

**Rhode Island Global Consumer Choice Compact Waiver  
Project Number 11W-0024242/1**

**Category II Change**

<b>Date of Request:</b>	June 8, 2009
<b>Proposed Implementation Date:</b> <i>(45 day notice required)</i>	July 22, 2009

**Fiscal Impact**

	<b>FFY 2009</b>	<b>FFY 2010</b>
<b>State:</b>	\$45,100	\$180,400
<b>Federal:</b>	\$79,900	\$319,600

**Description of Change:**

Attachment A

**Payment Methodology:**

Attachment B

**Assurances:**

Attachment C

**Attachment A: Description of Change**

This change adds a new service: Behavioral Health Acute Stabilization Unit (BHAS Unit). This service falls under the definition of “Rehabilitative Services” found in Section 1905(a)(13) of the Social Security Act.

**Service Description:**

The Behavioral Health Acute Stabilization unit (BHAS Unit) is a hospital diversion and step down unit for Rhode Island residents 18 years of age or older who are experiencing a psychiatric and/or substance abuse related crisis. This unit will provide on-going assessment and observation; crisis intervention; and psychiatric, substance and co-occurring treatment.

The unit must have access to a minimum of ten (10) beds located in one facility. The maximum capacity that can be located in one facility is sixteen (16) beds.

Individuals Eligible for Medicaid can access this service if they meet the following criteria:

- A. Individuals must be 18 years of age or older and a resident of Rhode Island.
- B. Individuals must have the capacity to safely stay in an unlocked facility.
- C. Individuals must voluntarily agree to be admitted into the unit.
- D. Individuals must be medically stable and receive medical clearance for the transfer by both the referring facility and the BHAS Unit when referred by an emergency room or if being stepped down from an inpatient facility. Disputes regarding medical clearance must be resolved at the physician level.
- E. Referrals will only be accepted through an emergency room, or an inpatient facility.

**Program Description of Services:**

**24 Hour Crisis Services:** All staff will be trained in risk assessment and crisis intervention services. Upon arrival to the program, individuals are to receive a face-to-face initial triage review by a licensed practitioner of the healing arts to assess acuity, risk status, and client level of need for the interim period prior to a full assessment and development of an initial treatment plan.

**Hospital Step Down Services:** The unit must offer step-down services for clients who do not require inpatient hospitalization or detox but who require further stabilization before returning to the community.

**Care Management Services:** Every client on the unit will have an identified care manager. The care manager is responsible for the coordination of care while the client is on the unit and also for insuring that the client has appropriate follow-up appointments upon discharge.

**Psychiatry Services:** The unit must have a psychiatrist available 24/7 to respond to medication orders and any medical concerns. The psychiatrist must also be scheduled to

be on-site at the program for psychiatric assessments and medication reviews as required by the specific client mix at any given time.

Medication Services: An RN is to be on-site 24/7 for the administration and monitoring of medication.

Inpatient Psychiatric and Medical Admissions: The unit will have a staff member meeting the requirements of the Rhode Island Mental Health Law on site 24/7 to facilitate inpatient psychiatric admission from the unit site to an inpatient facility if required. The unit will also have an RN on-site 24/7 to facilitate transfers for medical admissions.

Evidence Based Co-occurring Treatment Services: Services will be offered that are evidenced based for individuals with co-occurring treatment needs. Interventions to treat both disorders are to be listed in the treatment plan and implemented by staff with knowledge, skills, and qualifications to provide both mental health and substance abuse services.

Group and Individual Counseling: All individuals have access to participate in group and/or individual counseling as indicated by their treatment needs and treatment plan.

Discharge Planning: All individuals will have a discharge plan, which shall be started within 24-hours after admission.

- A. Follow-up appointments are not to exceed 48 hours for the first appointment and 14 days for a follow-up medication appointment.
- B. Individuals are not to simply be given phone numbers to contact as follow-up.
- C. Individuals referred to homeless shelters will have scheduled follow up appointments with providers and will also make attempts to have releases signed so that coordination of care between the unit and the homeless shelter can occur.
- D. Transportation issues are to be resolved and documented in the individual's record describing how the individual will attend the first appointment. (i.e. family member, self, public transit, staff to transport etc).
- E. All discharge plans will be documented and approved by a licensed practitioner of the healing arts.

Family Psycho education and Supportive Services: Services are available to family members to be involved in treatment planning and discharge meetings. Education, information, and support is to be provided to family members.

Proposed Length of Stay: Length of stay will be individualized based on each individual's service needs. A typical stay for diversion programs of this nature is 3-7 days and exceeds 14 days only on rare occasions.

**Qualified Providers:**

The BHAS Unit may be operated by a single Community Mental Health Organization (CMHO) or as a joint venture, which may include a hospital, provided that overall program governance, oversight, and day-to-day management and control is the responsibility of a single CMHO.

The program must be staffed 24/7. This includes on-site coverage at all times by nurses, counselors, and care managers, as well as access to a psychiatrist available to respond within 30 minutes.

The program is also to have on-site scheduled psychiatry time as required by the client mix at any given time.

Clinical supervisors of residential staff shall have, at a minimum:

Bachelor's Degree in a relevant human service field and have a minimum of three (3) years full time experience providing behavioral health services to the population served;

Or the following qualifications with education, license, and experience relevant to the service they are supervising:

Licensed Independent Practitioner; or

Licensed Chemical Dependency Clinical Supervisor; or

Licensed Chemical Dependency Professional who has completed a Department approved course in clinical supervision; or

Clinician with relevant Master's Degree and license and, at least, two (2) years full time experience providing relevant behavioral health services; or

Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

Each professionally licensed staff person employed by an organization shall have a current license to practice in Rhode Island.

All staff providing direct services who are not licensed independent practitioners shall receive clinical supervision on an ongoing basis.

**Attachment B: Payment Methodology**

**Reimbursement:**

The BHAS Unit fee is a per diem fee structured to capture all of the staff costs associated with delivering the specialized, intensive services required of the unit once the client arrives on site. BHAS Unit reimbursement can be claimed for the day of admission but not for the day of discharge.

**Proposed Fee Derivation**

10-Bed Acute Alternative/Step-Down Unit

<b>Unit Line Staff</b>	<b>Shift</b>	<b>Hrs/wk</b>	<b>FTE</b>	
RN	Day	32	0.8	
RN	Day	32	0.8	
RN	Evenings	32	0.8	
RN	Evenings	20	0.5	
RN	Nights	32	0.8	
RN	Nights	32	0.8	
RN	Floater	32	0.8	
	<b>RN Total</b>		<b>5.3</b>	<b>\$358,187</b>
Counselor	Day	40	1	
Counselor	Day	40	1	
Counselor	Evenings	32	0.8	
Counselor	Nights	40	1	
	<b>Counselor Total</b>		<b>3.8</b>	<b>\$203,260</b>
Care Manager	Day	36	0.9	
Care Manager	Day	36	0.9	
Care Manager	Evenings	20	0.5	
Care Manager	Evenings	36	0.9	
Care Manager	Nights	36	0.9	
	<b>Care Manager Total</b>		<b>4.1</b>	<b>\$159,498</b>
				<b>Total Line Staff</b>
				<b>\$720,944</b>

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<b>Unit Management Staff</b>	<b>Hours/Week</b>	<b>Rate</b>	
Unit Manager (Flat Rate)			\$23,400
Program Manager (\$30/hour)	10	30	\$15,600
Nurse Manager	10	40	\$20,800
			<b>Total Management Staff</b>
			<b>\$59,800</b>

<b>Prescribers</b>	<b>Hours/Week</b>	<b>Rate</b>	
Multiple Contracted Licensed Providers	12	75	\$46,800
			<b>Total Prescriber</b>
			<b>\$46,800</b>

<b>On Call</b>	<b>Rate</b>	
Administrator	Flat Rate	\$5,200
Physician	\$40 per night	\$14,600
		<b>Prescriber Total</b>
		<b>\$19,800.00</b>

<b>Line Staff Vacation Coverage</b>	<b>Hours/Week</b>	<b>Rate</b>	<b>Avg. Weeks</b>	
RN	212	44	2.50	\$23,320
Counselor & Care Mgr.	316	25	2.00	\$15,800
				<b>Vacation Coverage Total</b>
				<b>\$39,120.00</b>
				<b>Total All Personnel</b>
				<b>886,464.29</b>

<b>Admin and Operating</b>	<b>% of Direct Care Staff</b>	<b>Total DC Staff (line staff + prescribers + on-call physician + Vaca Coverage)</b>	
DMHRH standard	58.20%	\$821,464	\$478,092
			<b>Total Admin and Operating</b>
			<b>478,092.22</b>

			<b>Total All Cost</b>	<b>1,364,556.51</b>
<b>Per Diem Cost of</b>	<b>10</b>	<b>beds at</b>	<b>95.0% occupancy</b>	<b>\$393.53</b>

**Attachment C: Assurances**

**The State assures the following:**

- **This change is consistent with the protections to health and welfare as appropriate to title XIX of the Social Security Act (the Act)**  
The addition of this service will decrease inpatient psychiatric hospitalizations and will increase access to appropriate services.
- **The change results in appropriate efficient and effective operation of the program.**  
Responses to funding questions are found in Attachment D.
- **This change would be permissible as a State Plan amendment and is otherwise consistent with sections 1902, 1903, 1905, and 1906, current Federal regulations, and CMS policy.**

**Attachment D: Standard Funding Questions**

1. Section 1903(a)(I) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

**Response: Providers receive and retain the total Medicaid expenditures claimed by the State. No portion of the payments is returned to the State, local governmental entity, or any other intermediary organization**

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation were not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
  - (i) a complete list of the names of entities transferring or certifying funds;
  - (ii) the operational nature of the entity (state, county, city, other);
  - (iii) the total amounts transferred or certified by each entity;
  - (iv) clarify whether the certifying or transferring entity has general taxing authority: and,

- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations)

**Response: The State share of reimbursement for the BHAS unit comes directly from General Revenue appropriations to the State Medicaid agency.**

- 3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

**Response: No supplemental or enhanced payments are made for BHAS unit services.**

- 4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

**Response: This Waiver Change does not address clinic or outpatient hospital services.**

- 5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

**Response: No governmental providers are eligible to provide this service.**