COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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MEMORANDUM

December 3, 2019

TO: The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

Mr. Daniel Timberlake
Director, Department of Planning and Budget

FROM: Karen Kimsey KK
Director, Virginia Department of Medical Assistance Services

SUBJECT: Medicaid Residential Treatment Centers Rate Study

This report is submitted in compliance with the Virginia Acts of the Assembly – Item 303 QQQ. of the 2019 Appropriation Act, which states:

> *Item 303.QQQ. The Department of Medical Assistance Services shall review of the rates paid to residential psychiatric treatment facilities and determine if those rates are appropriate for those facilities. The department shall require residential psychiatric treatment facilities to submit cost reports to be used to conduct its review. The department shall report its findings to the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2019.*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KK/jh

Enclosure

Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Special: Medicaid Psychiatric Residential Treatment Facilities Rate Study

A Report to the General Assembly — *October 1, 2019*

Report Mandate:

Item 303.QQQ. The Department of Medical Assistance Services shall review of the rates paid to residential psychiatric treatment facilities and determine if those rates are appropriate for those facilities. The department shall require residential psychiatric treatment facilities to submit cost reports to be used to conduct its review. The department shall report its findings to the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2019.

Executive Summary

The General Assembly commissioned this study because Virginia Medicaid reimbursement for these facilities has not been inflated since 2008 and has not changed since 2011. Current regulations do not require annual inflation adjustments to these facilities' rates unlike other institutional providers (e.g., hospitals, nursing facilities). Psychiatric Residential Treatment Facility (PRTF) enrollment in Medicaid has increased from 30 providers in State Fiscal Year (SFY) 2014 to 32 providers in SFY 2018.

The Department of Medical Assistance Services (DMAS) reviewed cost data for current providers for SFY 2018 to determine the adequacy of current rates in meeting providers' costs. DMAS analyzed current rates and cost data from 19 in-state providers. Options for rate changes included: eliminating the statewide maximum rate, maintaining the maximum rate, and developing a statewide maximum rate based on the median cost per day or weighted average cost per day. The fiscal impact of potential rate changes for these providers ranges from $10.9 million to $22.7 million in Total Funds ($5.4 million to $11.4 million in General Funds).

About DMAS and Medicaid

DMAS' mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs. Through the Medallion 4.0 and Commonwealth Coordinated Care (CCC) Plus managed care programs, more than 1 million Virginians access primary and specialty health services, inpatient care, behavioral health, and addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to close to 400,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

Background

Residential treatment services are behavioral health interventions intended to provide clinical treatment to individuals with significant mental illness, including children that have, or are at risk of developing, serious emotional disturbances. Residential Treatment Services in this report consist of the Psychiatric Residential Treatment Facility (PRTF) services.[i] The Code of Federal Regulation (CFR) defines PRTF services as a 24-hour supervised, clinically and medically-necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive and training needs of an individual under 21 years of age in order to prevent or minimize the need for more intensive inpatient treatment.[ii,iii] PRTF reimbursement includes room and board.

The Virginia Medicaid PRTF network consists of 32 facilities. Twenty-one (21) facilities are located within the state and 11 are located out-of-state. Virginia Medicaid members are not routinely referred to out-of-state PRTF facilities; out-of-state centers have specialized treatment programs (e.g., trauma services) that are not typically available from the in-state network. Medicaid members account for approximately 67 percent of the utilization (days) for these facilities.

DMAS reimburses PRTF facilities using a daily (per diem) rate that is subject to maximum rate (or "ceiling"), similar to psychiatric services in freestanding psychiatric and acute hospitals. The current PRTF ceiling is set at $393.50 per day. Beginning in November 2013, DMAS contracted with Magellan of Virginia as the Behavioral Health Services Administrator (BHSA) to authorize and pay claims for these services.

The General Assembly commissioned this study because Virginia Medicaid reimbursement for these facilities has not changed since 2011. PRTF rates were established for each provider at the time they enrolled in Medicaid based on actual or proforma costs and have not been rebased to current costs. Providers received annual inflation adjustments through 2008; however, rates were reduced 4.0% in 2011 and have not been adjusted since then. Current regulations do not require annual inflation adjustments to these facilities' rates unlike other providers (e.g., hospitals, nursing facilities). PRTF enrollment in Medicaid has increased from 30 providers in State Fiscal Year (SFY) 2014 to 32 providers in SFY 2018. Medicaid expenditures for PRTFs were $97 million in SFY 2017, to $78 million in SFY 2018, and $84 million in SFY 2019.[iv]

Study Results

Cost Report Data

The Department of Medical Assistance Services (DMAS) reviewed cost data for network providers to determine the adequacy of current rates in meeting providers' costs. Cost reports reflect costs incurred during provider fiscal years ending in SFY 2018.[v] Providers submitted full cost reports (Form 608 V 2 Cost Report) directly to the DMAS cost settlement contractor, Myers and Stauffer, LC (MSLC). MSLC performed desk reviews on the cost report submissions and adjusted providers' reports to be fully compliant with Medicare Principles of Reimbursement, including the rules in the Provider Reimbursement Manual (CMS Publication 15-1). Cost report data included: beds, discharges and admissions, employees, depreciation, capital asset gains and disposals, administrative costs, and other operating costs such as dietary, housekeeping, utilities/maintenance, medical supplies, and physical/occupational/speech therapy. The data excluded costs for education, prescription drugs, and professional fees as providers are paid separately for those services.

A total of 25 providers submitted cost report data for the study. One current in-state provider failed to submit timely cost report data for inclusion in the study. DMAS excluded five (5) out of state providers as members are referred out of state on a limited basis. One in-state provider was not included because it did not enroll with Virginia Medicaid until June 2018. The final cost report data included 19 in-state providers (i.e., 90 percent of Virginia in-state network providers) that accounted for 93 percent of total PRTF days in SFY 2018.

Analysis

Provider Costs

DMAS analyzed program operating and program physical plant costs for all in-state facilities. DMAS standardized costs across facilities using a cost per day calculation. Table 1 provides the mean and median operating and physical plant costs per day for in-state PRTFs. Operating rates per day ranged from $286.78 to $676.31 per day with a median of $444.04 per day. Physical plant costs showed more variation with a mean of $20 and a median of $17.94 per day. Three (3) facilities reported a physical plant cost of less than $10

per day. Overall total cost per day (i.e., operating plus physical plant cost) averaged $465.32 per day.

Table 1: PRTF In-state Provider Costs Per Day (N=19)			
	Program Operating Per Day	**Program Physical Plant Per Day**	**Program RTF Cost Per Day**
Mean	$ 445.32	$ 20.00	$ 465.32
Median	$ 444.04	$ 17.94	$ 463.88
Weighted Average	$ 404.73	$ 18.60	$ 423.32
Day-Weighted Median	$ 418.87	$ 7.47	$ 426.34

Source: DMAS analysis of PRTF SFY 2018 cost report data

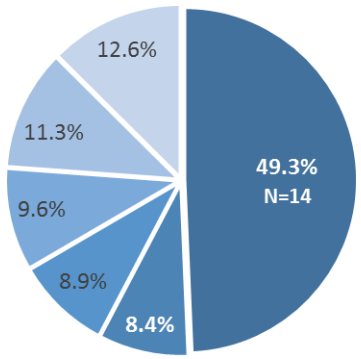
On average, the reported cost per day exceeded current DMAS rates by $102. A majority (89 percent) of facilities reported operating costs per day that surpassed their current DMAS rate. Two (2) facilities reported total costs per day that were less than their current DMAS rate.

PRTF Utilization

DMAS compared the program days submitted in the cost report with the number of days on the PRTF encounter files from the BHSA. The total program days submitted in the cost reports was approximately 99 percent of the total days for the same providers using claims data. In determining the cost per day, BHSA claims with dates of service during SFY 2018 served as the source of the Medicaid days.

In-state PRTF utilization varies substantially by provider in Virginia. During SFY 2018, five (5) in-state PRTF providers accounted for approximately 51 percent of in-state network PRTF utilization. Figure 1 illustrates this concentration with the remaining fourteen (14) providers accounting for 49 percent of PRTF utilization.

Figure 1: PRTF Utilization for In-State Providers (N=19)



Source: DMAS analysis of BHSA claims data (dates of service in SFY 2018) with runout through May 2019. Does not include utilization for in-state facility that did not submit cost report information.

Reported costs per day varied among the five major service providers, ranging from $299.73 to $486.11 per day. Appendix A provides information on SFY 2018 utilization, reported costs per day, and current DMAS rates for each in-state facility included in this report.

Rate Setting Options

A primary goal in Medicaid rate setting is to reflect the reasonable costs of providers delivering the majority of services while providing incentives for efficiency and economy. In reviewing the cost and utilization for these providers, DMAS considered several options for modifying PRTF rates. All options include rebasing per diem rates using more current costs from 2018. All but one option included maintaining the current methodology whereby provider costs per day are subject to a maximum rate or "ceiling". DMAS analyzed several possibilities including:

- Maintaining the current ceiling ($393.50 per day);
- Eliminating the ceiling (i.e., pay provider reported cost per day);
- Developing other ceilings including:
    - Statewide median cost per day;
    - Weighted average cost per day;
    - Day-weighted cost median.

These models reflect both the maximum and minimum potential fiscal impact. DMAS developed the weighted average cost (by total days) and the day-weighted cost median ceiling scenarios to reflect the concentrated utilization by certain providers of these services.[vi] The ceilings in these scenarios are more representative of the costs for providers with the highest proportion of utilization.

Fiscal Impact

To determine the fiscal impact, DMAS compared each potential option to the "no change" scenario, i.e., no rate changes from the current provider rates. DMAS compared total SFY 2018 PRTF expenditures to total expenditures under each option – the difference in expenditures represented the fiscal impact. DMAS utilized BHSA claims as the source of the expenditures. To determine current expenditures, DMAS used the lesser of each claim's billed amount or the facility's current rate times the units on the claim and subtracted any third party liability (TPL). To determine total expenditures under the rate options, DMAS used the resulting facility rate for each option multiplied by the units on the claim, and then subtracted any TPL. DMAS adjusted the initial fiscal impact (under each option) to account for an in-state provider that did not submit cost report data. DMAS inflated final SFY 2018 statewide totals by hospital inflation factors to reflect SFY 2020 expenditures.[vii] DMAS made no adjustments for potential changes in utilization between SFY 2018 and SFY 2020.

Table 2 provides the fiscal impact of each scenario. Each scenario provides a different method for determining the statewide ceiling. Under each option (except for Option #2) a provider's rate is set at the lesser of the provider's reported cost per day or the statewide ceiling. The fiscal impact analysis includes in-state providers currently in the Magellan network during SFY 2018; out-of-state providers are excluded.

Table 2: Fiscal Impact of Rate Setting Options (N=20)

Description of Option	Fiscal Impact (Total Funds)
#1 – Retain the current statewide rate ceiling ($393.50 per day)	10,894,380
#2 – Eliminate the statewide rate ceiling and pay the provider-reported cost per day	22,705,154
#3 – Set the ceiling to the statewide median cost per day	19,637,297
#4 – Set the ceiling to the statewide weighted average cost per day	15,199,391
#5 – Set the ceiling to the statewide day-weighted median cost per day	15,624,903

Source: DMAS analysis of PRTF cost report data for provider fiscal years ending in SFY 2018. Note: Fiscal Impact includes only BHSA in-state network facilities. Appendix A provides the list of facilities and their SFY 2018 utilization. DMAS added 4.52% to the SFY 2018 impact to account for utilization for a current network provider that did not submit cost report data. Final impact includes inflation adjustments to SFY 2020.

The lowest cost option resulted from setting the statewide maximum rate to the current PRTF ceiling – in this scenario all but two providers were paid at the current ceiling. The highest cost option stemmed from paying a provider's reported costs per day without a ceiling. The fiscal impact of the other "ceiling change" options ranged from approximately $15.2 million to $19.6 million.

Conclusion

Based on the DMAS review of PRTF cost reports, provider costs indicate substantial variation in the adequacy of current rates. As shown in Appendix A, the current rate expressed as a percentage of cost per day ranged from a low of 52.3 percent to a high of 131.3 percent. Among the providers with the highest PRTF utilization, this variation persisted. Overall four (4) providers had 90 percent or more of their reported costs covered under their current rate while a majority (13 of 19) had at least 70 percent of reported costs covered by their current rate. For other institutional providers (i.e., hospitals), DMAS limits the proportion of costs covered in the rate to less than 100 percent.

Given the substantial variation in the adequacy of current rates to cover providers' costs, DMAS has provided the General Assembly with several options for adjusting the rates paid to residential treatment providers. The methods chosen to adjust the rates should incentivize economy and efficiency while allowing for reasonable variation in costs to reflect specific program needs and market conditions. The General Assembly may want to consider requiring annual inflation adjustments or periodic rebasing of costs and/or ceilings (similar to hospitals and nursing facilities).

Appendix A: PRTF Facilities Included in Report

FACILITY NAME	SFY 2018 PRTF Utilization (days)	SFY 2018 Reported Cost per Day	Current DMAS Rate	Current Rate as Percent of Cost per Day
ALICE C TYLER VILLAGE OF CHILDHELP	18,254	$486.11	$345.22	71.0%
BARRY ROBINSON CENTER	325	$699.69	$393.50	56.2%
BRIDGES TREATMENT CENTER	11,472	$456.13	$348.89	76.5%
CUMBERLAND HOSPITAL LLC (PRTF ONLY)	2,351	$487.80	$338.86	69.5%
FAIR WINDS	3,916	$527.03	$363.85	69.0%
GRAFTON SCHOOL INC	15,156	$518.41	$393.50	75.9%
HALLMARK YOUTHCARE-RICHMOND	20,838	$426.34	$223.01	52.3%
HARBOR POINT BEHAVIORAL HEALTH CENTER INC	24,562	$345.17	$290.11	84.0%
JACKSON FEILD HOMES	13,462	$463.88	$393.50	84.8%
KEMPSVILLE CENTER FOR BEHAVIORAL HEALTH	4,967	$327.86	$290.11	88.5%
KEYSTONE NEWPORT NEWS	27,367	$299.73	$393.50	131.3%
LIBERTY POINT BEHAVIORAL HEALTH	7,829	$438.94	$375.42	85.5%
NORTH SPRING BEHAVIORAL HEALTH	19,387	$397.96	$393.50	98.9%
POPLAR SPRINGS HOSPITAL (PRTF ONLY)	11,636	$472.07	$391.02	82.8%
THE HUGHES CENTER FOR EXCEPTIONAL CHILDREN	14,106	$386.88	$393.50	101.7%
THREE RIVERS TREATMENT CENTER LLC	3,462	$617.57	$393.50	63.7%
TIMBER RIDGE SCHOOL	3,277	$587.76	$393.50	67.0%
UNITED METHODIST FAMILY SERVICES OF VA	12,888	$473.69	$393.50	83.1%
YOUTH FOR TOMORROW-NEW LIFE CENTER INC	2,630	$428.06	$393.50	91.9%

Source: BHSA claims with dates of service during SFY 2018 (runout through May 2019). Analysis excluded utilization of freestanding psychiatric facilities for providers enrolled with Medicaid as both a PRTF and a freestanding psychiatric facility.
Note: The report excluded cost report information for one facility that enrolled with Medicaid in June 2018.

Endnotes

[i] In Virginia, Residential Treatment Services also encompass Therapeutic Group Home services. This report excludes these services from the analysis.
[ii] A psychiatric residential treatment facility must meet the requirements as specified 42 CFR 441.151 to 441.182, and 483.350 to 483.376.
[iii] Under a CMS 1115 Waiver, Virginia Medicaid adult members (over age 21) may receive Addiction and Recovery Treatment Services (ARTS) in PRTFs. This report excludes adult ARTS utilization.
[iv] 2018 Medicaid and CHIP Data Book available from http://www.dmas.virginia.gov/#/deidentifiedreports; 2019 estimate from DMAS Budget Division Forecasting Unit.
[v] All but one provider submitted data corresponding to the state fiscal year 2018 (July 1, 2017 to June 30, 2018). One in-state provider's fiscal year ended December 31, 2017. DMAS inflated the provider's costs using one-half of the applicable hospital inflation factor from Global Insight to reflect costs for the remainder of SFY 2018.
[vi] DMAS nursing facility reimbursement methodology uses day-weighted cost medians in rate setting.
[vii] Initial totals were inflated by 4.52% to account for an in-state provider that did not submit cost report information. DMAS used hospital inflation factors from Global Insight (2.9% for state fiscal years 2019 and 2020).