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October 28, 2014

HAND-DELIVERED

Ms. Emily Whelan Parento, Executive Director
Cabinet for Health and Family Services
Office of Health Policy
275 East Main Street, 4W-E
Frankfort, KY 40621



RE: CON#: 034-15-1638(5)
The Ridge Behavioral Health System
Lexington, Fayette County

Dear Ms. Parento:

In response to your correspondence dated October 8, 2014, The Ridge Behavioral Health System is pleased to provide the following update. Since the approval of the above referenced Certificate of Need in February 2011 for 24 adult psychiatric beds, the Kentucky health care arena has changed significantly. With the implementation of Medicaid Managed Care, The Ridge's average daily census in youth was immediately reduced from pre-managed care utilization. With the Medicaid expansion and Health Benefit Exchange's successful implementation, expanded coverage has been provided to the citizens of the Commonwealth. These things, coupled with the expansion of services and providers under the State Plan Amendments (SPA) approved January 1, 2014, have continued to provide opportunities and challenges.

And finally, the same expansion of services and providers for adolescent chemical dependency under the KY Kids Recovery initiatives has created an opportunity for significant expansion of care for this population. Working with community partners, The Ridge will be opening multiple remote intensive outpatient programs. However, all of these populations require an integrated continuum of care to achieve maximum results.

The Office of Health Policy's *Certificate of Need Modernization: Core Principles* special memorandum published October 8, 2014, for stakeholder input describes the challenges and opportunities for Kentucky health care providers to respond to health reform. The Ridge is prepared to meet the Cabinet's vision of achieving the Triple Aim: better value, better care, and population health improvement guided by the principles proposed by the Cabinet. The ability to meet this challenge has one significant barrier, which, if eliminated, will expedite the implementation of the CON for 24 additional adult psychiatric beds. At this point, the barrier is the IMD exclusion which precludes free-standing psychiatric hospitals from providing inpatient care to adult Medicaid patient between the ages of 21-64. Opening access to additional providers to care for adult Medicaid patients is critical as access to treatment in acute care hospitals (general versus psychiatric) costs more, is not typically part of a full

continuum of care, and is not consistently available based on limited bed capacity or geographic barriers. The waiver of the IMD exclusion has been a critical conversation with the Cabinet, and has been advanced formally via the Hospital TAC on October 3, 2014, and the recommendation of the MAC on September 25, 2014. (See attached). The attached document details the need for consideration of a behavioral health carve-out from managed care. Under either of these scenarios, The Ridge can add the inpatient component of care for adult Medicaid patients in need of psychiatric or substance abuse treatment as a compensated benefit to the full continuum of outpatient services already in place. Absent this change in the Medicaid SPA, The Ridge can only continue to provide unreimbursed care to these patients when they present for urgent and emergent clinical situations.

The Cabinet has greatly supported the evolution of care delivery by advancing the outpatient centric model with coverage of partial hospital and intensive outpatient services. The SPA changes in 2014 have significantly incentivized the development of a full continuum, and improved access to care by bringing more providers to the table. Elimination of the IMD exclusion is the last barrier to a fully integrated behavioral health care delivery system for Medicaid members, the newly insured, and the remaining uninsured.

Existing licensed beds at The Ridge are not age specific, and the degree to which youth patient days increase as a result of the Recovery Kids KY initiative will also advance the full implementation of our CON. The Ridge is collaborating in two different awards with therapeutic foster care agencies and community mental health organizations to place up to 9 additional Adolescent CD IOP's in remote counties. This will require additional beds for those youth who require a higher level of care. Recovery Kids KY is an excellent example of the Cabinet supporting the evolution of care delivery and advancing partnerships and collaborations which have not previously existed.

All of these market and delivery of care changes have contributed to our thoughtful delay of implementation. However, The Ridge is committed to continuing to work with the Cabinet, payors, referral sources, and community partners to meet all patients' needs in the least restrictive, least costly, most appropriate, and highest quality level of care. This includes bringing the additional beds on line at the appropriate time as we evolve our services and practices in response to the Affordable Care Act and broader healthcare trends within the Commonwealth of Kentucky.

We appreciate the Cabinet's inquiry and are pleased to provide this detailed update to the Office of Health Policy. The Ridge feels strongly that the awarded CON for 24 additional beds will be fully implemented if the barriers to the care continuum are addressed.

Please contact me for any further information or clarification and I thank you for your consideration of retention of our CON.

Sincerely,


Nina W. Eisner

Chief Executive Officer
The Ridge Behavioral Health System

SECTION E - PROJECT SCHEDULE

1. Complete the following project schedule by filling in all dates that are applicable to the project.

- A. Land (site) acquisition Complete
- B. Plans and specifications completed 6 Months from IMD Approval
- C. Plans and specifications submitted to the:
 - (1) Fire Marshall 8 Months from IMD Approval
 - (2) Office of Inspector General 8 Months from IMD Approval
- D. Funding/financing secured Owner Financed
- E. Contracts secured and signed
 - (1) construction 8 Months from IMD Approval
 - (2) equipment 9 Months from IMD Approval
- F. Construction Time Frames
 - (1) commencement of construction 11 Months from IMD Approval
 - (2) completion of shelled-in structure 14 Months from IMD Approval
 - (3) completion of construction 18 Months from IMD Approval
- G. Completion and Operation of Project 18 Months from IMD Approval

2. Please sign and date the application.

I hereby declare that, to the best of my knowledge, the information provided in this application is true and accurate.

Nina W. Eisner 10-28-14
(Authorized Signature) (Date)

Nina W. Eisner
(Name - Print)

CEO
(Title)

KENTUCKY HOSPITAL TAC MEETING MINUTES

Health Services Building
275 East Main Street
Frankfort, Kentucky

October 3, 2014

1:00 p.m. EST.

The meeting of the Hospital Technical Advisory Committee (TAC) was called to order by Carl Herde, Chair.

The TAC members in attendance were: Carl Herde, Russ Ranallo (phone), Danny Harris, Michelle Lawless (phone) and Mark Birdwhistell. Ex officio members either in attendance or on the phone were: Tandi Keeling, Kyle White and Nina Eisner. Other provider representatives in attendance or on the phone were: Elaine Younce, Rob Moore, Kevin Riley, Jeff Presser, Tammy Logsdon and Jeff Lily.

Medicaid staff in attendance was: Neville Wise, Charles Douglass, David Dennis, and Barbara McCarter.

Others in attendance were: Scott Simerly, Tara Clark, and Jon Galliers, Myers & Stauffer; Nancy Galvagni and Steve Miller, Kentucky Hospital Association; Candice Bowen, WellCare; Jennifer Ecleberry and Matt Fitzner, Anthem of Kentucky; Prentice Harvey, lobbyist for Norton Healthcare.

Mr. Herde called the meeting to order. The meeting minutes of May 6, 2014 were adopted as written.

DRG REGULATION:

PHASE-IN RECOMMENDATION: Mr. Wise noted that DMS is intending to present the regulation back to the Administrative Regulation Review Subcommittee in November. A handout was distributed entitled Estimated Fiscal Impact under Revised APR-DRG V30 System that included blinded provider-specific detail and compared simulated payments with and without a phase-in period. He noted the last two columns of this handout compared what KHA had proposed to what the proposed system would be and he stated that what DMS is proposing spreads the transition rateably over a two-year phase-in.

Ms. Keeling asked if hospitals could get their own individual information and Mr. Dennis said to email him to get this information. Mr. Herde asked if this information could be provided as an Excel spreadsheet and Mr. Wise agreed to have this done.

Mr. Wise stated that another item that DMS proposes to change is the severity adjustment and the DRG "creep" due to the ICD-10. He noted that ICD-10 is scheduled to be implemented on October 1, 2015 and the first-year period would then be ending September 30, 2016. DMS will not be adjusting for coding until July 1, 2017. DMS would then have a full year of data of ICD-10 before making any adjustments based on a DRG severity change. Ms. Galvagni stated that KHA has a concern about putting an arbitrary percentage number in the regulation until there are studies to back it up and she stated these percentages should come out of the regulation.

Mr. Wise stated that the other percentage in the regulation is the historical change of a 1.5% severity increase. DMS will be looking at just fee-for-service data to get a different historical percentage for what is the normal change seen from year to year. This information will be shared with the TAC before the regulation is filed. Ms. Galvagni requested that the regulation not contain either the historical percentage or severity reduction so that the TAC can discuss how this percentage is calculated and review all data. She also wanted to go on record that KHA disagrees with excluding MCO data from the ongoing rebasing.

Mr. Wise stated that the language of the appeals section in the regulation has been reworded and it will be sent out to the TAC. If there are errors with an individual hospital that does not affect the statewide average rate, the hospital would not be able to appeal their rate.

OUT-OF-STATE HOSPITALS: Mr. Wise stated DMS proposes to leave the language as it is. Ms. Clark noted that the cost coverage for out-of-state hospitals is below the 72% corridor. The TAC requested to see information at a future TAC meeting concerning what types of services go out of state and to compare to what Kentucky gets paid from out-of-state hospitals for like services.

REBASING: Mr. Herde stated that the TAC's preference would be to exclude the language in the regulation that automatically excludes the MCO data, understanding that it has to be rebased. There was discussion regarding that if DMS relies solely on the traditional Medicaid volume and excludes using data from the MCOs that there will be numerous DRG's that will not have enough volume to be statistically relevant. Mr. Wise responded that the intent will be to use national weights. Further discussion pursued regarding as to how DMS has not been able to historically use national weights and that the national weights have been adjusted to the actual claim experience of KY providers. The TAC would like to have further discussion regarding the ramifications of changing to the national weight calculations.

Mr. Wise stated that DMS has encounter data and data that the MCO's are supplementing that includes unaccepted encounters but they do not want to cross mix the data with different reimbursement systems. Mr. Wise stated that the MCOs have more flexibility and do not have to follow state reimbursement; however, he indicated that the MCOs are saying they are going to follow the fee-for-service model.

Mr. Wise stated that the proposed regulation will go to the Administrative Regulation Review Subcommittee in early November and then to Health & Welfare in December with an effective date early January. Ms. Galvagni requested that new rate notices be sent to the hospitals. Ms. Clark indicated they would send out the information before Thanksgiving. Mr. Wise indicated that the SPA had not yet been filed with CMS but would likely be filed at the same time as the regulation moves forward.

NDC'S: Mr. Dennis stated he had met with Samantha McKinley, Pharmacy Director at DMS, and she has agreed to meet with a group of hospital providers to try to get this issue resolved. Mr. Herde asked the TAC members to email him names of people who may like to serve and then he will forward this list to Mr. Dennis.

MCO'S: Ms. Galvagni stated that DMS had filed a State Plan Amendment (SPA) last year with CMS stating that hospitals providing the care would be the ones to determine if a covered member's visit to the emergency room was considered an emergency. Two MCO's are not following the SPA. Mr. Wise noted this is in a "gray area" between it being a coverage provision or a reimbursement provision and he will review this. Mr. Herde asked that this be included on the next TAC meeting agenda.

CREDENTIALING: Ms. Galvagni noted there is inconsistency among MCO's on when a provider is considered credentialed. Ms. Bowen of WellCare stated that because WellCare has to be accredited by NCQA, their interpretation is they cannot make a provider effective in their network until they are credentialed with WellCare. Mr. Wise agreed to investigate and report back to the TAC what is contractually required of the MCOs as to whether in-network payments must be retroactive to the date of application once a provider is credentialed.

Ms. Galvagni asked if MCO's can delegate the credentialing function and Mr. Wise noted that theoretically they can. She also asked about the time frame that must be followed to complete credentialing. Mr. Wise stated that DMS was at 90 days but they are now down to 45 days, although there are exceptions to that. Mr. Herde asked if DMS would ask the MCO's to produce a report to show how the credentialing process is going.

OTHER BUSINESS:

Ms. Eisner spoke about the Behavioral Health Services Organization (BHSO) regulation and the confusion among providers concerning the published rate of \$58.26 for intensive outpatient services (IOP). She noted that IOP's are, by standard, three hours per day four days a week and she asked for clarification on the published rates. Mr. Douglass stated he would look into this.

Ms. Eisner also noted that there are some questions among providers about hospitals being able to provide the expanded services, especially substance abuse services, under their existing licenses. Many are being advised that they must also get a Behavioral Health Service Organization (BHSO), and if a hospital treats co-occurring disorders, they must get an AODE. She suggested a conference call with representatives from the OIG, the Cabinet and the hospital community.

Ms. Eisner asked for further clarification on the BHSO regulation stating that crisis stabilization cannot be delivered on the grounds of a hospital and she made a motion which was accepted by the TAC that hospitals not be prohibited from providing crisis stabilization on campus, given that all the other elements of crisis stabilization requirements are met.

Ms. Eisner asked that Medicaid consider ways to remove the Medicaid Institutions for Mental Diseases (IMD) exclusion for freestanding psychiatric hospitals to be paid for inpatient care delivered to adult Medicaid patients over

21 or under 65 so that the Cabinet can realize their vision of fully integrated care.

Ms. Galvagni asked what role the hospitals can play when open enrollment begins. Mr. Wise stated that a provider letter will be going out concerning this and what hospitals can do to assist.

Mr. Wise stated that Medicare has the Quality Incentive Program that's used in their reimbursement and he asked the TAC if this is something they would be interested in for the future. Ms. Galvagni stated there are issues with the re-admissions program and that a value-based purchasing approach is more supported by the industry if agreed-upon national measures are used and hospitals are involved in developing the program. Ms. Galvagni also noted that the Medicare VBP is budget neutral and not a straight cut as hospitals can earn money back and receive incentives for their scores. Mr. Herde noted that with the populations left in traditional Medicaid that he wasn't sure how much these incentives would apply.

Mr. Dennis stated that 3M will offer a webinar on the APR-DRG grouper for those interested.

Mr. Wise informed the committee that the updated software associated with the implementation of ICD-10 next year will be installed the weekend of October 11, 2014. KHA agreed to send out a notice to its members.

NEXT MEETING DATE: October 30, 2014 at 1:00 p.m.

The meeting was adjourned.

(Minutes were taped and transcribed by Terri Pelosi, Court Reporter, this the 16th day of October, 2014..