AB 66 SUMMARY

Section	Current Language	Proposed Changes	Fiscal and Program Discussion with Crisis Now
Section 1.1.(a)	*The Division shall establish, within each county whose population is 100,000 or more, a center to provide crisis stabilization services that is open to provide such services 24 hours per day, 7 days per week. The center must: (a) Operate in accordance with established administrative protocols, evidenced-based protocols for providing treatment and evidence-based standards for documenting information concerning services rendered and recipients of such services in accordance with best practices for providing crisis stabilization services;*	The Division shall establish, within each county whose population is 100,000 or more, a center to provide crisis stabilization services that is open to provide such services 24 hours per day, 7 days per week. The center must: (a) Operate in accordance with established administrative protocols, evidenced-based protocols for providing treatment and evidence-based standards for documenting information concerning services rendered and recipients of such services in accordance with best practices for providing crisis stabilization services;	1. LCB added the verbiage around counties with population of 100,000 or more. We have received some push back from rural partners regarding the lack of inclusion of their region/county in the bill. Some have expressed a desire/need for their "own" crisis stabilization in their region. Chuck and I have worked hard to explain the reasoning this is isolated to Washoe (and Clark as added by LCB): • Regional emphasis by Board per Statute • Different infrastructure of each county, particularly small counties • Unrealistic expectation – funding impossible and would "kill" the bill 2. Should be a medical model (vs social) (see next section for discussion on licensing) 3. There will need to be clinical staffing with psychiatric and nursing supervision during the triage and stabilization stay. 4. Crisis Now Model is proven successful, best practice and recognized by the State DHHS. 5. Crisis Now: "A fully functioning <u>psychiatric receiving center</u> that can accept both voluntary and involuntary patients with the majority coming from police contact in the streets or emergency department transfers generally will cost between $600-$1,000 a day. That includes the psychiatrist fees, programming, meds and absolutely everything. According to one survey, Crisis Residential Programs (CRPs) can vary greatly in cost from one region of the country to the next, but typical CRPs cost approximately $300 to $450 per day, <u>about 50- 60% of the cost of a psychiatric hospital per day.</u>" 6. Duarte: Again, these are estimates for the one aspect of

			crisis care not currently covered by Medicaid for adults, i.e. psychiatric residential stays. Based on the Crisis Now model bed calculator, there should be no or a very small fiscal note because of avoided costs for hospital and emergency room use. The potential savings for Medicaid inpatient care could readily cover the cost. The Crisis Now business case report indicates there is a savings of more than $2,200 for hospitals for each bed day avoided. That could be converted to Medicaid cost savings. 7. If AB 66 passes, Nevada Medicaid will need to establish coverage and reimbursement policies for stabilization bed days. Under federal regulations, Medicaid policy needs to be statewide and cannot be limited to ear-marked projects. AB 66, if passed, will require the state to establish these policies that will include provider qualifications, service definitions and payment rates. 8. Given the fact that the vast majority of Medicaid services are funded by the MCOs, DHHS could potentially reduce their capitation rates for the program. The MCOs would still profit. Right now two of the MCOs are reporting Medical Loss Ratios of 80% and 85% respectively. DHHS and the State Medicaid (DHCFP) actuaries should be hammering them to get an MLR closer to 88%. It is possible we could actually get the MCOs to fund this in the urban counties. We are encouraging the State to consider/view this as an overall savings to the Department.
Section 1.1.(b)	*Make available not more than eight beds for a stay of not more than 14 days;*	In recent discussions with the State, several options have emerged and in particular, we need to amend some of the following: • Increase bed size to 16 beds maximum; • Delete language about length of stay no more than 14 days;	1. State asked if crisis stabilization facilities as proposed in AB66 are residential or hospital. What about the concept of "No Wrong Door?" AB66 will propose to license as a hospital (hence the bed number) but act culturally as a stabilization facility. Crisis Now: Should be a short-stay hospital and is reimbursed as such. While the look and culture may be residential, and staff teams include peer supporters, they

		• Describing it as a short stay psychiatric hospital. DHHS staff is suggesting legislation may not be needed if we can get these facilities licensed under the current hospital licensing statutes.	are a hospital focused on a low ALOS and maintaining a high census to maximize the efficiency of staffing a 16 bed unit. 2. There are TWO components to a true "no-wrong door" crisis stabilization facility. • The entry point is a 23-Hour observation unit. There are a lot of ways that this unit can be licensed. They can be licensed as a hospital, as residential, and/or licensed as O/P. How they are licensed is really dependent on state law around the ability to order seclusion and restraint and ability to take involuntary patients. Think of this level of care as a "Psychiatric Emergency Department". The payment structure can be as simple as Fee for service (Psych eval, Crisis Stabilization Codes, Psychosocial Assessment, meds, groups, etc…..) or more complex via cost reimbursement by the local mental health authority with offsets by billing everything that can be billed and that coming back to the authority. – 70% of those seen should be discharged within 24 hours. • The second component is a 16-bed "short-Term Hospital" that is on the same campus but under a different license. In order to avoid the IMD exclusion rule, the CSF must be distinctly separate from any psychiatric hospital. For example, it cannot be on the same campus, share administrative, pharmacy or food services with a licensed psychiatric hospital. Governance must also be separate. There is an IMD exclusion test that must be met for the CSF. In Nevada, we would recommend a hospital license. These components can handle ANYONE that a traditional Psych Hospital can handle. They are working almost

			exclusively with the patients that are not discharge ready in the 23-hour observation unit before their time is up. The day rate is the same as a Hospital but the length of stay is shorter. This means the cost "per episode of care" is much less. Reimbursement is the key issue here. Traditional inpatient programs are paid by "heads in beds". They are incentivized to keep people as long as they can. A very real sustainable strategy for these programs is to pay for CAPACITY. The local authority pays a set price per month for all 16 beds (to keep non-IMD). The facility bills everything they can and that goes back to the authority. In this model, there is not extra incentive to keep people longer than they need as there is no financial incentive to do so. In fact, it becomes easier to create performance clauses around lower average lengths of stay. • These facilities need to have high throughput. If we have a 16 bed facility that has a 7 day length of stay, we can admit 64 people every 28 days. If I have a 16 bed facility that has a 3.5 average length of stay, I can admit 128 people every 28 days. The current model of reimbursement for hospitals supports the longer length of stay models which really cripples the capacity of the system. 3. Duarte: We have also checked with EMS. We will be working with REMSA on any concerns with transportation. In talking with East Fork Fire EMS, they have protocols to transport to Mallory Center in Carson City. We envision the same thing for any Crisis Stabilization Facility; developing collaborative protocols with EMS. According to Chief Fogerson of East Fork Fire, because the CSF is

			licensed as a hospital, EMS can get paid by Medicare for transportation. That is not the case when they drop-off at a non-hospital facility, like a Crisis Triage Center. Finally, as a 16 bed unit, it overcomes the IMD exclusion without the need for a waiver. 4. <u>Definition: IMD Exclusion:</u> Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64. IMDs for persons under age 22 or over age 64 are permitted, at state option, to draw federal Medicaid matching funds.
Section 1.1.(c)(1)-(3)	*Deliver crisis stabilization services:* *(1) In accordance with best practices for the delivery of crisis stabilization services;* *(2) Without regard to the race, ethnicity, gender, socioeconomic status, sexual orientation or place of residence of the recipient or any social conditions that affect the recipient; and* *(3) In a manner that promotes concepts that are integral to recovery for persons with mental illness, including, without limitation, hope, personal empowerment, respect, social connections, self-responsibility and self-determination;*	Deliver crisis stabilization services: (1) In accordance with best practices for the delivery of crisis stabilization services; (2) Without regard to the race, ethnicity, gender, socioeconomic status, sexual orientation or place of residence of the recipient or any social conditions that affect the recipient; and (3) In a manner that promotes concepts that are integral to recovery for persons with mental illness, including, without limitation, hope, personal empowerment, respect, social connections, self-responsibility and self-determination; NO CHANGE	1. What about Medical Clearances? <u>Crisis Now:</u> Crisis stabilization facilities accept all admissions except those requiring acute hospital inpatient or emergency medical care. The admission process follows this general scenario. Law enforcement or EMS drops off a patient. There is no issue with law enforcement drop-offs since they are not transporting anyone in medical/surgical distress. They do work closely with EMS on collaborative protocols to make sure they define which patients need medical/surgical clearance before drop off at Crisis Now facilities. 2. Their first (and last) contact is with a peer supporter. Their second is with a nurse who does a medical evaluation. While the Phoenix model has 24/7 nurse staffing and psychiatric physicians available for at least two shifts, they are not a medical/surgical hospital emergency department. They are more of a psychiatric emergency department. Only about 2% of their 23,000 admissions have to be re-routed to hospital emergency departments because of medical/surgical issues. Once they are medically cleared they are returned to Crisis Now facilities. 3. We have reached out to our EMS/REMSA partners and have received positive feedback regarding collaboration.

Section 1.1.(d)	*Promote the use of consumer-operated services to support recovery for recipients of crisis stabilization services;*	Promote the use of consumer-operated services to support recovery for recipients of crisis stabilization services; NO CHANGE	Peer Support
Section 1.1.(e)	*Use a data management tool to collect and maintain data relating to admissions, discharges, diagnoses and long-term outcomes for recipients of crisis stabilization services; and*	Use a data management tool to collect and maintain data relating to admissions, discharges, diagnoses and long-term outcomes for recipients of crisis stabilization services; and NO CHANGE	
Section 1.1.(f)(1)-(4)	*Employ or enter into a contract with at least two case managers to provide or arrange for the provision of: (1) Comprehensive services to intervene effectively when a behavioral health crisis occurs and address underlying issues that lead to repeated behavioral health crises;* *(2) Services to address basic needs, including, without limitation, housing, food and primary health care;* *(3) Treatment specific to the diagnoses of recipients of services; and* *(4) Aftercare services for persons who have received 39 services at the center.*	Employ or enter into a contract with staff sufficient in number and expertise to provide or arrange for the provision of: (1) Comprehensive services to intervene effectively when a behavioral health crisis occurs and address underlying issues that lead to repeated behavioral health crises; (2) Services to address basic needs, including, without limitation, housing, food and primary health care; (3) Treatment specific to the diagnoses of recipients of services; and (4) Aftercare services for persons who have received services at the center.	The CSF will need staff in number and expertise to stand up a facility of this type.
Section 1.2	*The Division may enter into a contract with an organization that specializes in the provision of*	The Division may enter into a contract with an organization that specializes in the provision of	Ensures our continued participation in the selection of any subrecipient, etc.

	behavioral health services to provide crisis stabilization services described in 1 subsection 1. Before entering into such a contract, the Division must consult with the regional behavioral health policy board created by NRS 433.429 for the region in which the crisis stabilization center is located concerning the scope of the contract.	behavioral health services to provide crisis stabilization services described in 1 subsection 1. Before entering into such a contract, the Division must consult with the regional behavioral health policy board created by NRS 433.429 for the region in which the crisis stabilization center is located concerning the scope of the contract. NO CHANGE	
Section 1.3	*The Division may accept gifts, grants and donations from any source for the purpose of carrying out the provisions of this section.*	The Division may accept gifts, grants and donations from any source for the purpose of carrying out the provisions of this section. NO CHANGE	
Section 1.4 (a)-(b)	*As used in this section :(a) "Consumer-operated services" means peer-run service programs that are owned, administered and operated by persons receiving behavioral health services that emphasize the utilization of self-help by recipients of services.* *(b) "Crisis stabilization services" means behavioral health services designed to:* *(1) De-escalate or stabilize a behavioral crisis or reduce the concerning or disruptive behavior associated with acute symptoms of mental illness or the abuse of alcohol or drugs; and* *(2) Avoid admission of a person to an inpatient mental health facility*	Delete section 1.4 describing it as a consumer run organization;	We may want to replace this section with language that requires DHCFP and its contract manager care organizations, Nevada Exchange plans and those plans under the jurisdiction of the Nevada Insurance Division that offer inpatient psychiatric services to contract with the CSF.

	or hospital.		