Today’s Agenda For Inpatient And Community Residential Beds

- Inpatient and community residential bed background
  - Adult, children, and forensic bed system overview
  - Inpatient & residential pressures
  - Capacity and utilization issues
- Stakeholder panel discussion

Today’s Background Objective

- Describe funding, number of beds, and costs of existing inpatient and residential system
- Allow for better understanding of system pressures, potential changes and implications
- Provide context for issues that will be discussed in the stakeholder panel

Mental Health Total Funding

- Total Mental Health Division spending on mental health inpatient, residential & outpatient services is $458 million in FY 03

- Outpatient: 38%
- Inpatient: 54%
- Residential: 8%
Inpatient and Residential System Funding

- The adult inpatient beds represent 78% of the total bed funding

- Children's Residential 1%
- Adult Residential 13%
- Forensic 11%
- Forensic + Other Adult Inpatient = 78%
- Children's Inpatient 8%
- Adult Inpatient 67%

Total fy 03 Bed Funding = $283 million
Adult Inpatient (Including Forensic) = $221 m, or 78%

Adult Mental Health

Current system
Funding components
Bed inventory
Bed costs and payments

Adult Mental Health Bed System Funding

- In fiscal year 2003, $226 million was spent on the adult inpatient and residential services.
- The largest cost component of adult inpatient services are the state hospitals.

Adult Mental Health System Total Beds

- There are approximately 2,300 residential service beds, which reflect about two-thirds of the total beds. The inpatient beds comprise the remaining one-third, or about 1,600.
Adult Mental Health System
Inpatient Beds

- Approximately 75% of the inpatient beds utilized are located at the two state hospitals.

State Hospital 75%
Comm. Hospital 17%
Eval & Treatm 8%

Adult Mental Health System Payments

- The average daily costs for a state hospital stay is about $465 per day.
- Community hospital payments primarily reflect a range of average costs between an $281 for a non-Medicaid client to $671 for a Medicaid client.
- Evaluation and treatment facilities report receive an average daily payment of $369.
- Residential service levels greatly vary and payments can range from $33 for supported housing to $224 for crisis respite.

System and Environmental Pressures

Utilization issues
Recent system changes
Access issues and analysis
Federal changes

Utilization Issues

- A 2002 study projected that 22 percent of state hospital patients discharged were delayed primarily because of a lack of community services.
- This study also estimated that approximately 25 percent of state hospital admissions could have been avoided by increasing community supports.
Utilization Issues

- State Hospital Bed Allocation and Liquidated Damages
  - The RSN allocation for beds at the state hospitals is based on a weighted formula which factors in total population, medicaid eligible, and previous utilization
  - This methodology modified the previous formula and is being phased in over a six year period ending in FY07
  - RSNs only pay when the collective exceeds the allocation at a hospital and pay proportional to their over-utilization

- In FY04 RSN’s paid $1.7 million for state hospital bed use that exceeds their allocation in liquidated damages
  - Spokane, King, and Pierce RSNs paid 85% of the liquidated damages assessed in FY04

Utilization Issues

- There are some inconsistencies in services available through the RSNs
  - Community Psychiatric Inpatient and E&Ts have limited availability in rural areas
  - The intensive residential beds available are concentrated in 5 of the 14 RSNs

Utilization Issues

- Community Psychiatric Inpatient and E&Ts are not available in 25 of 39 counties

Key:
- Solid counties have Inpatient beds
Utilization Issues

• 93% of the intensive residential beds are concentrated in 5 of the 14 RSNs
• Five of these have no access to intensive Long-Term Residential Beds

Recent Adult Mental Health System Changes

○ DSHS initiated a shift from state hospital beds to residential services in 2001.
  - The Expanded Community Service program closed 178 beds, shifted funding to the community for residential services and assumed general fund savings.
  - The average daily census of community inpatient beds (including E&T’s) increased by 13 percent from 2001-2003 while the average daily census at the state hospitals decreased by 11 percent.

Adult Mental Health System Changes

○ Community hospitals have reduced psychiatric capacity for public and privately funded consumers by 13% between 2000 and 2004. The hospitals contend that this is due to insufficient payment rates

Access Issues and Analysis

○ DSHS contracted with the Public Consulting Group in September of 2002 that provided an analysis of the adult inpatient and residential services.
  - DSHS has implemented a number of the recommendations. Expanded Community Services, Increased discharge coordination, Program for Adaptive Living Skills (PALS) closure plan, and the cross system crisis response project
Access Issues and Analysis

- DSHS has contracted with PCG to update the 2002 study and also includes children’s mental health services for the 2004 report.
  - The PCG recommendations from the study will be presented at the October task force meeting.

- The study will provide analysis and recommendations to address the significant access and utilization issues identified that include:
  - Publicly funded inpatient capacity
  - Preventable hospitalizations
  - Timely hospital discharge

Federal Changes

- Federal CMS Non-Medicaid policy changes
  - Current estimates reflect loss of funding in the range of $40 million to $50 million per year
  - Potential impact on residential and inpatient services from savings rule changes
    - Non-medicaid covered services
    - Residential placements for individuals not covered by Medicaid
    - Services provided to individuals living in an Institution for Mental Diseases (IMD)
Federal Changes – IMD Exclusion

- “Institution for mental diseases” (IMD) 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... [42 CFR 435.1009]

- IMD Exclusion Rule - Federal Financial Participation is not available for any medical assistance under Title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. (Medicaid Manual)

Federal Changes

- Impact is still being assessed but has implications of eliminating funding for IMD residential and impatient services and nursing homes currently funded by Medicaid.
- This may affect federal participation for all Medicaid services provided to approximately 770 to 2,529 inpatient and residential beds

Adult System Summary

- Mounting fiscal pressures that include low payment rates and budget reductions contribute to the recent reductions in bed capacity.

- Reduced federal funding participation will significantly add to the existing funding pressures beginning in January 2005.

Adult System Summary

- Difficult to collect system-wide data, particularly for residential services and community hospitals

- Consultant study update should provide better data and recommendations that will be reviewed at the October Task Force meeting.
Children’s Mental Health

Children’s System Overview

- Inpatient & CLIP treatment accounts for less than 5% of the Medicaid eligible children treated by the Mental Health Division. The rest are treated on an outpatient basis.
- Children’s Mental Health services are provided across many systems.

Children’s Mental Health Service Source

Children Receiving DSHS Mental Health Services in FY2000

Children’s Residential System Overview

- There is no requirement for RSNs to provide residential services to children.
- To the extent that they do provide these services, it is done jointly with the Children’s Administration.

JLARC, Children’s Mental Health Study, August 2002
Residential Beds:
Children’s Administration

Children’s Admin. Funded Services

<table>
<thead>
<tr>
<th>Type</th>
<th>Scale</th>
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<tbody>
<tr>
<td>Behavioral Rehabilitative Services (BRS)</td>
<td>~875 Children (Sept. 2003) 80% also have RSN contact in the same year</td>
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<tr>
<td>Children’s Hospital Alternative Program (CHAP)</td>
<td>~75 Children served during Sept. 2003</td>
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<tr>
<td>Totals</td>
<td>~950 Children served in Sept. 2003 47% in group care or staffed residential care 44% in treatment foster care 9% in home (own or relative placement)</td>
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Services for children in out-of-home placements or dependencies

Children’s Inpatient System Overview

- 3 types of inpatient services
  - Community Hospital Inpatient Beds
  - CLIP Beds
  - E&T Beds
- Hospital & CLIP beds are statewide resources
- E&T beds are local resources
- No IMD exclusion for children

Distribution of Children’s Inpatient Beds (Hospital & CLIP)

Distribution of Children’s E&T Beds by RSN
Children Mental Health Inpatient and CLIP Funding

- In FY03 $27 million was spent for children’s inpatient and CLIP services.
- Of that, $8 million was spent for CSTC
- Community hospitals have the highest unit cost at $671 with the CLIP beds at $339 per day

Clip Utilization Trends

Children’s Mental Health System: Capacity & Utilization Issues

CLIP Average LOS by Facility

1998-2002 (Year of Admission)
Children Mental Health System: Systemic Pressures

- Funding for children’s mental health services are fragmented across DSHS divisions with differing services, eligibility standards and reporting requirements.
- Many children services are provided services away from their home RSN.
  - Capitated system
  - Home RSN does not have funds to pay for service providers outside their system
  - RSN where child is located does not have funds for this child

Children Mental Health System: Unique Pressures

- Lack of access to inpatient services near family may damage fragile family situations
  - 17% experience a custody change while in treatment
  - 36% of children in voluntary admissions and 20% in involuntary admissions are in state custody at some point during their inpatient stay
- Most children in CLIP facilities are eligible for special education

Children Mental Health System: Funding Rate Pressures

- Reimbursement rates have been a significant factor in the actual or threatened closure of both inpatient and CLIP beds
  - Martin Center closed June 30, 2004
  - Fairfax Hospital Board threatened denial of service to public clients due to rates
- The number of children served from FY 00-03 has also slightly decreased but the reason is unclear
Children Mental Health System: Capacity Pressures—Forensic

- Competency evaluation and restoration for children is a relatively recent phenomenon
- CSTC provides all the competency restoration services in the state

Competency Restoration at CSTC

Referrals 2001 – 2004

Bed Days 2001 – 2004

Summary: Children

- Most RSNs don’t have access to E&T facilities for Children
- Rate issues have caused the loss and threatened loss of beds
- Statewide children’s facilities raise funding issues
- Children’s system has most of the same pressures as the adult system but also faces additional issues (custody, special ed)
Forensic & Correctional Mental Health

Competency Restorations By Year

FY 2003 State Hospital Forensic Utilization By RSN

Forensic Pressures

- Facilities at capacity with waiting lists
- Increase in outpatient evaluations in Eastern Washington creating increase in inpatient restorations
- Decrease in Western Washington inpatient restorations attributed to Sell case
- Estimate of 7 bed/month increase requires new ward per fiscal notes
Jail Mental Health: Survey Overview

- Responses on survey received from 21 of 38 county jails and 7 city jails
- There is no consistent information kept across jails
- Most jails provided information about the percentage of mentally ill inmates, most common disorders, type of treatment available, and the total prescription expense

Jail Mental Health: Consumers

- Percentages of inmates with a serious mental illness
  - The largest group of jails reported that 10-20% of inmates had a serious mental illness
  - An additional 4 jails reported 20-30%
- The most frequent diagnoses:
  - Schizophrenia/schizoaffective disorder
  - Major depression/suicidal
  - Bipolar Disorder
  - Psychosis NOS
  - Co-occurring mental health & chemical dependency disorders

Jail Mental Health: Civil System Interaction

- Most jails estimate that 70-80% of mentally ill inmates are charged with felonies
  - Felony restoration is 90-180 days rather than a maximum of 29 days at the state hospital
- A few jails reported prior involvement
  - 20-798 inmates Medicaid enrolled at booking
  - 25-85% prior outpatient contact
  - 30-45% prior inpatient contact

Jail Mental Health: Services

- The most frequently cited services were referrals to outside treatment providers or CDMHPs
- Several jails provide some level of treatment either with their own staff or outside providers
  - Of those using outside providers, 4 stated that no treatment is available to inmates who are not clean and sober, even if suicidal
Jail Mental Health: Prescriptions

- All prescription drugs were paid by jails
- 6 jails spent less than $20K/year. 5 of these had capacities of 5-30 inmates
- 6 jails spent between $20-50K
- 4 jails spent $50-100K
- 4 jails spent over $100K, 2 over $1M
- 3 jails separated psychotropic drug cost
  - 1 small jail estimated 50% of $26,400/year
  - 1 large jail estimated 50% of $492,705
  - 1 jail spent $707K of $1,061,000

Jail Mental Health: Pressures

- Long waits pre-trial
  - Mentally ill defendants in jail 3 times as long pre-trial as non-mentally ill
  - 2+ month wait for competency restoration
- Jail staff expected to act as mental health professionals without training
- Loss of benefits happens at admission even if found not guilty
- Costs are increasing without funding

Summary: Forensic

- State hospital forensic units are full and have long waiting lists
- Increase in felony bookings puts additional pressure on state hospital beds
- Mental health costs to jails are increasing, especially drug costs
- Loss of benefits delays reintegration into mental health services
- Sobriety requirements prevent services even to suicidal inmates in some jails