and/or MH Peer Support services is a reasonable proxy to estimate the individuals most likely to utilize Clubhouse services. These high utilizers of Day Support and MH Peer Support are demonstrating active engagement and represent the type of client appropriate for referral to Clubhouse services, which could potentially be used instead of Day Support or separate MH Peer Support. Typically, Clubhouse services are targeted to individuals with higher needs, more chronic conditions, and/or more challenging social situations. Among these individuals, some users of Clubhouse will access this service extensively, while others may only access it sporadically over the course of a year. There can be broad variability between individual users of Clubhouse services.

Based on review of historical CY 2017 Washington utilization, this approach results in an estimate of about 2,550 Medicaid users of Clubhouse services statewide on an annual basis, though, as illustrated in the below table, the anticipated level of need varies by BHO. Similar to the calculation of users for SUD Peer Support, we applied overall penetration rates for Day Support and MH Peer Support from the CY 2017 BHO data to CY 2017 SW eligibility data in order to estimate SW users and get to a statewide estimated user count.

BHO/FIMC REGION	ESTIMATED ANNUAL MEDICAID CLUBHOUSE USERS
Great Rivers	140
Greater Columbia	70
King	730
North Central	60
North Sound	60
Pierce	890
Salish	120
Southwest*	170
Spokane	220
Thurston Mason	90
Total	2,550

*Southwest users were estimated by applying overall penetration rates for Day Support and MH Peer Support from the CY 2017 BHO data to CY 2017 Southwest eligibility data.

⁶ Defined as 18+ for this analysis, as Clubhouse services typically focus on adult members only

Number of Clubhouses Estimate

Based on discussion with HCA, the expectation is that each BHO/FIMC region within the State would have at least one Clubhouse facility to ensure the service is being offered statewide. Further, based on those discussions it is Mercer's understanding that HCA Clubhouses within Washington will, ideally, be based on the Clubhouse International model and demonstrate fidelity to that model, including that the Clubhouse be located in its own physical space, separate from any mental health center or institutional setting. However, based on regional population and geographic considerations, as well as availability of evolving alternative models, in order to meet this capacity expectation, HCA may also be interested in considering use of Consumer-Operated programs⁷ and Recovery Café programs⁸. Likewise, in more rural or remote areas, it may be necessary to consider Clubhouse services being offered in available space within other community-based locations (e.g., community centers, mental health centers, available space on church grounds). Alternatively, a particular region may not need its own Clubhouse at all if members from that region are easily able to access Clubhouse services in another nearby region.

Mercer reviewed the anticipated need for Clubhouse services within each BHO/FIMC region and considered the costs and capacity associated with the potential combinations of large Clubhouse facilities (assuming a 200-member capacity) and small Clubhouse facilities (assuming a 100-member capacity) to meet that need. Based on that review, Mercer estimated that between 18 (comprised of 12 large and 6 small) and 30 (comprised of 4 large and 26 small) Clubhouse facilities would be necessary to meet the estimated statewide need for this service.

Annual Cost per Clubhouse

Based on discussions with HCA, and as noted above, it is Mercer's understanding that Clubhouses within Washington will be based on the Clubhouse International model. The Clubhouse International website states that a Clubhouse program with an active membership of 100 to 125 and an average daily attendance of 60–70 people would need an operating budget of about \$500,000 annually, noting that significant additional funding would be necessary for equipment and capital expenses⁹.

Utilizing the estimated annual cost from the Clubhouse International website, Mercer developed a range of annual Clubhouse costs from \$500,000 for smaller facilities (100-member capacity) to \$750,000 for larger facilities (200-member capacity).

Additional OP/Offsetting Costs

The State evaluated the potential offsetting costs to higher levels of care as a result of adding Clubhouse services to the State Plan, as well as the potential increase in other MH and PH OP

⁷ <https://www.hca.wa.gov/assets/essb-6032-clubhouse-programs-12-01-18.pdf>; accessed December 12, 2018.

⁸ Ibid.

⁹ http://www.clubhouse-intl.org/starting_clubhouse.html, Accessed December 12, 2018.

service costs, and found the net impact to be neutral. Mercer relied on the results of that analysis and did not independently analyze detailed historical claims data. Based on the results of the State's analysis as well as Mercer's clinical evaluation, no expected offsetting costs were included within the fiscal estimate calculation. For example, as Clubhouses successfully engage members, we can anticipate reduced utilization of ED, IP and Crisis services, as well as reduced utilization of Day Support and MH Peer Support (as a stand-alone service). However, we could see increased utilization of other OP behavioral health counseling and medication management services, as well as increased participation in primary care/specialty PH appointments and preventative screening activities, and improved adherence to any prescribed medications for MH, SUD and/or PH conditions.

Fiscal Estimate Range

Based on the estimated range and mix of the number of large and small Clubhouse facilities necessary to meet the need of the anticipated Medicaid users as well as the range of annual costs per Clubhouse, Mercer has developed an estimated annual fiscal impact range of adding Clubhouse services to the State Plan from about **\$12.0 million to \$16.0 million**, in total. This estimate does not reflect consideration for any facility start-up costs or current funding for this service through other state-only funding streams.

Based on the historical split within the anticipated population between Legacy (non-Newly Eligible populations) and Newly Eligible individuals, we have estimated that about 57% of the anticipated Clubhouse users will be Legacy and 43% will be Newly Eligible. Using that distribution as well as a 50% FMAP for Legacy and the CY 2020 FMAP of 90% for Newly Eligible, Mercer has estimated the split between State and Federal funding. The results are further illustrated in the below table.

	CALCULATIONS	LOW RANGE	HIGH RANGE
Expected Medicaid Clubhouse Users	(A)	2,550	2,550
Estimated Number/Mix of Clubhouse Facilities	(B)	18 Total (12 Large; 6 Small)	30 Total (4 Large; 26 Small)
Cost per Clubhouse	(C)	\$750,000 for Large \$500,000 for Small	\$750,000 for Large \$500,000 for Small
Cost of Clubhouse Services	(D) = (B) x (C) <i>for each facility size</i>	\$12.0 million	\$16.0 million
Additional OP/Offsetting Costs	(E)	\$0	\$0
Total Fiscal Impact — CY 2020 Basis	(F) = (D) – (E)	\$12.0 million	\$16.0 million
Federal Share — CY 2020 Basis	(F) = (E) x [(57% x 50%) + (43% x 90%)]	\$8.1 million	\$10.8 million
State Share — CY 2020 Basis	(G) = (E) x [(57% x 50%) + (43% x 10%)]	\$3.9 million	\$5.2 million

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PARTIAL HOSPITALIZATION SERVICES

Partial Hospitalization services, commonly referred to as Partial Hospitalization Program or PHP, were identified by HCA as a high priority for coverage consideration. While initial discussions with HCA focused on both SUD and MH PHP services, further review of existing State Plan SUD services indicated that HCA covers SUD IOP services, which is similar to SUD Partial Hospitalization. The only difference between SUD IOP and SUD PHP is the number of hours per week of services received by an individual (i.e., less than 20 hours per week for IOP and 20 or more hours per week for SUD Partial Hospitalization). Programming and staffing are the same in IOP and SUD Partial Hospitalization. With the recent approval of Washington's 1115 demonstration waiver, the "Medicaid Transformation Project" and the addition of residential and inpatient treatment for individuals with SUD, including in facilities that meet the definition of an IMD, the State has instituted a comprehensive SUD service continuum. As such, Mercer limited our focus to mental health (MH) PHP services with the understanding that this level of care may be necessary to more clearly articulate the breadth of Washington's MH continuum of care and define step-up/step-down service options, particularly for certain sub-populations such as children with eating disorders.

MH PHP SERVICE DEFINITIONS — MEDICARE AND STATE EXAMPLES

Mercer included sample descriptions of MH PHP services to highlight similarities and differences between selected states' Medicaid MH PHP services and level-set understanding about the service. Descriptions were also intended to help HCA understand where the service could fit within the existing MH continuum as well as provide context regarding PHP coverage options.

Since there is no uniform definition of PHP, and since the only Medicaid description of partial hospitalization in the State Medicaid Manual has not been updated in twenty-one years, Mercer used the Medicare definition to represent the most comprehensive description of PHP requirements. Medicaid-covered PHP services in Maryland, Nevada and New Jersey are also described to contrast with the Medicare PHP definition. It is important to note that example descriptions are for illustrative purposes to convey how some states describe MH PHP and should not be viewed as recommendations for how HCA should define the service.

A few notable highlights are that:

- **Medicare** PHP is covered as a service that is in lieu of an inpatient psychiatric hospitalization or for those at-risk of inpatient psychiatric hospitalization.

- **Maryland** Medicaid PHP is very similar to the Medicare model in that it is an alternative to inpatient care when the consumer can safely reside in the community.
- **Nevada's** Medicaid PHP service is also similar to the Medicare model and parallels the intensity of services provided in a hospital.
- **New Jersey** is slightly different in that the state offers two types of Medicaid PHP services:
 - Acute partial hospital (APH), an intensive and time limited acute psychiatric service intended to minimize the need for hospitalization
 - Partial hospital, a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation to assist individuals who have serious mental illness in maximizing independence and community living skills
 - › It is also important to note that New Jersey's PHP programs were audited in April of 2017 by the U.S. Department of Health and Human Services (US DHHS) Office of Inspector General (OIG) and that the state was found to have improperly claimed over \$30 Million in federal Medicaid reimbursement over four years for PHP services that were determined unallowable.¹⁰
 - › Findings from the OIG audit indicated that for some claims:
 - » Services did not meet the Federal requirement that hospital outpatient services be provided by a licensed hospital
 - » Services were not documented or supported
 - » Services did not meet staffing ratio requirements
 - » Services were improperly paid at the partial hospitalization rate
 - » Progress notes were not documented
 - » Requirements for face-to-face visits with a psychiatrist were not met
 - » Referrals and certifications were not documented

¹⁰ See New Jersey Claimed Federal Medicaid Reimbursement for Children's Partial Hospitalization Services That Did Not Meet Federal and State Requirements at <https://oig.hhs.gov/oas/reports/region2/21601008.asp>.

- » For one claim, adult services were paid at a higher rate — one used for treating children
- › According to the OIG audit report, “The deficiencies occurred because the State agency did not (1) work with [the Department of Health] DOH to ensure that partial hospitalization services are provided by appropriately licensed hospitals, (2) adequately monitor the partial hospitalization program to ensure that providers complied with Federal and State requirements, and (3) have adequate controls to ensure that services were paid at the proper payment rate.”

Key Elements of Medicare PHP Services

- PHPs are structured to provide **intensive psychiatric care** through active treatment.
- The treatment program of a PHP closely resembles that of a **highly structured, short-term hospital inpatient program**. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational or diversionary activities are not considered partial hospitalization.
- PHPs work best as part of a community continuum of mental health services which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support. PHPs may be **covered under Medicare** when they are provided by a **hospital outpatient department or a Medicare-certified community mental health center (CMHC)**.
- Eligibility criteria:
 - Patients admitted to a PHP must be **under the care of a physician** who certifies the need for partial hospitalization. The patient requires comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational and/or educational functioning. Such **dysfunction generally is of an acute nature**.
 - Patients meeting benefit category requirements for Medicare coverage of a PHP comprise two groups: those patients who are **discharged from an inpatient hospital treatment program**, and the **PHP is in lieu of continued inpatient treatment**; or those patients who, in the absence of partial hospitalization, would be **at reasonable risk of requiring inpatient hospitalization**.
- Covered Services: Items and services that can be included as part of the structured, multimodal active treatment program:
 - **Individual or group psychotherapy** with physicians, psychologists or other mental health professionals authorized or licensed by the State in which they practice

- **Occupational therapy** requiring the skills of a qualified occupational therapist (if required in the treatment plan)
- **Services of other staff** (social workers, psychiatric nurses and others) trained to work with psychiatric patients
- **Drugs and biologicals** that cannot be self-administered and are furnished for therapeutic purposes
- **Individualized activity therapies** that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals
- **Family counseling** services for which the primary purpose is the treatment of the patient's condition
- **Patient training and education:** to the extent the training and educational activities are closely and clearly related to the individuals care and treatment of his/her diagnosed psychiatric condition
- Medically necessary **diagnostic services** related to mental health treatment
- Frequency and Duration of Services: **There are no specific limits on the length of time that services may be covered.** There are many factors that affect the outcome of treatment, among them are the nature of the illness, prior history, the goals of treatment and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued.

Maryland Medicaid PHP Services

- PHP, also known as **Psychiatric Day Treatment Services**, must be rendered by a provider approved under Maryland Law (COMAR 10.21.02).
- PHP is an outpatient, short- term, intensive, psychiatric treatment service that parallels the intensity of services provided in a hospital, including medical and nursing supervision and interventions. **PHP is an alternative to inpatient care** when the consumer can safely reside in the community. This level of service is a benefit for children, adolescents and adults.
- **PHP services may or may not be hospital-based** and have reimbursement rates depending on their site. A multidisciplinary team, including a psychiatrist, nurse, etc., should be available to provide this service.

- **Providers** who choose to provide a **full-day of PHP services must provide at least 6.5 hours of treatment. Free-standing PHPs may provide a full day or a half day (minimum of 4 hours) of treatment.**
- A **physician's service may be billed for** a Medicaid recipient, in addition to the Partial Hospital stay, when provided in a hospital setting. One psychiatric visit per day is allowed without a separate authorization. **Non-hospital based partial programs** do not have a provision for this additional **physician payment**, as it is **already included in the Partial Hospital rate.**
- **Occupational therapy** performed in a hospital or Partial Hospitalization setting, by the staff of these organizations, does not require an authorization.

Nevada Medicaid PHP Services

- Partial hospitalization is a nonresidential treatment program that is **hospital-based.**
- The program provides diagnostic and treatment services **on a level of intensity similar to an inpatient program**, but on less than a 24-hour basis.
- These services include **therapeutic milieu, nursing, psychiatric evaluation, medication management, group, individual and family therapy.** The environment at this level of treatment is highly structured, and there should be a staff-to-patient ratio sufficient to ensure necessary therapeutic services.
- Partial Hospitalization may be appropriate as a time-limited response to **stabilize acute symptoms**, transition (**step-down from inpatient**), or as a stand-alone service to **stabilize a deteriorating condition and avert hospitalization.**
- The hospital must be licensed or formally approved as a hospital by the Nevada Department of Health and Human Services Regulation and Licensure.
- Partial Hospitalization may be available **7 days/week with a minimum availability of 5 days/week.** Staff must be available to schedule meetings and sessions at a variety of times in order to support family/other involvement for the individual. **Partial Hospitalization can be provided in full-day increments of 6 hours or half-day increments of 3 hours.**
- **Length of service is individualized** and based on clinical criteria for admission and continuing stay, but considering its time-limited expectations, **a period of 14 to 21 days with decreasing attendance hours is typical.**

New Jersey Medicaid PHP Services

- New Jersey Medicaid offers **two types of partial hospitalization services** to Medicaid beneficiaries with serious mental illnesses:

- **APH:** Intensive and time limited acute psychiatric service for individuals who are experiencing, or at risk for, rapid decompensation. This mental health service is intended to minimize the need for hospitalization. The purpose of the APH services shall be to stabilize acute symptomatology in order to divert eligible beneficiaries from the need for inpatient psychiatric hospitalization. Treatment shall be provided at a level of intensity based upon clinical evaluation and formulation.
 - › **To be eligible for APH services,** an individual must at least be age 18 or older with severe mental illness (SMI) and be referred by the local designated screening center or psychiatric emergency service as a diversion from hospitalization or by an inpatient psychiatric facility if the treating psychiatrist or APN clearly justifies acute clinical need.
 - › **Reimbursable APH services are:** psychiatric services in APH, treatment services (e.g., Individual and group therapy, cognitive behavioral skill-building groups, relapse prevention groups, and promotion of the beneficiary's commitment to change problematic behaviors and to follow-up with aftercare plans), medication-related services and a range of other services.
- **Partial hospital:** Individualized, outcome-oriented psychiatric service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation to assist individuals who have serious mental illness in maximizing independence and community living skills. The purpose of PH services is to assist beneficiaries with SMI to achieve community integration through valued living, learning, working and social roles. The role of PH is, therefore, to facilitate the beneficiary's integration into the community, not to become a permanent outcome, although it is recognized that some beneficiaries may need the support of PH for long periods of time.
 - › **To be eligible for PH services,** an individual must at least be age 18 or older with SMI and have impaired functioning as described in administrative regulations. Individuals shall be referred by the APH or be significantly impaired such that a need for PH exists, and receive from the interdisciplinary treatment team certification containing the clinical evidence to justify the necessity for a beneficiary to receive PH services, documenting the beneficiary's specific conditions.
 - › **Reimbursable PH services are:** psychiatric services in PH, counseling and case management services, psychoeducational services, prevocational services, community integration services and a range of additional skill building and supportive services.

OPTIONS AND CONSIDERATIONS

State examples included in this document serve to illustrate the different ways Medicaid agencies describe MH PHP services. If HCA determines that including a specific service titled Mental Health Partial Hospitalization Program is necessary to more clearly articulate the breadth of Washington's

MH continuum of care and define step-up/step-down service options, particularly for certain sub-populations, such as children with eating disorders, the State may want to consider the following options for covering MH PHP as a Medicaid State plan benefit — amend the current MH Rehabilitative Services SPA or provide for MHP PHP coverage as an outpatient hospital service.

The following options and considerations are based on Mercer's discussions with HCA to-date and prior to state budgetary proposals for expanding behavioral health treatment options. To the extent additional information becomes available; Mercer is prepared to update these options and considerations accordingly.

Current Washington State Plan Coverage

The Washington Medicaid Mental Health Rehabilitative Services State Plan Amendment (SPA), effective August 11, 2013, provides coverage for an extensive array of community based MH treatment, recovery and support services (e.g., Day Supports, Crisis Services, Stabilization Services, Mental Health Services in Residential Settings, Therapeutic Psychoeducation, etc.). Although Day Supports services are defined in the SPA as an intensive rehabilitation program available 5 hours per day, 5 days per week and designed to “assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning,” HCA believes that the staffing and service intensity levels in Day Support programs are more similar to those offered in a drop-in center or clubhouse setting. Crisis Services are also covered and intended to stabilize an individual and provide immediate treatment in the least restrictive environment. However, Crisis Services do not consist of other PHP elements such as group/individual/family therapy or skill building (though such elements are available as part of other HCA Mental Health Rehabilitative Services), and Crisis Services do not serve as a step-down from, or alternative to, inpatient psychiatric hospitalization.

HCA does provide coverage for Stabilization Services, which are described as “short-term (less than two weeks per episode)” interventions that are a follow-up to Crisis Services and consist of face-to-face assistance with life skills training and understanding of medication effects. Although titled *Stabilization Service*, components of the service are similar to New Jersey's Partial Hospital (PH) service. However, New Jersey's PH service indicates that “some beneficiaries may need the support of PH for long periods of time.” In addition, New Jersey's PH service is described as including a broader range of reimbursable services than what is available under HCA's Stabilization Service (i.e., New Jersey's PH includes counseling, case management, psychoeducational, prevocational, skill building and supportive services.)

Amend Current MH Rehabilitative Services SPA

Mercer discussed amending the current MH Rehabilitative Services SPA as one option. Under this option, existing community behavioral health treatment providers eligible to deliver services under the current MH Rehabilitative Services SPA would provide MH PHP services. Although the service title includes the term “hospitalization,” providers would be limited to community behavioral health treatment providers and eligibility for delivery of the service would not extend to hospital

organizations. However, the SPA has not been amended in over 15 years. Opening up the SPA to add MH PHP could result in scrutiny by Centers for Medicare and Medicaid Services (CMS) on issues such as questioning the eligibility of CMHCs and not individual behavioral health practitioners to enroll as MH rehabilitative services providers. Another issue that may surface relates to whether HCA intends to establish PHP capacity in all 10 regions and whether that capacity will be in place prior to the submission of a State plan amendment. Medicaid statewideness requirements do not stipulate that all services must be available in all areas of the state. The provision does require that State plan services are *in operation* statewide, meaning that Medicaid eligible individuals cannot be denied a service because it is only in operation in part of the state. However, given HCA's prior experience with CMS regarding 1915(b)(3) Clubhouse services which resulted in HCA electing to take down the service and also given new federal access to care guidance for fee-for-service benefits and recently issued network adequacy regulations, HCA may not wish to undertake a host of service capacity issues that CMS may raise about a new MH PHP or other existing mental health rehabilitative service.

Coverage as Outpatient Hospital Service

One area where HCA expressed potential interest in covering MH PHP is as an outpatient hospital service in a hospital-based setting. Since outpatient hospital services are a mandatory benefit, HCA would not necessarily need to seek an amendment to the outpatient hospital section of the SPA to add MH PHP as a covered service. However, HCA may need to modify the outpatient hospital reimbursement methodology and update the outpatient hospital fee schedule to reflect the MH PHP service rate. This approach may also enable the State to develop capacity to extend services beyond what is available through the MH Rehab Services benefit (i.e., diagnostics, drugs and biologicals) and provide for an additional level of care that supports hospitals' ability to reduce bottlenecks for patients experiencing difficulty with transitions to lower levels of care. Depending on which PHP model the state may choose to implement (i.e., step-down from inpatient psychiatric care, alternative to an inpatient setting or a comprehensive, structured, interdisciplinary treatment and psychiatric rehabilitation for program), this option may also help the State address transition of care challenges for children with eating disorders, which was identified by HCA as an important issue. Finally, pursuing MH PHP as an outpatient hospital service would provide HCA with a pathway to pay for PHP services through using a bundled daily rate as opposed to individual components billed by rehabilitative services providers.

This option may require further analysis of HCA data, as well as a review of the existing MH benefit continuum, to validate whether a gap in care exists within the current continuum or whether the State merely needs to articulate the breadth of the current mental health continuum of care and more clearly define existing step-up/step-down service options and shore up transition points (e.g., through Medicaid health homes) to ensure that access to available levels of care is unimpeded. Further analysis may also help to identify opportunities for strengthening current capacity for transitions supports, confirming the populations most at-risk, and also determine whether MH PHP is the best approach for mitigating barriers for accessing step-up/step-down service options.

Additional Considerations

Prior to settling on a definitive approach for MH PHP coverage, HCA may be interested in hearing from other states about their experiences with MH PHP and MH PHP-like services, including states that elected to forego PHP (e.g., Georgia and Ohio) and instead pay for other services determined to be equally effective in achieving state goals. HCA should also continue to explore the most appropriate federal authorities that may be necessary for its coverage of the services. It is not clear what federal authority New Jersey uses for its coverage of PHP programs. However, both Maryland and Nevada use the 1915(i) State plan Home and Community-Based Services (HCBS) benefit for *Intensive In-Home Services* (Maryland) and *HCBS Day Treatment or Other Partial Hospitalization Services* (Nevada). Finally, HCA should identify the MH PHP service model it may be interested in implementing to begin cost modeling and estimating the fiscal impact of paying for the new service.

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CONCLUSION

This report was developed in collaboration with HCA, based on information available at the time, to develop considerations and estimates for implementing SUD Peer Support, Clubhouse and Partial Hospitalization services through the Medicaid State Plan. All estimates are based upon the information and data available as of the date of this letter 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.

If you have any questions on any of the information provided, please feel free to call Laura Nelson at 602 522 6157, Alicia Smith at 937 212 6151 or Angela Ugstad at 612 642 8927.

MERCER (US) INC.
333 South 7th Street, Suite 1400
Minneapolis, MN 55402
www.mercer.com