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Department of Health and Human Services

Crisis Stabilization Center Kick-off

Division of Health Care Financing and Policy

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11/30/2021

Helping people. It's who we are and what we do.

Agenda

1. Introduction
2. Overview
3. Scope of Service
4. Primary Objective
5. Requirements
6. Provider Responsibilities
7. Admission Criteria
8. Reimbursement
9. Discussion

Timeline

AB 66/SB 156 legislation requires the Department of Health and Human Services (DHHS) to ensure that crisis stabilization services provided at hospitals with a crisis stabilization center endorsement are covered and reimbursable services under Medicaid.

The goal of this legislation is to add a place to go as a critical element of the crisis continuum of care to support an array of crisis services critical in caring for individuals experiencing a behavioral health crisis.

	Complete by	
☐		This legislation is effective 7/1/2021
☐	11/19/2021	Project Kick-Off with all units, Gainwell, and representative from MCOs Friday - 11/19/21 10-11:30 a.m.: • Presentation of Rates and Medicaid Services Manual (MSM) Policy • Request feedback regarding system impact • Request feedback regarding MCO impact • Request feedback regarding other policy impact
☐	11/22/2021	Send Tribal Notification Letter (TNL)
☐	11/29/2021	Public Workshop Agenda and Presentation to Doc Control for posting
☐	12/13/2021	Public Workshop to engage public feedback Monday - 12/13/21 9a.m. -11a.m.: • Presentation of Rates and MSM Policy • Engage public and prospective provider feedback
☐	12/29/2021	Present to DHCFP Leadership for approval • Present State Plan Amendment (SPA) for Rates • Present MSM Ch. 400 Policy
☐	1/07/2022	Provide all documents for SPA and MSM to Document Control • SPA Documents o SPA Agenda o CMS 179 o CMS FAQ o TNL o SPA pages with edits remediated • MSM Documents o MSM Agenda o Medicaid Transmittal Letter (MTL) o MSM policy edits remediated o TNL
☐	2/22/2022	Public Hearing • Present proposed SPA for approval to submit to CMS • Present proposed MSM for approval • Possible February 23, 2022 effective date for SPA
☐		MMIS System Update • Develop new Provider Specialty under PT 12 • Establish codes for billing under PT 12 (S9484 per hour/S9485 per diem) • Set service limitation on codes? • Establish rate for codes • Allow for Acute inpatient admission or discharge on the same date of service as Crisis Stabilization
☐		Forms • Develop Billing Guide • Develop Enrollment Checklist • Post authorization form? • Develop Fee Schedule

Overview

- New policy language, with addition of a new Section, 403.6I, being added within Chapter 400 – Mental Health and Alcohol/Substance Abuse Services for Crisis Stabilization Centers (CSCs) per legislation, AB 66 later amended in SB 156.
  - This legislation authorizes DPBH/HCQC to issue an endorsement to a licensed hospital to provide services as a crisis stabilization center.
- Crisis stabilization services is defined as behavioral health services designed to:
  - (1) de-escalate or stabilize a behavioral crisis; and
  - (2) avoid admission of a patient to another inpatient mental health facility or hospital. (NRS 449.0915).
- Existing law requires an applicant for renewal of an endorsement as a crisis stabilization center to be accredited by certain organizations. Rural hospitals are exempt from the accreditation requirement.
- Existing law also requires managed care organizations that provide health care services to recipients of Medicaid or enrollees in the Children's Health Insurance Program to negotiate in good faith to include a hospital that holds an endorsement as a CSC in the network of providers under contract to provide services to such persons.
- New policy documentation includes scope of services for CSCs, their primary objective, requirements, best practices, provider responsibilities, and admission criteria.
- CSCs best outcomes will be for patients getting better immediate care and a more positive behavioral health crisis response with the overall intent to try to avoid inpatient hospitalization if stabilization can be achieved in 23 hours and 59 minutes.

CSC Scope of Service

- Crisis stabilization is an unplanned, expedited service for an individual to address an urgent condition that requires immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services, which, if the condition and symptoms are not treated, present an imminent threat to the recipient or others, or substantially increases the risk of the recipient becoming gravely disabled.
- CSCs are considered an emergency healthcare alternative, providing persons with an acute behavioral health problem (including co-occurring disorders) with prompt action, gentle response, and effective support in a respectful environment. They are part of a continuum of crisis services designed to stabilize and improve symptoms of distress.
- CSCs are a no-wrong-door access. They are a short-term, subacute care for recipients which support an individual's stabilization and return to active participation in the community.
- Key elements include a welcoming and accepting environment, which conveys hope, empowerment, choice, and higher purpose. This model is traditionally meant to last 24 hours or less.
    - If recipients cannot be stabilized in this period, the next step would be to refer them to an appropriate level of care at an inpatient facility. Recipients who can be stabilized in a crisis stabilization center are anticipated to be discharged to a lower level of care.

CSC Primary Objective

- CSCs are to promptly conduct a comprehensive assessment of the individual and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that can be managed at a lower level of care.
  - Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated.
  - As mentioned on a previous slide, crisis stabilization services means behavioral health services designed to:
    - De-escalate or stabilize a behavioral health crisis, whether this is occuring concurrently with a substance use disorder or not; and
    - When appropriate, avoid admission of a patient to another inpatient mental health facility or hospital and connect the patient with providers of ongoing care as appropriate for the unique needs of the patient.

CSC Requirements

- CSC's must operate in accordance with established administrative protocols, evidenced-based protocols for providing treatment and evidence-based standards for documenting information concerning services rendered to recipients of such services in accordance with best practices for providing crisis stabilization services.
- Has a policy structure in place that establishes, including but not limited to:
  - Procedures to ensure that a mental health professional is on-site twenty-four hours a day, seven days a week;
  - Procedures to ensure that a licensed physician, physician assistant, or psychiatric Advanced Practice Registered Nurse (APRN) is available for consultation to direct care staff twenty-four hours a day, seven days a week;
  - Procedures to ensure RNs, LPNs, social workers, community health workers, and peer support specialists (as defined per Chapter 449 of the Nevada Revised Statutes) are available to adequately meet the needs of recipients;
  - Procedures to assure that restraint and seclusion are utilized only to the extent necessary to ensure the safety of patients and others;
  - Delivers crisis stabilization services:
    - To all persons who come in the door, whether as walk-ins or drop-offs from law enforcement or a mobile crisis team.
  - Uses a data management tool to collect and maintain data relating to admissions, discharges, diagnoses and long-term outcomes for recipients of crisis stabilization services.

CSC Requirements Con't…

- Operating in accordance with best practices for the delivery of crisis stabilization services, CSCs must include:
  - Recovery Orientation
    - In a manner that promotes concepts that are integral to recovery for persons with behavioral health issues, including, without limitation, hope, personal empowerment, respect, social connections, self-responsibility and self-determination
  - Trauma-informed care
    - Many individuals experiencing a behavioral health crisis or substance use disorder have experienced some sort of trauma in the past
  - Significant use of peer staff
    - People with lived experience who have something in common with the recipients needing help
  - Commitment to Zero Suicide/Suicide Safer Care Principles
  - Strong commitments to safety for consumers/staff
  - Collaboration with Law Enforcement

CSC Provider Responsibilities

- For endorsement renewals, which are done when the hospital licensure is due for renewal, hospitals must submit:
  - Proof that the applicant meets the requirements per NRS 449.0915;
  - Proof that the hospital is a rural hospital or is accredited by the Commission on Accreditation of Rehabilitation Facilities, the Center for Improvement in Healthcare Quality, DNV GL Healthcare, the Accreditation Commission for Health Care, or the Joint Commission, or their successor organizations;
- A medical record shall be maintained for each recipient and shall contain the following items in addition to requirements listed in 403.9B(2):
  - An assessment for substance use disorder and co-occurring mental health and substance abuse disorder including a statement of the circumstances under which the person was brought to the unit and the admission date and time;
  - An evaluation performed by a mental health professional to include at a minimum:
    - Mental status examination; and
    - Assessment of risk of harm to self, others, or property
  - Review of the person's current crisis plan
  - The admission diagnosis and what information the determination was based upon
  - Coordination with the person's current treatment provider, if applicable
  - A plan for discharge, including a plan for follow up that includes:
    - The name, address, and telephone number of the provider of follow-up services; and
    - The follow up appointment date and time, if known

CSC Provider Responsibilities Con't…

- The clinical record must contain a crisis stabilization plan developed collaboratively with the recipient and/or guardian that includes:
  - Strategies and interventions to resolve the crisis in the least restrictive manner possible;
  - Language that is understandable to the recipient and members of the recipient's support system; and
  - Measurable goals for progress toward resolving the crisis and returning to an optimal level of functioning
- If antipsychotic medications are administered, the clinical record must document:
  - The physician's attempt to obtain informed consent for antipsychotic medication; and
  - The reasons why any antipsychotic medication is administered over the recipient's objection or lack of consent

CSC Admission Criteria

- Accepts all patients, without regard to:
  - Race, ethnicity, gender, socioeconomic status, sexual orientation or place of residence of the patient;
  - Any social conditions that affect the patient;
  - The ability of the patient to pay; or
  - Whether the patient is admitted voluntarily to the hospital pursuant to NRS 433A.140 or admitted to the hospital under an emergency admission pursuant to NRS 433A.150;
  - Performs an initial assessment on any patient who presents at the hospital, regardless of the severity of the behavioral health issues that the patient is experiencing:
    - All beneficiaries receiving Crisis Stabilization shall receive an assessment of their physical and mental health. Assessment and stabilization services will be provided by the appropriate staff. If outside services are needed, a referral that corresponds with the recipient's need shall be made.
    - Has the equipment and personnel necessary to conduct a medical examination of a patient pursuant to NRS 433A.165;
      - Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital.
      - Medical backup means immediate access within reasonable proximity to health care for medical emergencies.
    - Considers whether each patient would be better served by another facility and transfer a patient to another facility when appropriate.

CSC Admission Criteria Con't…

- Crisis stabilization services that may be provided include but are not limited to:
  - Case management services, including, without limitation, such services to assist patients to obtain housing, food, primary health care and other basic needs;
  - Services to intervene effectively when a behavioral health crisis occurs and address underlying issues that lead to repeated behavioral health crises;
  - Treatment specific to the diagnosis of a patient; and
  - Coordination of aftercare for patients, including, without limitation, at least one follow-up contact with a patient not later than 72 hours after the patient is discharged.

Reimbursement

- Crisis stabilization models are expected to vary widely dependent on the geographic location within the state
- Because of this we want to ensure providers can cover the costs associated with providing these services
- We will pursue a model that includes:
  - A default rate of $563 per day
  - The ability to submit a cost report after providing services for one full fiscal year (based upon the providers individual fiscal year)

Reimbursement (continued)

- Default rate was based upon the estimated costs of staffing and providing services.
- Cost Report approach will be made available to providers who have provided a full individual fiscal year of services
  - The cost report used will be based upon the CCBHC cost report which allows for expenses to be documented on a more granular level
    - This allows better insight to what costs are allowed
    - The average cost to have cost reports audited and a rate calculated is approximately $10,000
      - Providers will be required to split the cost with DHCFP to perform this audit and calculate the rate

Discussion Items

- What should be the maximum time-frame that a CSC could bill for the all-inclusive rate?
- Is a PT 12 with a subspecialty a good idea for how to have CSCs enroll under, if not what are other potential options for enrollment?
- How do we handle capacity issues with providers where CSC clients may be discharged to?
  - If there is nowhere to send them after the maximum timeframe is reached, how do we ensure clients are receiving the care required?
- What kind of proposed system updates do we need?

Questions?

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