IMPROVING PAYMENT & DELIVERY STRUCTURE FOR INPATIENT PSYCH PROVIDERS

SUMMER STUDIES COMMITTEE'S – AUGUST17, 2016

ISSUES WHICH IMPACT MENTAL HEALTH RESOURCES

- Teen Suicide Rate
- Reservation – Suicide and Unfavorable Domestic Situations
- Domestic Violence
- Detox units are limited – overcrowded and underfunded
- Drug related crime
- Depression impacting all socioeconomic groups
- Inadequate number of facilities
- Shortage of trained staff and doctors

INPATIENT PSYCH CARE - "CURRENT STATE"

Care included:

- Nursing
- Counseling – group & individual
- Drug Therapy
- Limited Outpatient Care
- Addressing security concerns for all patients
- Physician Care excluded from the "per diem" system

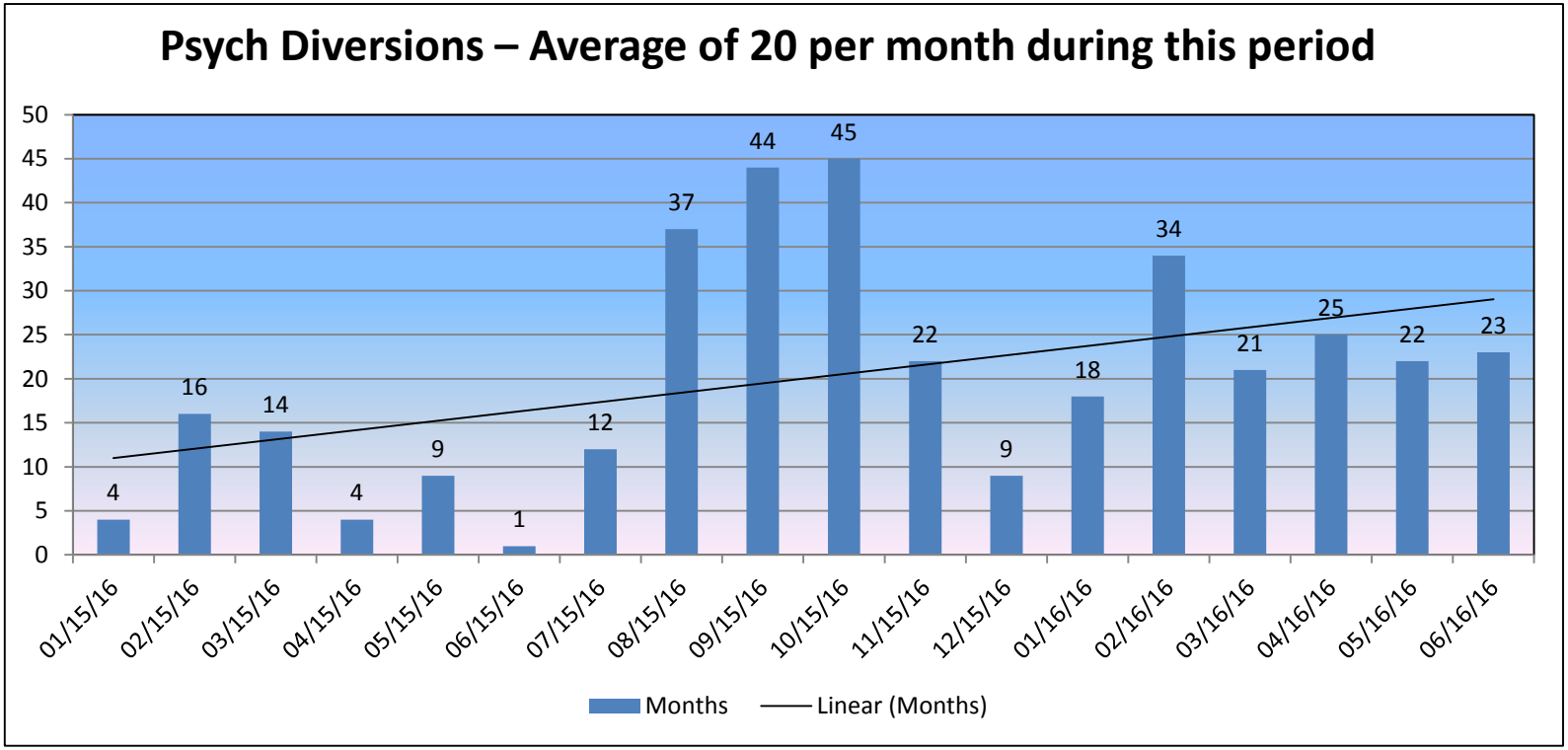
Care costs/ payment:

- Current SD Medicaid Per Diem of $699 – full rate
- Placement Status rate is half the full per diem
- Costs per day > $900
- Cost of care continues to increase
- Lack of adequate payment inflation to reflect costs
- Security resources to keep all patients & staff safe
- Payment for the Psychiatrist is separate

RCRH – COSTS VS. MEDICAID PER DIEM - TREND

	Per Medicare Cost Report					
	Nursing Costs	Ancillary Costs	Capital Costs	Total Costs	Medicaid Per Diem	Difference
FYE June 30, 2015	$ 701.57	$ 183.76	$ 17.83	$ 903.16	$628.00	(275.16)
FYE June 30, 2013	$ 709.21	$ 183.17	$ 35.60	$ 927.98	$620.96	(307.02)
FYE June 30, 2011	$ 708.65	$ 141.95	$ 24.52	$ 875.12	$698.00	(177.12)
FYE June 30, 2009	$ 849.58	$ 166.73	$ 58.67	$ 1,074.98	$698.00	(376.98)
FYE June 30, 2007	$ 852.84	$ 173.95	$ 56.40	$ 1,083.19	$597.00	(486.19)

PATIENT DIVERSIONS – RCRH BEHAVIORAL HEALTH UNIT – (JAN 2015 THRU JUNE 2016)



KEY METRICS AND STATISTICS – RCRH

	FYE 16	FYE 15	FYE 14
Total Psych Admissions	2,000	2,456	2,110
Total Psych Patient Days	9,232	9,746	7,708
Total - Psych ALOS	4.62	3.97	3.65
T-19 Psych Admissions – SD only	418	772	691
T-19 Psych Discharges – SD only	425	771	688
T-19 Psych Patient Days – SD only	2,428	3,362	2,729
T-19 - Psych ALOS – SD only	5.81	4.35	3.95
T-19 Share based on Pt Days	26.3%	34.5%	35.4%
IPT Psych Diversions	315	212	not available

WHAT SHOULD CHANGE – "FUTURE STATE"

1. Increase Payments to reflect cost increases and staff needs. DSS funding for inpatient Behavioral Health services is currently inadequate
2. Consider payment structures used by other state Medicaid programs to increase services to a level which would make South Dakota a leader in this area
3. Coverage extending the number of days covered for an average inpatient case. We are down from 15 day Average Length of Stay (ALOS) in the 80's to 4- 5 days per stay today. There is just not enough time to address all of the underlying patient issues.
4. Provide patient incentives to encourage care after the inpatient stay. Follow a proven approach for outpatient care which involves a multi-faceted approach to improving the overall situation that includes an examination of the personal environment, job options, and root causes of their current/long term behavioral health issues.

SUMMARY & RECOMMENDATIONS

- Increase Per Diem rates with differentiation between Adult and Adolescents & accelerate the planned increases for Behavioral Health (BH) per diem.
- Establish a HSC West facility to deal with increasing West River demand for Mental Health Services
- HSC in Yankton needs to give patients in RCRH's BH Unit priority for admission to that facility due to limited available travel days and extensive travel time required to reach the facility in Yankton
- Decision on financial Responsibility for "1-Day" stays – County or State Medicaid?
- Backlog of patients for admission to RCRH BH Unit which causes additional pressure on acute care as Psych patients who present at ER must be housed somewhere until a bed in our unit becomes available
- Study surrounding state Medicaid programs and their coverage and payment levels of inpatient Behavioral Health services

Conclusion & Summary
The time to act is now

Mental health - a serious SD issue

More facilities and higher payments

Remove the stigma of attaining care

"People don't care what you know, until they know you care" - As a State, WE MUST CARE

Testimony for Summer Study – Legislative Committee

By David Goehring, Regional Health, Aug 17, 2016

Good morning. My name is David Goehring, and I work for Regional Health in Rapid City. I have worked at Regional Health since November 1987. During most of that time I was Director of Budget/Reimbursement, but since July 2006 I have been Treasurer and Director of Financial Reporting.

Earlier in my career, I worked as a Medicare auditor for Blue Cross of Montana and Arizona. Due to my experience, I understand the Medicare Cost Report mechanics and reimbursement methods used by Medicare and Medicaid quite well.

Rapid City Regional Hospital operates a 56 bed inpatient Behavioral Health unit in a facility which is in west Rapid City, near the old Baken Park outdoor mall. The unit is housed in the hospital previously known as the Bennett Clarkson Hospital. This hospital was impacted by the 1972 Rapid City flood. In fact, the 1972 flood probably was a primary stimulus which moved the community of Rapid City to form a group which purchased the land where the current main campus of RCRH sits today along Fairmont Blvd and 5th street on the southeast side of Rapid City.

Today, I have been asked to testify on the payment structure used by the South Dakota Medicaid program to pay for inpatient behavioral health care and some of the unique issues facing our physicians and staff providing behavioral health care in Rapid City.

Per discussions with our Behavioral Health Nurse Manager, Janel Brown; Behavioral Health Medical Director, Dr. Harry Hamlyn, and one of our Associate General Counsel's, Jason Green the primary challenges are as follows:

Primary Issues and Topics as we see them in Western South Dakota

1. Nursing Care – current payment levels negatively impact our ability to pay staff at market rates. This causes significant staffing and recruiting issues.
2. Physician Care – payment levels to physicians are separate from the hospital payment (per diem). These rates are not adequate to retain the necessary physicians.
3. Medicaid share of our Behavioral Health inpatient population – has ranged between 27 - 40% over the past 5 years. Medicaid funding is very important revenue source to the operation the Rapid City Regional Hospital's unit.
4. Difficult patient placement to the State's Human Services Center in Yankton – has become significantly more acute since the problems within the HSC in Yankton have reduced their capacity to house transfers from the Rapid City unit.
5. Inadequacy of SD Medicaid Payment creates a need for subsidy of Medicaid patients by RCRH private pay patients.
6. "Placement Status" issue – occurs when a patient no longer meets inpatient criteria to remain in our Behavioral Health unit per the South Dakota Medicaid guidelines. At this point, the per diem payment to the hospital is reduced by 50% of current regular Medicaid per diem payment. However, due to the "no beds available at HSC" or no beds at other facilities, such as addiction centers for adolescents, RCRH is caught in the middle, still providing the care, but not receiving adequate payment for the services provided.

7. County Hold & One Day Stays – currently payment responsibility for these services are in dispute by County and State Governments.
8. Older inefficient facility – our facility had a major renovation in 1990, but that renovation now is 26 years old. The facility needs updating and improvement to address how care is delivered today. Our facility needs to be renovated or replaced, and current Medicaid per diems make this impossible.

Solutions/changes for Medicaid - Behavioral Health hospital care in Western South Dakota

1. Funding increases to recruit and retain appropriate staff levels and replace aging inefficient physical facilities
2. Refining the "Placement status" determination and transfer process so the appropriate care is delivered and payment for that care level is adjusted to reflect resources used. RCRH is financially punished under the current program.
3. Consideration of different payment levels for adults versus adolescents as more resources generally are utilized to care for younger patients.
4. Financial responsibility for the county holds and "one-day" stays must be determined and put into state law.
5. State consideration of building/opening a HSC type facility in Western South Dakota. Possibly the Custer facility could be renovated to house a HSC unit for western SD.
6. Compensation levels for HSC Providers (Psychiatrist, professional counselors, and others) must be updated to market levels so recruitment and retention of trained and experienced staff is not as challenging as it is now.

Other Information – not covered in Testimony

1. Our Behavioral Health staff has indicated that the Foundation for Medical Care which is the "authorizing agency" for State Medicaid is very good to work with on the inpatient Behavioral Health cases.
2. Adult Patients have better access to HSC in Yankton than Adolescent patients in our Behavioral Health Unit – per our primary Behavioral Health Case Manager.
3. Adolescents require more intensive resources with virtually constant monitoring by staff and a very structured day for care, counseling, and activities.
4. Patients within the unit are required to be segregated by sex and age. Adolescents are further divided between teens and pre-teens.
5. Once Placement Status ends, RCRH receives no hospital services payment. That situation does not occur often, but it does occur sometimes.
6. RCRH Behavioral Health unit has placement problems, in-take issues for one day stays, capacity issues related to maintaining the required segregation of patients, and acute medical capacity issues when Behavioral Health patients, due to a lack of Behavioral Health beds in our unit are, by necessity, housed in our acute patient Tower. This situation causes acute medical patient diversions.
7. Community resources (police, fire) also are impacted by Behavioral Health needs.
8. Over the past two years, the mix of patients has been 57 % Adults and 43 % Adolescents among the Medicaid patients seen in Rapid City.