Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

Cost Benefit Analysis for Rules and Regulations for Behavioral Healthcare Organizations

210-RICR-10-10-1

June 2023

Introduction

The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (the Department) proposes to adopt regulations regarding the implementation and enforcement of the Rules and Regulations for Behavioral Healthcare Organizations (BHOs) [212-RICR-10-10-1], which includes new rules with respect to a new category of BHO licensure known as an Enhanced Mental Health Psychiatric Rehabilitation Residence (E-MHPRR). This analysis estimates the societal benefits and costs that result from the adoption of the proposed regulation.

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

Within the State of Rhode Island there is a complex population of individuals ages 18 and over, who have a history of Serious and Persistent Mental Illness (SPMI) and current or previous hospitalizations. These individuals require a structured environment with services to promote recovery and empowerment and to enable the individual to improve or restore overall functioning. Many of these individuals will present with one or more problem issues, including:

1. Persistent symptoms (e.g., psychosis, mood, anxiety, trauma, substance use disorder symptoms)
2. Severe dysfunctional behaviors (e.g., suicidal, sexual misconduct, or aggressive behaviors that will require a level of security/supervision in the community)
3. Mental disabilities concurrent with physical health complications and/or developmental disabilities and/or neuro-cognitive impairment
4. Problems in social and community functioning (e.g., legal/incarceration, homelessness, etc.)

These individuals require significantly enhanced support related to their unique recovery processes but do not require hospital level of services. Many of these individuals have experienced repeated placement failure due to the severity of their illness.

According to the Rhode Island Behavioral Health System Review Technical Assistance--Final Report, 2021 (“Faulkner Report”), complex behavioral health (BH) program participants are 4.4 times more likely to use the emergency department and 19.9 times more likely to utilize inpatient services compared to those without a BH diagnosis. Medicaid expenditures on behavioral health services have been steadily shifting away from community-based services toward inpatient services, as inpatient services increased from 29% to 41% of total

expenditures from SFY 2012-2017. The report indicates that this is a significant behavioral health systems concern including outcomes that are worse for Rhode Island than regional/national benchmarks; further, according to the 2021 National Survey on Drug Use and Health (NSDUH) survey state estimates, the percentage of individuals in Rhode Island who reported experiencing a serious mental illness in the previous year increased from 4.9% in 2018 to an estimated 6.0% in 2021.

Under the *Olmstead* decision (*Olmstead v. L.C.*, 1999, U.S. Supreme Court), the Court held that qualified individuals with disabilities have a right to receive supports and services from public entities in the community rather than in institutions. The syllabus of the decision, at p. 581, notes that a federal regulation to implement the Americans with Disabilities Act, upon which the *Olmstead* decision was based, requires that a " 'public entity [must]administer programs…in the most integrated settings appropriate to the needs of qualified individuals with disabilities.' 28 CFR §35.130(d)." By placing individuals in a level of care that is consistent with their needs, the state will fulfill its obligations under *Olmstead* and thereby comply with the Americans with Disabilities Act.

This regulatory initiative was developed to create capacity within the community to place individuals in less restrictive settings instead of in psychiatric units of hospitals when a hospital level of care is no longer needed. In conceptualizing this initiative, the Department has prioritized the health, safety, treatment, and recovery needs of these individuals.

Currently, Medicaid reimburses residential rehabilitative services provided to clients who reside in licensed group homes, known in the current BHO regulations as either Basic Mental Health Psychiatric Rehabilitation Residence (B-MHPRR) or Specialized Mental Health Psychiatric Rehabilitation Residence (S-MHPRR). A level of care above these traditional group homes was identified as necessary to serve inpatients at Eleanor Slater Hospital, the Rhode Island State Psychiatric Hospital, and psychiatric inpatient units at community hospitals who are ready for discharge to placements that provide less than a hospital level of care, but who face difficulty being admitted to B-MHPRRs or S-MHPRRs due to their complex needs. This new level of care would include a higher staff-to-client ratio, a lower bed capacity, and more intensive services than those provided at traditional group homes.

Article 12 of 2021 House 6122 Substitute A as amended[1] authorized the Executive Office of Health and Human Services (EOHHS) to pursue a State Plan Amendment (SPA) to Rhode Island's Medicaid State Plan to establish an intensive and expanded MHPPR. The SFY 22 Enacted Budget also included funding in the EOHHS budget for a $525 Medicaid per-diem payment to eligible providers. The Department subsequently submitted to EOHHS a request for a Medicaid State Plan Waiver to permit creation of a level of care to serve as a stepdown from inpatient psychiatric hospitalization and would be reimbursed at a higher per-diem rate than existing

[1] 2021 H 6122 Aaa

MHPRRs. The increased per-diem is intended to compensate the operating agency for the provision of increased staff and services.

The Department received notification through EOHHS that the federal Centers for Medicare and Medicaid Services (CMS) approved the SPA for high-intensity MHPRR group homes, which the Department will refer to as Enhanced MHPRRs (E-MHPRRs), in contrast to the existing Basic and Specialized MHPRR group homes.

Purpose

The purpose of this regulation is to provide licensing requirements for E-MHPRRs, to allow for the transition of individuals from Eleanor Slater Hospital, Rhode Island State Psychiatric Hospital (RISPH) and inpatient psychiatric units at community hospitals to E-MHPRRs.

Stakeholders

Stakeholders identified by the Department that are affected by this regulation include:

- State government agencies
    - BHDDH: The Department does not anticipate that additional staff will be required to administer the regulation; compliance and monitoring will be conducted internally in the course of normal licensing operations.
    - EOHHS: The Department does not anticipate that additional staff will be required to administer the regulation; Medicaid will process and monitor payments to E-MHPRR providers consistent with normal payment processes.
    - Once an individual transitions from the RI State Psychiatric Hospital to an E-MHPRR, the State will no longer incur the entire the cost of providing services for these individuals because the RI State Psychiatric Hospital , as an IMD, is not eligible for Medicaid reimbursement. Similarly, when an individual transitions from the Eleanor Slater Hospital or an inpatient psychiatric unit at a community hospital, the cost of the state's share of Medicaid expenditures incurred at an E-MHPRRs will be lower than the cost of hospital level care.
- Private businesses
    - Community hospitals: These hospitals will benefit by having the ability to discharge patients who have been maintained in the hospital due lack of an appropriate placement. For individuals who are unnecessarily maintained in inpatient psychiatric units, community hospitals do not receive the full Medicaid per-diem rates. By establishing an alternative placement for individuals who no longer require hospital inpatient psychiatric level of care, community hospitals will receive full Medicaid rates for patients who have been determined to require a hospital level of care.

    - Community providers considering whether to open an E-MHPRRs: The enhanced per-diem rate will cover costs associated with providing the higher level of care needed for persons eligible for placement in an E-MHPRR.
- Individuals
    - Persons who may be appropriate for transition from a hospital level of care to E-MHPRRs will be able to receive services in the lease restrictive setting appropriate for their individual needs. While quantifying these benefits is beyond the scope of this analysis, there is a benefit to individuals who will transition to E-MHPRRs in terms of happiness, human dignity, and personal autonomy.
    - Individuals who previously were unable to gain admission to a psychiatric inpatient unit due to a lack of available beds will be more likely to be admitted and receive services in a more timely manner.

Regulatory Analysis of Discretionary Components

Baseline

Without the proposed regulation, the gap in the state's continuum of care for individuals with serious and persistent mental illness will continue to widen. Individuals who no longer require a hospital level of care will continue to be served in private and state-owned inpatient hospital settings as there currently is no appropriate lower intensity care option available to this population. Not only is this an inappropriate placement for those for whom there is no suitable alternative, but by not moving those individuals from a hospital level of care to a lower level, the beds they currently occupy will remain unavailable to those who do require a hospital level of care. When it is determined that an individual no longer meets a hospital level of care but there is no appropriate placement available, Medicaid may not compensate the hospital for the full hospital rate.

As of May 2023, there are 35 discharge-ready individuals waiting transfer to an appropriate lower level of care. The Department has estimated that there will be an additional 36 individuals who will be eligible for placement in an E-MHPRR under the proposed regulatory change, based on a clinical analysis of current patient characteristics. These individuals are in state-owned and community hospitals. If these individuals are unable to transition to community placements that meet their individual needs, psychiatric hospital beds will continue to be unavailable to individuals who require hospital-level care.

Scope of the Analysis

Based on the estimated number of individuals who are expected to be eligible for the new E-MHPRRs, the Department considered how quickly providers could set up operations and become licensed to operate E-MHPRRs. Given the proposed requirements of the regulation, the Department estimates there will be sufficient providers to serve the estimated need by state

fiscal year (SFY) 2034. Therefore, this analysis looks at costs and benefits over the eleven-year period of SFY 2024 through SFY 2034.

Findings

As detailed below, the Department has estimated that the net present value of benefits of the proposed regulation ranges between $99 million with a 7% discount rate and $123 million with a 3% discount rate. These savings are the estimated difference between the costs of serving patients in an E-MHPRR relative to the costs of serving these individuals in an inpatient hospital setting.

There are also benefits that were beyond the scope of this analysis to quantify, for example, the benefits to patients' health and well-being from receiving the correct level of medical and mental health care. These benefits accrue to patients who no longer require a hospital level of care who now will be able to be placed in an appropriate placement in an E-MHPRR, as well as for patients who have previously been unable to receive hospital level of care because there were no available beds.

The Department found the net present value of costs to providers for acquiring licenses to operate an E-MHPRR were minimal compared to the benefits, ranging between $9,121 utilizing a 7% discount rate and $10,602 utilizing a 3% discount rate.

By limiting the number of beds in each facility to nine, the proposed regulation may delay some savings that would accrue from transitioning patients from the hospital to E-MHPRRs more quickly if more beds were allowed per facility. The Department determined that the potential costs in terms of health and safety did not justify the higher bed count, and that the regulation still has a significant overall net benefit to the state with the proposed nine bed limit. The Department anticipates that the costs to providers to meet the facility requirements in the regulation have been factored into the $525 per diem Medicaid rate.

After weighing the considered alternatives, the Department believes that the proposed regulation presents the best option for achieving the desired net societal benefits.

Discussion of Costs, Benefits, and Alternatives by Provision

The proposed regulation is consistent with Rhode Island's Medicaid SPA and adoption of E-MHPRR Certification Standards, and has three major types of regulatory discretion:

1. **Eligibility requirements.** Section 1.6.12(F)(1) sets the criteria that determine which patients are eligible to use the E-MHPRR step-down pathway.

2. **Facility requirements.** The requirements for facilities will determine whether E-MHPRR providers enter the market, thereby providing the beds for the patient population defined in 1, above. As discussed below, the requirements for facilities regarding bed capacity, staffing, holding beds open, services provided, etc. determine how many

providers open and how many patients can be served.

3. **Licensing requirements**. Providers who wish to provide E-MHPRR services must make application to, and receive approval from, the Licensing Unit at the Department. The duration of each E-MHPRR license is two years from the date of approval. By implementing a two-year licensing period for E-MHPRRs, the Department is aligning the E-MHPRR license with the duration of existing BHO licenses which are in effect for two years. The Department also considered license durations of one year and greater than two years but determined that a two-year period is the optimal length of time for the Licensing Unit to ensure provider compliance with licensing requirements and E-MHPRR regulations.

Eligibility Requirements

The eligibility criteria were based on a clinical review of all individuals waiting for more than thirty days in hospital settings, including Eleanor Slater Hospital, the Rhode Island State Psychiatric Hospital, and inpatient psychiatric units at community hospitals. As a result of that review, the characteristics of the population that were identified led the Department to establish three categories of E-MHPRRs, each with a particular focus: Medically Intensive, Intensive Behavioral, and Intensive Forensic Supportive E-MHPRRs.

Given these eligibility criteria, BHDDH estimates that there will be 71 individuals over the next eleven years who would be eligible to move from an inpatient setting to an E-MHPRR.

Alternatives

The criteria were based on the identification of individuals who are in the most restrictive level of care and clients who have been identified as being discharge ready, respecting the *Olmstead* decision. The Department considered expanding the eligibility criteria to make the E-MHPRRs available to more patients; however, individuals with more intensive medical or psychiatric needs would require a hospital level of care and those with less intensive medical or psychiatric needs do not require the E-MHPRR level of care. Individuals who have different characteristics than those identified may pose a health and safety risk to other residents and staff in E-MHPRRs and to the community.

Facility Requirements

Nine-bed restriction for facilities

The creation and licensing of E-MHPRRs will allow patients to be moved from inpatient hospital settings to E-MHPRRs. The per-diem costs for inpatient stays are higher than the per-diem rate for an E-MHPRR; therefore, there are benefits from moving patients to the E-MHPRRs. When estimating the savings from transferring patients, the Department restricted the number of beds per facility to nine, as included in the proposed regulation.

The all-inclusive Medicaid rate for Eleanor Slater Hospital is $1,770 per day, and the enacted per-diem Medicaid rate for E-MHPRRs is $525, a savings of 70% percent. Total Medicaid costs are apportioned between federal and state governments subject to an established match rate, as described below. There are also additional general revenue costs of an average of $88 per day per hospital patients for incidental expenses. In addition to the $525 per-diem Medicaid reimbursement for E-MHPRRs, the Department estimates there will be an average of $16 per day in additional Medicaid services that are not included in the per-diem rate. These additional costs for E-MHPRRs are based on the use of additional Medicaid services in B-MHPRRs and S-MHPRRs.

The average cost for an acute inpatient Medicaid-reimbursed community hospital stay is $1,375 per day based on claims data for members who would likely qualify for an E-MHPRR. The E-MHPRR costs of $525 per diem are lower by $850 per day, or 62%.

The State-operated Rhode Island State Psychiatric Hospital is classified as an Institution for Mental Diseases (IMD), a CMS term, which means the Rhode Island State Psychiatric Hospital is not permitted to seek federal reimbursement for its costs. Without the federal share from Medicaid, the state incurs the entire cost of operating the facility and provides services through general revenue. When inpatients are discharged from the Rhode Island State Psychiatric Hospital to an E-MHPRR, the rate is not only lower, but the cost will be reimbursed in part by federal dollars through Medicaid. The average per-diem cost at the Rhode Island State Psychiatric Hospital is $1,858 ($1770 per-diem, $88 incidental expenses), with the $541 E-MHPRR rate ($525 per-diem rate, $16 additional Medicaid expenses) representing an overall savings of 71%.

Of the estimated 71 individuals who would be eligible for placement in an E-MHPRR, the Department further estimates that approximately 40% will be inpatients at Eleanor Slater Hospital, 25% will be inpatients at the Rhode Island State Psychiatric Hospital, and 34% will inpatients at psychiatric units at community hospitals. These percentages are based on the current distribution of patients identified as eligible for E-MHPRR placement.

To estimate the net benefits from moving individuals from inpatient settings to E-MHPRRs, the Department calculated the expected cost of serving these patients in the hospital setting and then subtracted the estimated cost of serving these same individuals in an E-MHPRR, using the assumptions and costs listed above. The Department assumed a phase-in based on the number of providers expected to open and operate an E-MHPRR over the eleven-year period, expanding from two providers to eight over that period, with each provider serving a maximum of nine residents. Medicaid expenditures are funded jointly between the federal government and the state, with Rhode Island paying 44.25% of Medicaid costs in SFY 2024, and an estimated 45.25% in subsequent years. While there will be federal savings from moving

individuals from hospital settings to E-MHPRRs, this analysis focuses on costs and benefits to Rhode Island. The estimated benefits are included in Table 1, below.

Table 1: Estimated Savings of Patients Moving to Nine-Bed E-MHPRRs from Inpatient Settings

	SFYs 2024-2034
State Share of Savings	$146,960,000
Net Present Value with 3% Discount Rate	$122,978,000
Net Present Value with 7% Discount Rate	$98,822,000

To determine net present value, the Department discounted the estimated savings over the eleven-year period utilizing both a three percent (3%) and a seven percent (7%) discount rate. Policy analysts often use a 7% interest rate to represent the rate of return for private capital in the U.S. and a 3% discount rate to represent social costs.

Alternatives

The plan to move individuals to a less restrictive setting consistent with the level of need, led to the decision to establish the E-MHPRR program. As part of the planning process, a $525 per diem rate was established. The rate build-up model,[2] based on staffing costs, work hours, and shifts, yields nine beds per facility with the enacted $525 per diem. EOHHS Medicaid cannot deviate from the $525 per diem without legislative approval for an additional SPA.

The nine bed per facility model does not limit the total number of individuals who can move from a hospital to an E-MHPRR, because there is no limit on the number of facilities which can open. As this is current law, EOHHS will adjust future increases or decreases in utilization in its twice annual Caseload Estimating Conference, now limited to 27 beds under the current state budget.

In the SPA, CMS authorized no more than 16 beds in each E-MHPRR. Sixteen beds are the maximum allowed before the Institute for Medical Diseases (IMD) exclusion is applied. The Department considered three options in determining the maximum bed limit for E-MHPRRs: 16, 12, and 9. The Department did not consider fewer than nine beds per E-MHPRR because the per-diem rate approved by CMS would not support the costs associated with operating the residence, including providing staff for this reduced number of residents.

The nine-bed limit was determined to best meet the needs of the anticipated residents who have very complex clinical characteristics and also adheres to the approved $525 per-diem rate. At the same time, the nine-bed maximum allows providers to meet the costs of providing the

[2] The model is proprietary and was created by EOHHS Medicaid's actuaries for BHHDH and EOHHS use.

necessary level of residential services in a safe environment with a clinically determined therapeutic milieu.

In determining a nine-bed maximum to be the optimal number of beds for each E-MHPRR, the Department also considered two alternatives: a 12-bed option and a 16-bed option. In doing so, the Department focused on the potential impact that an increase in the number of residents would have on staffing needs and the ability of the E-MHPRR to maintain an environment in which residents will be effectively and safely treated.

Under the rate model discussed above, a maximum of 12 beds would increase the cost of each bed-day to $527, which exceeds the per-diem rate of $525 approved by CMS. If the number of beds were even higher and raised to 16 beds, the cost of each bed-day combined with the necessary additional staff would be $493.

Increasing the capacity of each E-MHPRR to serve 12 or 16 residents would result in being able to serve eligible patients sooner, which would accelerate the rate at which inpatients could be transitioned from the hospital to an E-MHPRR.

12 bed option

Each provider could serve three additional individuals beyond the planned nine-bed residence. Under this option, the estimated 71 individuals who are expected to transition from inpatient hospitals to E-MHPRRs would be transferred within seven years rather than the expected eleven years. This could lead to additional savings over the eleven-year period, as shown in Table 2.

16 bed option

Each provider could serve seven additional individuals beyond the planned nine-bed residence. Under this option, the estimated 71 individuals who are expected to transition from inpatient hospitals to E-MHPRRs would be transferred within five years rather than the expected eleven years. The additional estimated savings under this option are also shown in Table 2 below.

Table 2: Additional Savings from Moving Patients to E-MHPRRs from Inpatient Savings, With 12- and 16-Bed Options, SFYs 2024-2034

	12-Bed Option	**16-Bed Option**
Additional Savings to State	$33,580,00	$53,564,000
Net Present Value with 3% Discount Rate	$29,098,000	$47,446,000
Net Present Value with 7% Discount Rate	$24,372,000	$40,853,000

Decision Calculus

These alternative options—12 beds and 16 beds—were considered and placing together a large group of high-acuity individuals was determined not be appropriate to meet the clinical needs of the residents nor for ensuring the health and safety of the residents, staff or the community. As previously indicated, some of the individuals who would be eligible for placement in an E-MHPRR have previously failed other placements that had a higher resident census than is currently proposed for E-MHPRRs under these regulations.

The Basic MHPRRs (B-MHPRRs) are permitted to operate with no more than 16 beds. The individuals who are appropriate for placement in a B-MHPRR do not have the high-acuity needs of those who will be served in an E-MHPRRR. In fact, many of those who are under consideration for placement in an E-MHPRR were considered for transfer to a B-MHPRR but were determined to require a level of high-intensity services that is not available in a B-MHPRR.

By transitioning such individuals into an E-MHPRR the Department also seeks to be consistent with *Olmstead* requirements that individuals receive services in the least restrictive environment that meets the individual's needs (e.g., outside of a hospital whenever possible).

The decision to limit the number of residents in an E-MHPRR was based on a clinical assessment of the therapeutic needs of individuals with the psychiatric characteristics that have made them difficult to place and to be successful in the existing continuum of care. Similarly, the psychiatric characteristics of those who will transfer to an E-MHPRR from a hospital require that there be no more than nine residents to create an environment where the therapeutic milieu is appropriate for the mix of individuals who will reside there. All residents will have high-intensity needs based on psychiatric histories that are complex, and that will frequently include histories of trauma and difficulties with social interactions. Based on the psychiatric characteristics of the individuals who need the E-MHPRR level of service, it is important to create an effective, safe therapeutic milieu in the E-MHPRR and one approach for doing so is to limit the number of residents present to nine.

The limit on the number of beds in each E-MHPRR has been planned to provide increased supervision and services compared to the B-MHPRR, to reduce the likelihood of returning to an inpatient hospital setting and to reduce the high costs associated with inpatient settings.

Although an increase in the number of beds in each E-MHPRR would accelerate the schedule for transferring individuals from hospitals to E-MHPRRs, an accelerated schedule also may present significant challenges with respect to procuring a suitable site to support transitioning individuals either to a 12-bed or 16-bed E-MHPRR. When identifying a suitable site, the Department must ensure that the location of the E-MHPRR will comply with local and state statutes and regulations as well as local ordinances. Once identified and purchased, a building must then be remodeled to conform with all relevant safety requirements and designed so that it functions consistent with the clinical characteristics for that E-MHPRR.

Given the characteristics and severity of the behavioral and medical challenges experienced by the population that will be served by E-MHPRRs, not only is a safe environment more difficult to achieve with a higher number of beds allowed per facility, but logistical considerations associated with a higher census are likely to present significant challenges to successfully establishing an E-MHPRR.

Staffing Requirements

Under the SPA approved by CMS, E-MHPRRs are required to have a core staffing pattern of 3:3:2. This staffing pattern reflects the requirement that for the first and second shifts there will be three direct care staff on duty for each shift. On the third shift there will be two direct care staff on duty. Direct care staff shall have at a minimum the following qualifications relevant to the service they are providing:

- A license as a Registered Nurse; or
- An associate degree in a human services field; or
- A combination of education and prior work or life experience that the E-MHPRR program determines is comparable and that has been approved in writing by the Department.

Each E-MHPRR is required to have the following three staff positions in addition to the direct care staff:

- *Licensed Occupational Therapist*
    - Must be licensed by the Rhode Island Department of Health or otherwise have permission to practice in Rhode Island.

- *Residential Manager*
    - The Residential Manager shall meet at least one of the following qualifications:
        - Licensed Independent Practitioner;
        - Licensed Chemical Dependency Clinical Supervisor with a bachelor's degree;
        - Licensed Chemical Dependency Professional with a bachelor's degree who as completed a Department-approved course in clinical supervision;
        - Clinician with relevant master's degree and license and at least two (2) years full time experience providing relevant behavioral health services;
        - Registered nurse with American Nurses Credentialing Center (ANCC) certification as a Psychiatric and Mental Health Nurse or at least two (2)

years full time experience providing relevant behavioral health services; and/or

- A combination of education and experience that is deemed by the E-MHPRR program to be a substantial equivalent to the above qualifications and has received written approval from the Department of the Residential Manager's qualifications.

- *Licensed Registered Nurse (RN)*
    - Must be licensed by the Rhode Island Department of Health or otherwise have permission to practice in Rhode Island.

If the E-MHPRR has a client who has a substance use disorder, either the Residential Manager or Registered Nurse, or any one of the direct care staff, must have experience in caring for clients with substance use disorders.

Costs: The Department does not anticipate that the required staff will prevent providers from entering the E-MHPRR market, because the approved per-diem rate covers the cost of the 3-3-2 core staff as well as the three professional staff positions.

Benefits: Even if occupancy at an E-MHPRR fluctuates, there will be an adequate number of staff to address the complex needs of this high-acuity population. The prospective residents have multiple clinical needs. The three professional staff are required to enable the E-MHPRR to serve as a locus of treatment for the residents and create a safe, therapeutic environment. The Residential Manager will be able to provide support for clinical interventions and the RN will be able to provide necessary care for psychiatric medical needs. The use of psychiatric medications makes it essential to have an RN to supervise the administration of medications and to be available to diagnose and consult on any medication interactions.

Since most of the residents may have lived in an institutional setting for many years and/or have had recent extended inpatient community hospitalizations prior to admission to the E-MHPRR, occupational therapy is an essential component of their treatment. To gain greater independence and to achieve a greater likelihood of success in the E-MHPRR, it is imperative to have the services of an occupational therapist (OT) to enhance an individual's activities of daily living (ADL).

Alternatives

The alternative of requiring an E-MHPRR to have on staff an occupational therapy assistant (OTA) rather than a licensed OT was considered. The Department did not choose this option after a review of the requirements associated with the scope of work of OTAs pursuant to RI General Laws. R.I. Gen. Laws § 5-40.1-21(c) states:

> "a licensed occupational therapy assistant may practice limited occupational therapy only under the supervision of a licensed occupational therapist. Supervision requires at a minimum that the supervising licensed occupational therapist meet in person with the licensed occupational therapy assistant to provide initial direction and periodic on-site supervision…"

Further, in § 5-40.1-21(d), it states: "A licensed occupational therapy assistant:

> **(1)** May not initiate a treatment program until the patient has been evaluated and the treatment planned by the licensed occupational therapist;
>
> **(2)** May not perform an evaluation, but may assist in the data-gathering process and administer specific assessments where clinical competency has been demonstrated, under the direction of the licensed occupational therapist;
>
> **(3)** May not analyze or interpret evaluation data;"

Because RI law requires OTAs to be supervised by an OT and their scope of work is also limited by state law, the Department decided to require each E-MHPRR to have licensed OTs on staff. The approved per-diem rate would not support including both positions into the required staffing pattern.

Holding Beds Open when a Resident is Hospitalized

The proposed regulation requires that an E-MHPRR hold a bed for a resident when that resident is hospitalized.

Costs: The Department considered the costs to providers who must keep a bed open when setting the $525 per diem rate. The rate build-up model (see footnote 2) takes into consideration the requirement that when a resident is hospitalized, the E-MHPRR must hold the bed open until the resident returns. The model assumes that each hospital inpatient stay is seven days and that 10% of client months will result in an inpatient hospital stay. A 4% vacancy rate has been built into the per-diem rate in anticipation of empty beds while a resident is in the hospital.

The Department will track hospitalizations once an E-MHPRR is open and can make recommendations to change the per-diem rate should hospitalization deviate from the initial assumptions.

Benefits: This requirement benefits residents, providers and the mental health system. By holding the bed open for a resident, it allows the resident to return to a familiar environment, including staff and other residents. Holding the bed open prevents a resident being unnecessarily held in a hospital until another E-MHPRR bed becomes available. If it is determined that the person does not meet criteria for a hospital level of care, there also is the

possibility that the person will be discharged and may become unhoused (homeless), enter the criminal justice system, or face a dangerous situation as a result of not receiving appropriate treatment. These potential outcomes would be detrimental to the resident, the provider, and the system. The built-in vacancy rate serves to avoid this undesirable result.

The Department's Approval of Discharge of Residents from an E-MHPRR

The proposed regulation requires the Department to approve the discharge of a resident from an E-MHPRR. This requirement addresses two concerns: discharge of residents due to closure of an E-MHPRR and individual resident discharges.

Costs: If a provider decides to discharge patients for the purposes of closing an E-MHPRR, the provider will be required to remain in the market until such time as appropriate alternative placements for residents are secured. A provider would be required to submit a transition plan to be approved by the Department prior to transitioning any residents. As the number of remaining residents is reduced, the transition plan would include a plan for safe reduction in staff until the last resident is transitioned to another setting. By reducing staff as the census of the home is reduced, the costs to the provider would be minimized.

If the provider is not required to seek approval from the Department prior to discharging an individual resident, that resident may be placed at-risk of homelessness and/or criminal justice involvement (and its attendant costs) if there is no appropriate discharge plan. Alternatively, the resident could be returned to higher-cost hospital level of care without the benefit of possible intervention by the Department to either address the problem(s) at the E-MHPRR or to assist in locating an alternative placement outside of a hospital.

Benefits: The proposed requirement will provide stability for clients and ensure that they continue to receive care and treatment in the least restrictive setting that is appropriate to their individual needs. By receiving written notice of a proposed individual discharge, the Department will have the opportunity to intervene and suggest alternative approaches to alleviate any clinical reason that may be leading to the discharge. In both circumstances, prior notification would benefit the resident(s) who would avoid either the transfer to a potentially unfamiliar, more restrictive setting, which could result in an *Olmstead* violation; or the discharge to an unsafe and potentially dangerous situation.

Required Services

The proposed regulation lists the services that an E-MHPRR must provide to clients, consistent with a patient's treatment plan. The Department's existing regulations, 212-RICR-10-10- 1.6.12 (B) Residential Services, list the minimum required services for a B-MHPRR. As the proposed regulations for an E-MHPRR state, all the services required by regulations for a B-MHPRR apply to an E-MHPRR, unless there is a conflict, in which case the E-MHPRR requirements would apply.

In deciding on the additional services beyond those that are required in the B-MHPRRs, the Department referred to evidence-based practices (EBPs). The Department utilized the following EBPs authorized by the Substance Abuse and Mental Health Services Administration (SAMHSA):

- Psychosocial Interventions for Older Adults with Serious Mental Illness
- Strategies to De-Escalate Aggressive Behavior in Psychiatric Patients
- Supported Employment Evidence-Based Practices (EBP) Kit
- Screening and Assessment of Co-occurring Disorders in the Justice System
- The Evidence: MedTEAM (Medication Treatment, Evaluation, and Management) Evidence-Based Practice
- Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) Kit

The Department reviewed EBPs and research to determine the best services for residents who have the characteristics of those who will be served by E-MHPRRs. The Department selected the above EBPs in accordance with its statutory role as the State Mental Health Authority planning for treatment for SMI/SPMI clients, and in coordination with licensing regulations associated with residential treatment. As a result of the Department's review process, no other specific clinical practices were identified for the characteristics of the residents who will be transferred to E-MHPRRS.

Naloxone (Narcan)

The proposed regulations require that each E-MHPRR maintain unexpired naloxone (Narcan) in sufficient quantity to administer life-saving treatment for anyone suspected of experiencing an opioid overdose. The proposed regulations also require that each E-MHPRR provide twice yearly training on the administration of Naloxone (Narcan) to all staff and to document and maintain attendance records of such trainings.

These requirements are necessary because it is expected that there will be residents in the E-MHPRRs who have co-occurring substance use disorders; in addition, there may be residents who take prescription opioids. In either situation, the potential for an overdose requires that each E-MHPRR maintains a supply of unexpired naloxone. Naloxone administration is a standard treatment to reverse an opioid overdose and best practice dictates that staff receive training in the administration of naloxone.

The Department has not identified any costs associated with either requirement. Naloxone is available free-of-charge from the state, and because the length of time needed to train in the proper administration of naloxone is minimal, there will not be additional staff costs associated with this requirement.

Frequency of Health and Safety Audits conducted by the Department

A two-year frequency of health and safety audits of E-MHPRRs to be conducted by the Department was established to be consistent with other health and safety audits it conducts. These audits will be conducted within the usual work of current Department personnel. These audits will benefit the residents, staff, and the community by ensuring compliance with health and safety requirements as well as E-MHPRR regulations.

Licensing Requirements

Costs to Providers to Apply for a License to Operate an E-MHPRR

Under the proposed regulation, each provider must apply for a license to operate an E-MHPRR and renew that license every two years. While the Department does not currently assess licensing fees, It is estimated that the total number of hours required to complete the initial application for an E-MHPRR license is 20 hours. The range is between one day and one week depending upon the availability of the information necessary to complete the application; therefore, the Department selected a mid-point of 2.5 days (8 hours x 2.5 = 20 hours). The Department utilized a median hourly rate of $58 for medical and health services managers based on Occupational and Wage Statistics[3] from the Rhode Island Department of Labor and Training to determine licensing application costs.

The Department estimates that the total number of hours required to complete a re-application is minimal and assumes two hours at the median hourly rate of $58 for medical and health services managers.

Based on these assumptions, the initial license application will cost an average of $1,160 per provider in staff time, and $116 in staff time for each renewal which occurs every two years. The costs for the licensing requirements over the eleven-year period are shown in Table 3 below.

Table 3: Estimated Licensing Costs for E-MHPRR Providers

	SFYs 2024-SFY 2034
Licensing Costs for Providers	$12,064
Net Present Value with 3% Discount Rate	$10,602
Net Present Value with 7% Discount Rate	$9,121

Conclusion

The financial costs associated with establishing eight E-MHPRRs over the next eleven years is offset by the significant cost savings that will be realized in transitioning individuals who meet the criteria for placement in an E-MHPRR from high-cost hospital settings to the lower cost E-

[3] Occupational Employment and Wage Statistics (OEWS) | RI Department of Labor & Training

MHPRRs. In addition to the cost-savings, this initiative will benefit individuals who have remained in hospital settings even when no longer medically necessary because there has been no appropriate setting to which these individuals could be discharged.