Senate Bill 2399

Senate Human Services | Representative Lee, Chair

North Dakota Medicaid Psychiatric Residential Treatment Facilities | Sarah Aker
February 4, 2025

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Key Medicaid Tenets

- **Entitlement Program**
  - Anyone who meets eligibility rules has a right to enroll and be served in Medicaid
    - HCBS waivers can be limited by a total number of slots.
  - Federal financial support
- **Partnership with the Federal Government**
  - Federal mandates and regulations obligate state action and expenditures
  - Federal approval required for changes to Medicaid program
- **Not a traditional grant**
  - Open ended funding source; no cap on total federal funds
  - Cost sharing model; State funding match required for use of federal funds

Rate Methodology Guiding Principles: Traditional Medicaid

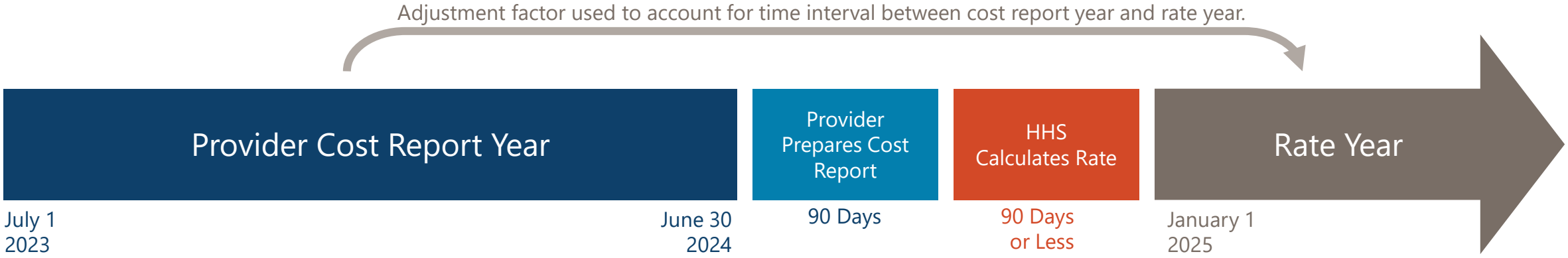
- Predictable
- Consistent
- Transparent
- Data Driven
- Population Focused
- Quality & Outcomes Oriented
- Incentivizes Innovation, Efficiency & Community Based Care

Payment Methodology
Psychiatric Residential Treatment Facilities

- Administrative Code 75-02-09 details ratesetting for Psychiatric Residential Treatment Facilities.
  - Prospective Rate Setting based on historical costs as reported on the provider's cost report. Defines cost categories in 75-02-09-06:
    - Administration
    - Direct Care
    - Dietary Costs
    - Laundry
    - Plant & Housekeeping
    - Property
  - Includes provisions in 75-02-09-04 to account for changes to the rate related to services or staff.

- Section 1902(a)(30) of the Social Security Act (SSA) requires that Medicaid payments be consistent with efficiency, economy and quality of care.
- CMS requires states to follow Medicare's principles of reasonable cost reimbursement found in 42 CFR Part 413.

How are cost reports used to set rates?



The rate methodology for the service uses cost report data to calculate provider rates.

- An adjustment factor is used to inflate costs forward from the cost report year to the rate year.
- Some costs are not allowable (ex. lobbying) for use in calculating reimbursement rates.
- Cost categories are used to ensure costs are not duplicated.
- Cost categories have limits to ensure that costs are reasonable and efficient.
- Provider cost reports and underlying data are audited to ensure that costs were appropriately reported and allocated.

Direct Care Definition

Administrative Code 75-02-09-06

Direct care costs include:

- Salaries and fringe benefits for individuals providing treatment or supervision of residents;
- Personal supplies used by an individual resident;
- Clothing necessary to maintain a resident's wardrobe;
- School supplies and activity fees, when not provided by or at the expense of the school;
- Costs incurred for providing recreation to the residents including subscriptions, sports equipment, and admission fees to sporting, recreation, and social events
- All costs related to transporting residents, and transportation costs that may include actual expenses of facility-owned vehicles or mileage paid to employees for use of personal vehicle;
- The cost of services purchased and not provided at the facility, including case management, addiction, psychiatric, psychological, and other clinical evaluations, medication review, and partial care or day treatment; and
- Training required to maintain licensure, certification, or professional standards requirements, and the related travel costs.

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"Direct care costs" are the costs incurred by a licensed psychiatric residential treatment facility to provide care for residents of the facility, including the costs incurred by the facility to meet licensure and accreditation requirements.

Special Costs

Administrative Code 75-02-09-04

The department may provide for an increase in the established rate for additional costs necessary to add services or staff to the existing program.

(1) The facility shall submit information, to the department's medical services division, supporting the request for the increase in the rate. Information must include a detailed listing of new or additional staff or costs associated with the increase in services.

(2) The department shall review the submitted information and may request additional documentation or conduct onsite visits. The established rate will be adjusted if an increase in costs is approved. The effective date of the rate increase will be the later of the first day of the month following approval by the department or the first day of the month following the addition of services or staff. The adjustment will not be retroactive to the beginning of the rate year and will exclude adjustment factors provided for in subsection 8.

(3) For the rate year immediately following a rate year in which a rate was adjusted under paragraph 2, the facility may request consideration be given to additional costs. The facility shall demonstrate to the department's satisfaction that historical costs do not reflect twelve months of actual costs of the additional staff or added services in order to adjust the rate for the second rate year. The additional costs would be based on a projection of costs for the remainder of a twelve-month period, exclusive of adjustment factors provided for in subsection 8.

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"Emergent costs" are direct care costs incurred by a licensed psychiatric residential treatment facility that are:

(1) Nonrecurring costs that will be offset in the next cost-analysis period; or

(2) Not considered in the submitted cost report, which enhance treatment efficacy, reflect changes in requirements for licensure or accreditation, address workforce changes, or are necessary to ensure resident safety, which will not be offset in the next cost-analysis period.

Upper Payment Limit

- Medicaid payments are required to be "consistent with efficiency, economy, and quality of care."
- CMS requires states to demonstrate compliance that payments for certain providers do not exceed an upper payment limit (UPL).
- The UPL is a reasonable estimate of the amount that would have been paid for the same service under Medicare payment principles.

Required Upper Payment Limit Demonstrations in North Dakota:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Nursing Facility Services
- Institutions for Mental Disease (IMD)
- Clinic Services
- Intermediate Care Facility for the Individuals with Intellectual Disabilities (ICF/IID)
- Psychiatric Residential Treatment Facility (PRTF)

Federal Financial Participation Limit:

- Durable Medical Equipment

What's next in Value Based Care?

Refinement and Expansion of Current Programs

Exploration of New Provider Groups

- High-Cost Services
- Opportunity to Impact Care Outcomes and Improve Services
- Ability to Incentivize Innovation
- Need to Stabilize Funding

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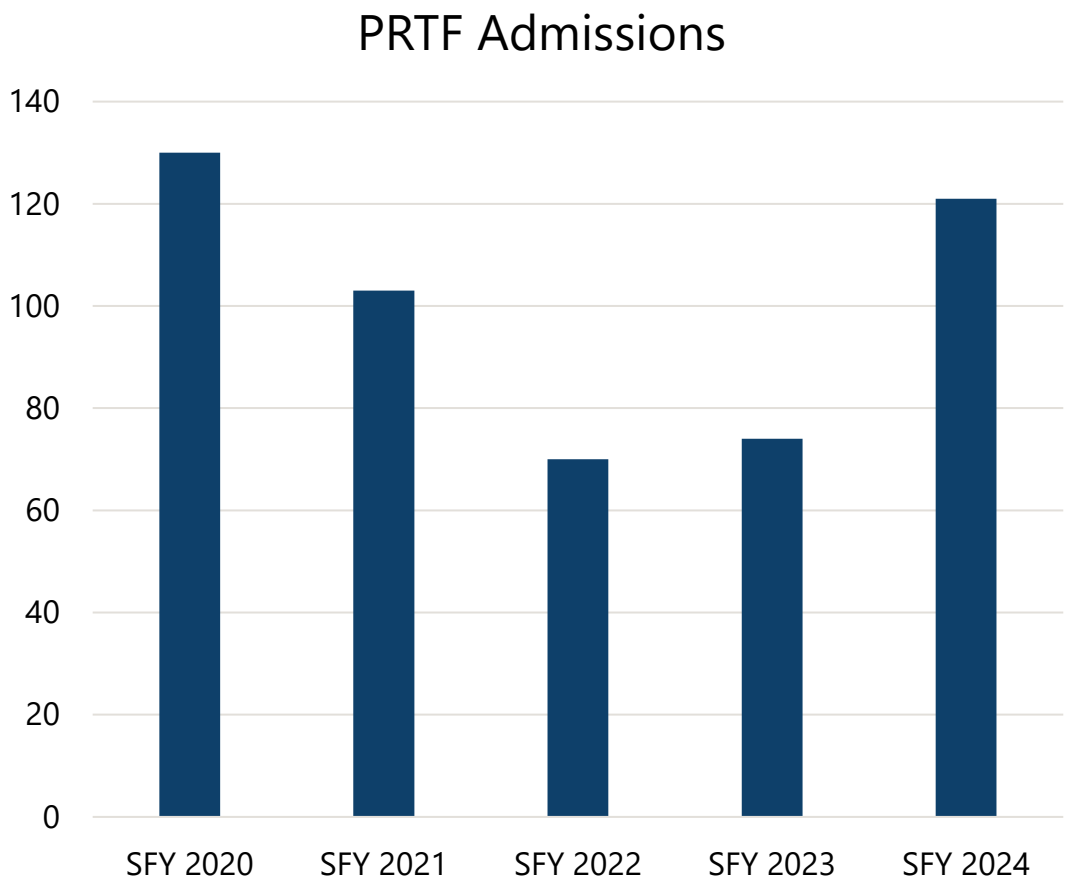
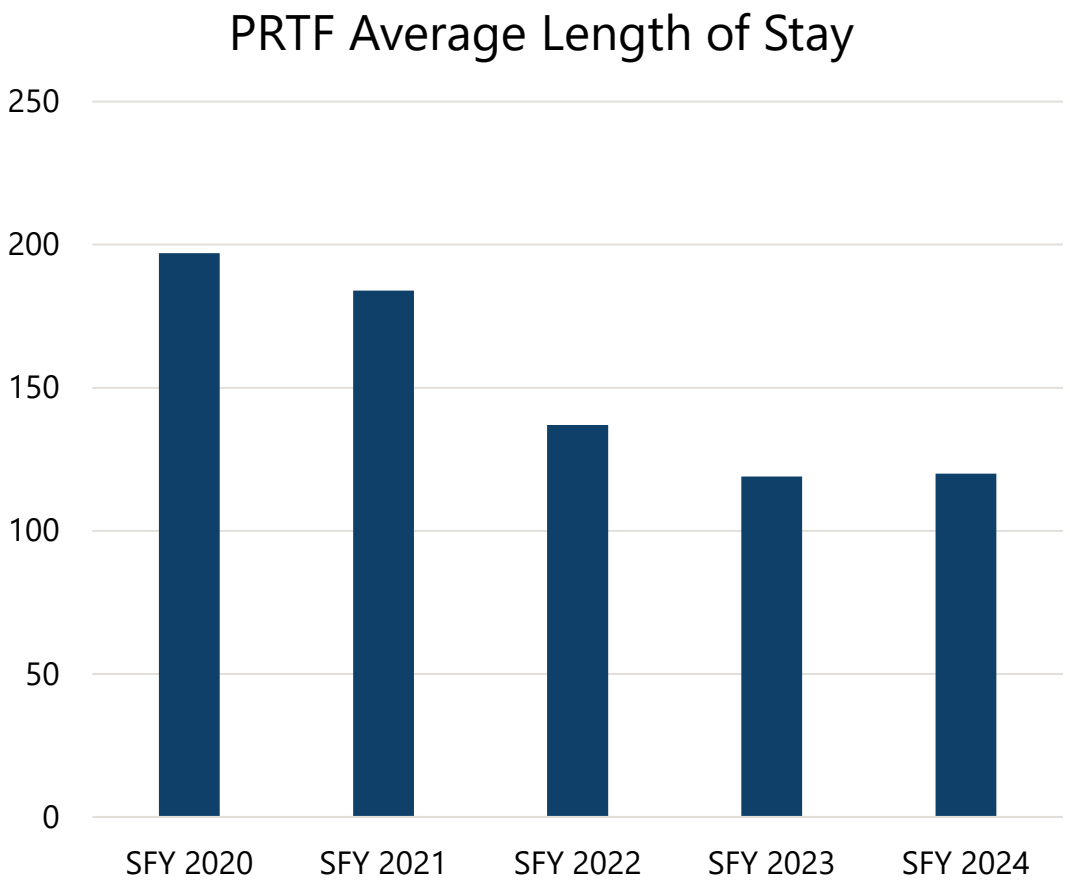
Psychiatric Residential Treatment Facilities





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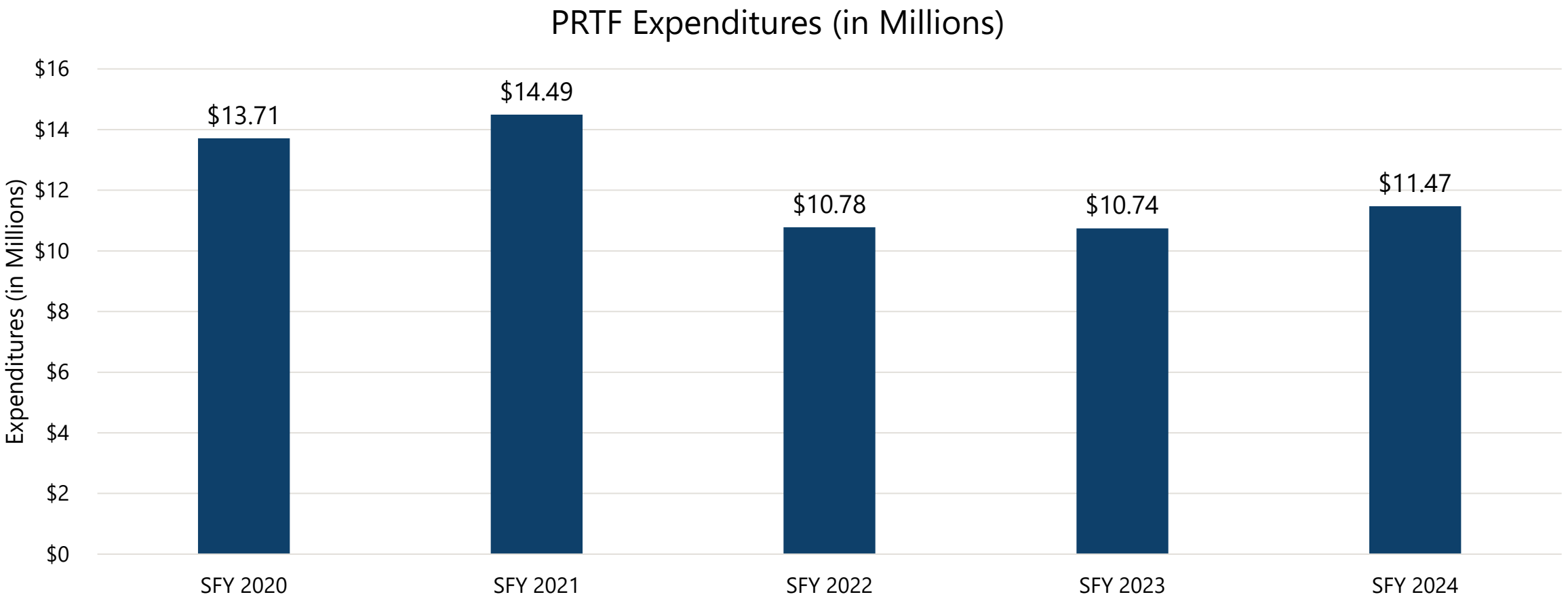
Psychiatric Residential Treatment Facility Expenditures



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Value Based Care
Ongoing

Total	**$2,000,000**
General	$1,000,000
Federal	$1,000,000

Expand care focused on value to additional provider groups and continue to refine current programs to ensure populations are supported with person-centered care and support.

Refinement and Expansion of Current Programs

- Continue to grow and refine current value-based programs.
- Review attributed populations and supports available to individuals with complex health care needs.
- Strengthen care coordination to ensure service delivery provides comprehensive, person-centered care focused on ensuring access and appropriate follow-up supports across multiple delivery systems.

Exploration of New Provider Groups

- Expand health system value-based program to rural delivery system to include critical access hospitals and associated primary care providers. Ensure rural VBP design builds on the current program to improve healthcare quality, accessibility, and sustainability in rural areas.
- Explore a value-based purchasing model with PRTFs and QRTP providers to drive towards enhanced services and outcomes for youth while ensuring stability of safety net service delivery for children with behavioral health needs in North Dakota.

Funding will support:

- Subject Matter Expertise
- Value Based Program Provider Workgroup Facilitator
- Service Infrastructure Development

Federal Requirements for Youth Behavioral Health Inpatient and Residential Services

- 42 CFR Part 441 Subpart D requires state Medicaid programs to have an independent team certify the need for services when a youth under age 21 is admitted to inpatient psychiatric services.
  - Inpatient psychiatric services include services provided in hospitals and psychiatric residential treatment facilities (PRTF).
  - ND Medicaid also issues a level of care for youth served in Qualified Residential Treatment Programs (QRTPs).

Level of Care Process

Pre One Assessment
Services before July 1, 2024

- **Fragmented and Inconsistent**. Prior to the one assessment, North Dakota had separate entry points and review processes for PRTF and QRTP levels of care. Additionally, the review and documentation process differed substantially between settings. PRTF reviews were based on narrative documentation only and referral information was submitted by the PRTF provider while QRTP reviews included interviews with families and youth.
- **Not Person Centered.** PRTF reviews did not include interviews of youth and families.
- **Potential for Bias.** PRTF reviews only focused on narrative documentation, not medical records.
- **Duplication.** Multiple assessments and dual determinations for the same youth.

Post One Assessment
Services After July 1, 2024

- **Streamlined approach.** One assessment and evaluation, regardless of the type inpatient or residential behavioral health treatment requested.
- **Independent.** Medical documentation review is completed by an independent third party and is broader than a narrative description.
- **Family and person-centered.** Includes interviews with youth and families. Ensures care is provided in the least restrictive, most appropriate setting to meet the youth's needs.
- **Consistent.** Clinical criteria are applied consistently for all youth across North Dakota. Eliminates variance in provider interpretation of clinical criteria.

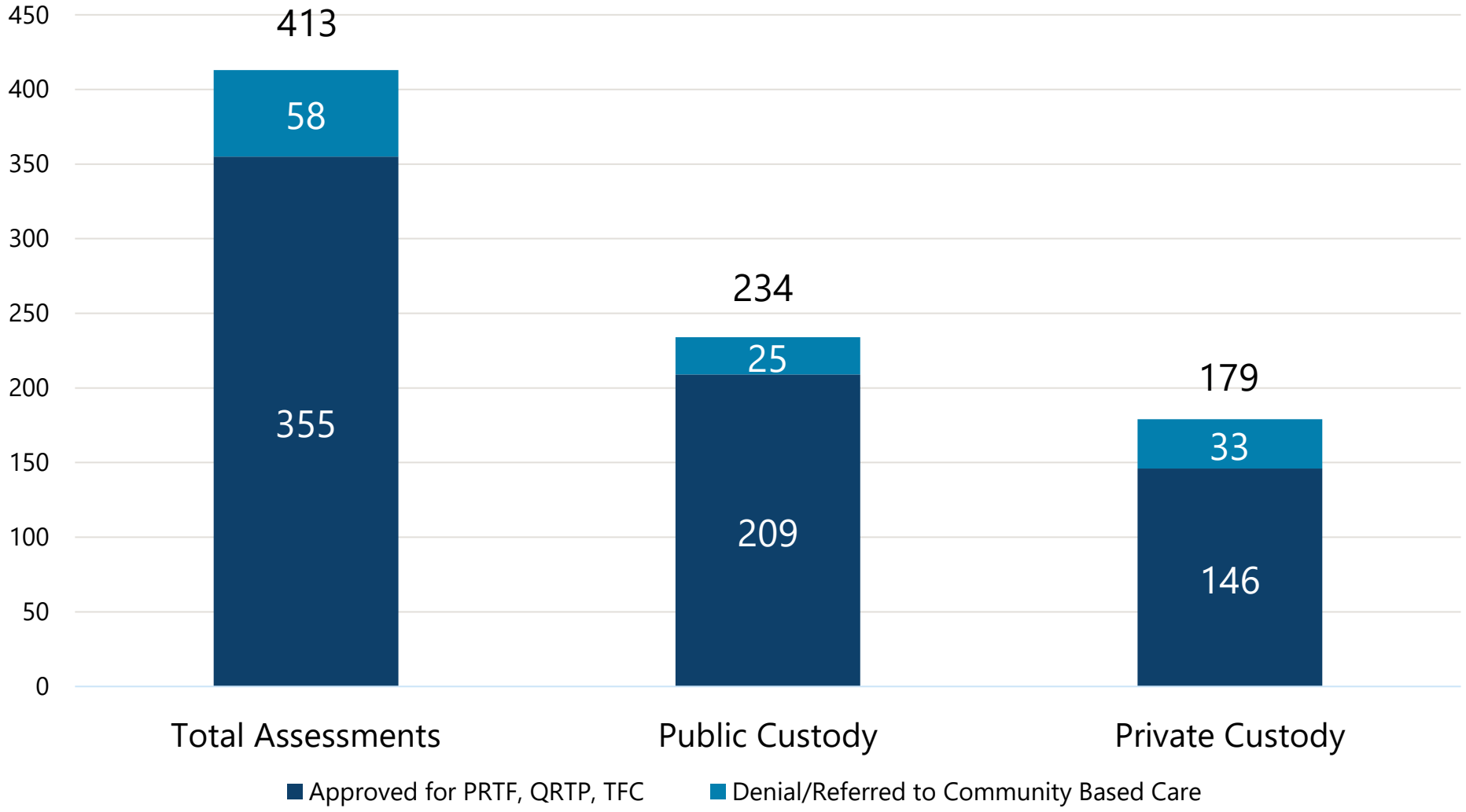
One Assessment Transition

Did clinical criteria change?	No, the one assessment is a process change only and did not change the clinical criteria for PRTF or QRTP admission. The clinical criteria for PRTFs were updated in June 2023 and providers were trained in the criteria at that time and have had a year to adjust to the clinical criteria. The one assessment adds independent verification of clinical criteria and provider submitted information through review of clinical notes and an interview with youth and families but does not change the certificate of need (CON) clinical requirements in place prior to the one assessment.
How does this change impact the care of kids?	The new assessment will allow better supports for youth and families entering treatment service by streamlining entry and ensuring the right care at the right time, provided in the least restrictive, most appropriate setting. The one assessment creates an opportunity for NDHHS to assist families who do not qualify for PRTF level of care to identify other treatment options and resources in the community. NDHHS will also have more data related to youth entering services to allow the state to monitor and identify trends related to service delivery across the continuum of care.
What has ND HHS done to help facilities and families?	NDHHS has collaborated with providers and families to navigate changing processes. NDHHS provided multiple educational sessions to providers before, during, and after implementation of the One Assessment, with opportunities to provide feedback and ask clarifying questions. NDHHS has added a Behavioral Health Navigator to support families in determining the right source of care. NDHHS continues to assess the behavioral health landscape of North Dakota and has included stakeholders in discussions to consider further enhancements to ensure youth have the right care at the right time, provided in the least restrictive, most appropriate setting.

One Assessment

- The new process is one assessment for both PRTF and QRTP levels of care, along with the addition of Treatment Foster Care.
  - The process change to one assessment is centered around streamlining services for youth and families and ensuring that care is provided in the least restrictive, most appropriate setting.
  - This new process will ensure families and youth come through a single point of entry, allowing ND HHS to have better data about PRTF admissions and denials and an opportunity to assess and help ensure youth with behavioral health needs are directed to appropriate supports at all levels of care.
  - Under the one assessment, referrals for Children's Treatment Services assessment will go to one 3rd Party Vendor. The vendor will assess for PRTF, QRTP, and TFC level of care, and complete independent interviews with youth and families and review additional required documentation to limit bias to ensure that clinical criteria are applied appropriately and consistently for all youth across the state.

Children's Treatment Services Level of Care
July 1, 2024 -December 31, 2024



85.9%
Approved for PRTF, QRTP, and TFC

14.1%
Denials/Referred to Community Based Care

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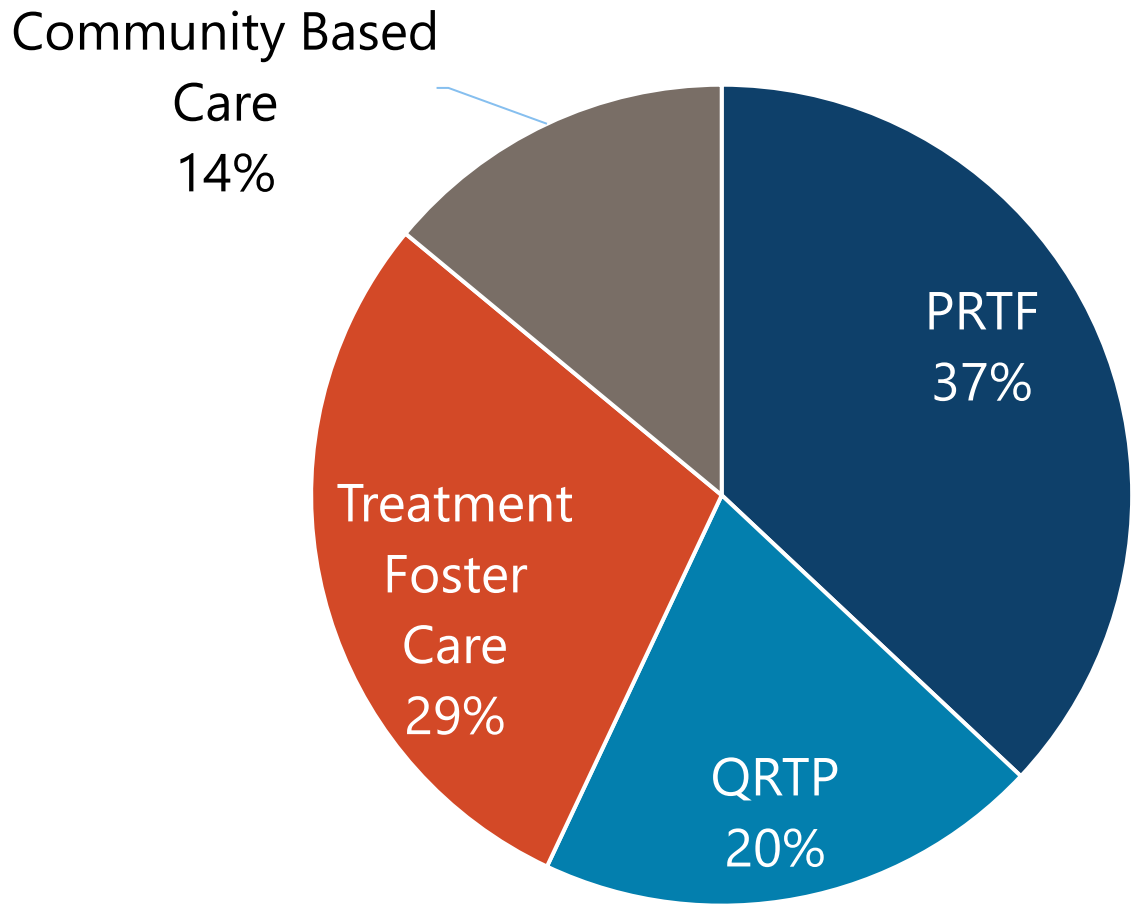
One Assessment Determinations
July 1, 2024 – December 31, 2024

Determination	Assessments
Community Based Care Appropriate	58
PRTF Appropriate	153
QRTP Appropriate: Difficulty of Care Level: Base	9
QRTP Appropriate: Difficulty of Care Level: 2	55
QRTP Appropriate: Difficulty of Care Level: 3	19
Treatment Foster Care Appropriate	119
TOTAL	**413**



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