Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Regulatory Analysis: Licensing of Behavioral Healthcare Organizations

Introduction

The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (Department) proposes to amend the existing Rules and Regulations for the Licensing of Behavioral Healthcare Organizations (ERLID 7819) to be consistent with updated statutory requirements in R.I. Gen. Laws Chapter 40.1. Pursuant to R.I. Gen. Laws § 42-35-2.9, the below regulatory analysis examines several proposed regulatory changes.

Pursuant to the Administrative Procedures Act (APA), R.I. Gen. Laws § 42-35-2.9, the Department has conducted a regulatory analysis for the proposed regulation. The Department used the best available information at the time of publication to estimate the benefits and costs of the proposed regulatory provisions. The following analysis examines the costs and benefits of the discretionary decisions made by the Department.

Background

The Behavioral Healthcare Organization (BHO) Regulations were last revised in August 2004, and amended on ten (10) occasions since then. It became clear over time that the regulations were no longer meeting the needs of the changing regulatory climate due to changing federal standards and priorities through the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) requirements for federal funding, which supports all Department behavioral healthcare programs. Additionally, the stakeholder community's continued growth in recognizing, embracing and implementing person-centered practices required that the regulations reflected that progress.

Lastly, the Governor's initiative to reduce the regulatory footprint by fifteen percent (15%) was very timely. In reviewing these regulations, it was clear that there were redundancies, areas in which the regulations exceeded its mandate and areas in which the stated regulations could be better addressed in more appropriate formats, such as policies and standards. The project to rewrite the BHO Regulations was, therefore, established to improve the regulations, make them

more accessible and to ensure that they are reflective of industry standards and actual required practice.

Regulatory Development

Prior to beginning the process of revising the regulations, the stakeholders were clear that they desired to have full involvement in the process. In that spirit, the Department invited key stakeholders to participate in the revision process. The stakeholder groups included: representatives from participant groups; advocates; providers; and representative organizations; BHDDH staff; and, other interested parties. A plenary group was formed and met regularly to review progress. Workgroups, that met regularly and as frequently as bi-weekly initially, were organized to develop identified sections of the regulations. In approaching the revision, the teams focused on person-centered concepts, principles and language. In considering what constitutes "regulation," the teams regularly asked the following questions before committing the rule to the regulatory document:

- is it regulatory in nature;
- does it meet the standard of requiring the "force and effect of law;" and
- is it within the mandate of these regulations?

Their revisions were presented to the plenary group for comment. The completed drafts were reviewed by the Department's legal team.

Main Changes to Status Quo

While specific changes are analyzed in the section titled "Benefit-Cost Analysis by Provision," overall the proposed changes cover three (3) areas.

First, the most significant change to the regulations is that they have been modernized to conform with current practice, industry standards and best practice in the delivery of behavioral healthcare services. Person-centered, community-based themes and language were addressed throughout the document. Safety of consumers and staff was also a major focus.

The second significant focus is on clearly defining the types of services associated with the levels of care provided by licensed behavioral health organizations and ensuring alignment with best practice standards established by nationally recognized bodies.

The final significant changes were to remove redundancies and language that is non-regulatory in nature. The teams worked to ensure that rules were only stated once in the document, either in the licensing section of the regulations or in the BHO Regulations if the content was specific to behavioral health. Policy statements were removed from the document to be addressed by the appropriate oversight authority. For example, language in the regulations governing the Department was removed to be addressed under the Department's internal policies as regulations

are not intended for agencies to regulate themselves. Similarly, all language in the regulations that exceeds the Department's regulatory mandate was removed. The changes are documented and references are made on how those changes are addressed to maintain appropriate safeguards for the population served by these regulations.

Key Alternatives Considered

Pursuant to the APA, R.I. Gen. Laws § 42-35-2.9(b)(1), the regulatory analysis must include:

- Analysis of the benefits and costs of a reasonable range of regulatory alternatives; and
- Demonstration that there is no alternative approach among the alternatives considered during the rulemaking proceeding which would be as effective and less burdensome to affected private persons as another regulation.

During the regulatory revision process described above, the Department and stakeholders considered a number of options that would meet the goals for updating the regulations to meet the current required standards, practices and federal requirements. It was vitally important that the final regulations would be "person-centered" and that remained a guiding force throughout the process. There are currently thirty (30) licensed providers and forty-eight (48) residential service licenses that are impacted by the changes being proposed in the regulations. Each provider has at least two (2) licenses that include an agency license and at least one (1) service license. There is a range in licenses held by providers from two (2) to thirty (30) depending upon the number of services for which the provider is licensed.

More information about alternatives to specific provisions can be found in the section titled "Benefit-Cost Analysis by Provision."

Determination

The Department has determined through its internal work, the stakeholder process, and this analysis that the benefits of the proposed BHO Regulations justify the costs, and that the proposed rule has greater net benefits than other regulatory alternatives.

Benefit-Cost Analysis by Provision

This section of the analysis looks at individual proposed changes in more detail, and discusses the benefit and costs of each change. These changes are grouped into four (4) main categories:

- Program Requirements;
- Staffing and Supervision;

- Process and Planning; and
- Medication.

As noted earlier, the current BHO Regulations are being repealed and replaced with a new version. This analysis looks at the status quo for providers and participants and analyzes how this new regulation will change their experience.

At the end of this section there is also a list of additional changes that were considered de minimis for the purposes of the benefit-cost analysis.

Program Requirements

Overview of proposed change:

Proposed regulation brings RI Assertive Community Treatment (RIACT) program eligibility criteria, staffing ratios, qualifications and hours of operation in line with current practice.	*Citation in previous regulation:* 35
	Citation in new regulation: 1.6.11(B)
	Was this change discretionary? Yes

Costs of proposed change:

No marginal economic impact.

Benefits of proposed change:

No marginal economic impact.

Rationale for proposed change:

Updates the program to reflect current practice.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Regulations do not reflect actual status quo.

Overview of proposed change:

The proposed regulations changes some of the nomenclature regarding Mental Health Psychiatric Rehabilitative Residences (MHPRR) referenced in system of care section. What was formerly one (1) category now has four (4) types of services: Basic, Specialized Supervised Apartments and On-Site Supported. Each type has a different service delivery and acuity.	*Citation in previous regulation:* 38.4
	Citation in new regulation: 1.6.12(B)
	Was this change discretionary? Yes

Costs of proposed change:

No marginal economic impact. Amended language describes categories of services that are already in place.

Benefits of proposed change:

No marginal economic impact. Amended language describes categories of services that are already in place.

Rationale for proposed change:

Updates the program to reflect current practice.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Regulations do not reflect actual status quo.

Staffing and Supervision

Overview of proposed change:

The proposed regulation adds required staffing ratios for substance use residential treatment programs: • One (1) direct care staff to eight (8) residents during the day, and • One (1) direct care staff to twenty (20) residents at night.	*Citation in previous regulation:* 12.8
	Citation in new regulation: 1.6.12(F)
	Was this change discretionary? Yes

Costs of proposed change:

This requirement is expected to mostly fall on the four (4) largest substance use disorder treatment agencies in the state. This analysis looks at each agency, the number of patients each agency has, an estimate of the current staff at each provider, and the staff that would be required under the new ratios. The marginal change between the new staffing and the new required staffing is estimated to be 36.6 Full Time Equivilents (FTEs). The cost of this requirement is quantified below:

Cost to Providers for Additional Staff	
Hourly Wage per Direct Care Worker*	$13.50
Total Increase in FTEs Required Across All Agencies**	36.6
Annual Hours Per New FTE	1,900
Total Provider Cost	*$938,790*

* Source: BHDDH Provider HR Database
** Source: BHDDH Provider Capacity Database

It should be noted that agencies can ask for variances from these staffing requirements, so this estimate is an upper-bound cost.

Benefits of proposed change:

The main benefit from these required staffing ratios is increased client safety, through the prevention of deaths and injuries in residential treatment programs. For example, in 2017 a RI facility experienced a potentially preventable suicide consistent with national trends that indicate there is a significantly greater incidence of suicide among individuals struggling with substance use disorders.

One benefit from these higher staffing ratios would be a decreased risk of a preventable suicide which is quantified below. This quantified benefit is intended to be illustrative and is not comprehensive of the benefits of this policy.

Reduction in Suicide in SUD Residential Population Due to Staffing Ratios						
CY 2017 SUD residential admissions*	**RI suicide rate****	**Odds ratio SUD and suicide death*****	**Average annual suicide death in SUD residential population**	**Value of a statistical life**	**Assumed decrease in suicide rate**	**Savings due to reduction in ER visits**
2,350	11.24 per 100,000	1.49	0.39	$9.1M	5%	$179,074
					10%	$358,147

* BHDDH Database Census and Admissions/BH/SUD:2017
** Rhode Island Department of Health, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4499285/, https://store.samhsa.gov/shin/content/SMA16-4935/SMA16-4935.pdf
*** *Substance use disorder and risk of suicidal ideation, suicide attempt and suicide death: a meta-analysis*, https://www.ncbi.nlm.nih.gov/pubmed/26503486

Rationale for proposed change:

The staffing ratios are derived from industry best practice and will ensure consistent staffing by providers in order to promote safety.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Treatment programs are not applying standards consistently.

Overview of proposed change:

The proposed regulation codifies staff to client ratios for Mental Health Psychiatric Rehabilitative Residences (MHPRR). Staffing can be based on the acuity of residents in the household. Preference is for one (1) direct care staff to eight (8) residents during periods when residents are awake (1:8). The Department reserves the right to require the BHO to have increased staffing levels based upon health and safety needs.	*Citation in previous regulation:* N/A
	Citation in new regulation: 1.6.12(B)
	Was this change discretionary? Yes

Costs of proposed change:

All of Rhode Island's licensed MHPRRs have sixteen (16) or fewer beds, therefore, none would need to increase staff to meet the minimal staff to client ratios described above. In current practice, the facilities have, at minimum, one (1) staff on at night and typically have two (2) staff during the day (if more than eight (8) clients are in residence); therefore, there are no marginal costs.

Benefits of proposed change:

The main benefit of appropriate staffing is increased client safety. Because staffing is not expected to change under this revised regulation, there is no marginal benefit to client.

Rationale for proposed change:

Current MHPRR staffing, while adequate, is not codified in current regulation. This proposed amendment will set a guideline while also allowing the Department the flexibility to tailor staffing requirements to the needs of clients. While the proposed regulations allow for negotiations for health and safety needs, the requirement is not prescriptive and is consistent with current practice that requires all facilities to have individualized treatment plans that take health and safety into consideration. This requirement further ensures that any future licensed facility greater than sixteen (16) beds would be required to meet these minimum requirements.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Does not set any standards to staffing at MHPRR, which creates risks that staffing could fall below adequate levels.

Overview of proposed change:

The proposed regulation adds staffing requirements for Integrated Health Homes (IHH). These staffing requirements, per 200 clients, are for the following positions: • Master's Level Program Director (1 FTE) • Registered Nurse (2) • Hospital Liaison (1) • CPST Specialist (5) • Peer Specialist (1) Providers can request variances from these requirements.	*Citation in previous regulation:* N/A *Citation in new regulation:* 1.6.11(A)(3) *Was this change discretionary?* Yes

Costs of proposed change:

Currently, IHHs are staffed with these positions, and this staffing model is built into IHH Medicaid reimbursement rates. Codifying these requirements in regulation will have no marginal economic impact.

Benefits of proposed change:

Because IHHs are already complying with this requirement, there is no marginal economic impact.

Rationale for proposed change:

This proposed change will codify existing practice and make clear the requirements that IHHs must follow.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Would not meet the goal of ensuring regulatory requirements are properly included in regulation.

Overview of proposed change:

The current regulation stated that programs may conform to American Society of Addiction Medicine (ASAM) standards regarding levels of care. The proposed regulation requires conformity.	*Citation in previous regulation:* N/A
	Citation in new regulation: 1.6.12(F)
	Was this change discretionary? Yes

Costs of proposed change:

No marginal economic impact. Providers are generally complying with these standards currently.

Benefits of proposed change:

No marginal economic impact. Providers are generally complying with these standards currently.

Rationale for proposed change:

This change is intended to ensure compliance with industry best practice.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Would not bring RI facilities in line with industry best practice.

Overview of proposed change:

Changes language governing how managers must supervise both licensed and non-licensed staff. The current regulation requires four (4) hours per month (one (1) individual, three (3) group) for licensed staff. The current regulation requires four (4) hours per month (two (2) individual, two (2) group) for unlicensed staff. The proposed changes amends this to require supervision that is "regular and predictable schedule on a monthly basis."	*Citation in previous regulation:* 9 *Citation in new regulation:* 1.6.B *Was this change discretionary?* Yes

Costs of proposed change:

There is a potential for reduced quality of care as supervising clinicians spend less time reviewing and monitoring those employees under their supervision. The amended regulation still allows for greater levels of supervision if warranted, and it is expected that supervisors will tailor the amount of supervision to maintain quality of care.

Benefits of proposed change:

The Department estimates that supervisors at BHOs will, given this new flexibility, halve the number of hours per month spent in one-on-one supervising meetings. To not double count the time for multiple employees involved in group supervision, this analysis only assumes a decrease in supervision of one hour per month per employee. To simplify the analysis, this one (1) hour per month is assumed to be a reduction in one-on-one supervision, which means that both the supervisor and the supervisee (direct care staff) will experience a time savings. The value of this time saved is quantified below:

Benefit to Direct Care Staff of Reduced Mandatory Supervision	
Total Employees of Direct Care at BHOs*	2,472
Marginal Decrease in Monthly Supervision Per Employee	1
Total Annual Reduction in Supervising Hours	29,664
Hourly Wage of Direct Care Staff*	$21.04
Hourly Wage of Supervising Clinician*	$33.36
Direct Care Staff Time Savings	*$624,130*
Clinical Supervisor Time Savings	*$989,591*
Total Provider Savings	*$1,613,722*

*Source BHDDH Database, Provider HR: 2017-2018

Rationale for proposed change:

This proposed change increases flexibility, allows more time for clinicians to see clients, and eliminates a prescriptive requirement that was placing limits on the expansion of the BH workforce.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Reduce the number of hours but still prescribe them.	Given the varying needs of employees being supervised, allowing flexibility makes sense.

Overview of proposed change:

The current regulation requires fifty percent (50%) of direct care staff to hold a credential in co-occurring mental health and substance use disorders. This requirement is being eliminated.	*Citation in previous regulation:* 32
	Citation in new regulation: 1.6.9
	Was this change discretionary? Yes

Costs of proposed change:

No marginal economic impact. This credential is no longer offered.

Benefits of proposed change:

No marginal economic impact. Training on co-occurring disorders is being incorporated as a core competency in the base licensure, so the benefit of this training will continue.

Rationale for proposed change:

RI Certification Board no longer offers the co-occurring credential so it doesn't make sense to require half of employees at BHOs to hold this credential.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Credential that was required is no longer offered, so status quo was untenable.

Process and Planning

Overview of proposed change:

The proposed regulations lengthen the time period that clinicians have to complete treatment plans for Mental Health Psychiatric Rehabilitative Residences (MHPRR) 40.4,40.4.1 (was one (1) week, now thirty (30) days) and integrate clinical and other medical documentation (was thirty (30) days, now sixty (60) days).	*Citation in previous regulation:* 40.4; 40.4.1; and 40.5
	Citation in new regulation: 1.6.12(B)
	Was this change discretionary? Yes

Costs of proposed change:

No marginal economic impact.

Benefits of proposed change:

No marginal economic impact.

Rationale for proposed change:

To allow providers to coordinate for physical care and to allow providers the actual time required to establish a comprehensive treatment plan from the initial preliminary treatment plan.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Shorter time period requirements were untenable as scheduling follow up appointments can sometimes take several weeks.

Overview of proposed change:

Clinician will be required to check prescription drug monitoring program (PDMP) database during treatment planning.	*Citation in previous regulation:* 19.8
	Citation in new regulation: 2.37.5(H)
	Was this change discretionary? Yes

Costs of proposed change:

This proposed change has a de minimis cost from increased staff time required to check the database. This requirement already exists in opioid treatment programs. The service area where that is impacted by this new requirement, residential long-term care, has a low number of admissions.

Benefits of proposed change:

Increased safety of program participants from avoided drug interactions and accidental overdoses.

Rationale for proposed change:

The change has a safety benefit and would make the practice of checking the PDMP consistent across different types of substance use disorder treatment settings.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Would not provide safety benefit to participants in residential treatment programs.

Overview of proposed change:

The grievance process for participants that is currently used in the Developmental Disability (DD) Regulation is being adopted for BHOs.	*Citation in previous regulation:* 15
	Citation in new regulation: 2.38(B)
	Was this change discretionary? Yes

Costs of proposed change:

No marginal economic impact.

Benefits of proposed change:

No marginal economic impact.

Rationale for proposed change:

To be consistent across both DDOs and BHOs.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Would not be consistent.

Medication

Overview of proposed change:

The proposed regulation aligns methadone take-home privileges with federal regulation.	*Citation in previous regulation:* 45
	Citation in new regulation: 1.6.14
	Was this change discretionary?

Costs of proposed change:

No marginal economic impact. While allowing greater take-home privileges has the potential to increase abuse or illicit sale of methadone, the federal standard provides adequate protection to minimize these effects.

Benefits of proposed change:

There is a time savings to both the clinician and the patient. Only patients enrolled in methadone programs for more than six (6) months but less than three (3) years will see a change in their take-home privileges. Newer patients will see a savings of two (2) visits per week while other patients will save one (1) visit per week; this was averaged to a saving of 1.5 visits per week for this analysis. Because the time commitment of clinicians providing treatment is not changed by this regulatory amendment, the marginal benefit is assumed to accrue mainly to the patients. The time savings for patients is quantified below:

Benefit to Patients of Avoided Visits	
Total Methadone Clients (>6 months, <3 years)*	2,399
Decrease in Visits Per Week	1.5
Decrease in Visits Per Year	78
Assumed Hours Per Visit (with travel)	1
Median Hourly Wage, Rhode Island**	$19.45
Total Participant Savings	$5,459,284

* BHDDH SUD Database: 2017

** Bureau of Labor Statistics, May 2017 State Occupational Employment and Wage Estimates Rhode Island

Rationale for proposed change:

Greater convenience for the patients means they are more likely to successfully adhere to the treatment.

Other alternatives considered:

Alternative	*Rationale for not selecting this alternative:*
Status quo.	Stricter take home privileges do not seem to have any marginal benefit.

De Minimis Changes

- Combined two (2) Research sections for ease of reading.
- Adds clarity to class of restraints (adds more detail).
- Changes Department's policy for mandating staff qualification and permitting providers flexibility and responsibility for appropriate staffing assignments for the population being served.