Behavioral Health in Nevada

Recommended Initiatives and Improvements

Submitted electronically to Senator Fabian Donate at:
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Dear Senator Donate:

The members of the Nevada Hospital Association appreciate the opportunity to share our observations, concerns, and recommendations regarding behavioral health services in Nevada. In this document we address numerous issues, but three issues require immediate attention:

1. Law enforcement, EMS, and other first responders should not take people experiencing a mental health crisis to hospital emergency rooms unless they have a medical condition. The noises and constant activity of an ER creates a poor environment for people deescalating from a behavioral episode. Moreover, a disruptive behavioral health patient can impede the care provided to other patients in the ER.
2. Hospitals need places to discharge behavioral health patients once they are medically cleared for discharge.
3. Inpatient behavioral health services should be reimbursed by Medicaid at higher rates generally, and specifically, Medicaid reimbursement rates should be tailored to a patient's acuity. Behavioral health patients are not all the same. Some patients require intensive services and supervision.

Soon, Nevada will have a significant source of funds available for behavioral health services from the Private Hospital Medicaid Provider Fee Program. We hope this money will be spent wisely to address the systemic problems in our behavioral health system. We welcome the opportunity to assist in developing a strategy to improve our behavioral health delivery system and discuss the challenges highlighted in this document.

Area of Focus	Description
Medicaid policy and reimbursement	• Enrolling mental health patients in Medicaid is slow and difficult. This causes delays in care. In other states, the enrollment process is rapid. Providers can begin services immediately and bill for treatment; thus, the patient is better served. • Medicaid reimbursement for behavioral health services is inadequate. Many youth and adult healthcare providers struggle financially.

	• Reimbursement for behavioral youth services is lower than adult services. • Almost all youth inpatient behavioral services, partial hospitalization (PH), and intensive outpatient (IOP) services are provided in behavioral health hospitals and inpatient units of acute care hospitals. These providers need to be adequately reimbursed by Medicaid to ensure services are available to the community. • When youth cannot be appropriately placed, the state turns to Behavioral Health Hospitals who are reimbursed a fraction of the normal Medicaid rate for adults. • Hospitals are paid a flat rate per day. No extra reimbursement is provided when a hospital room is blocked because a youth requires a private room or when a youth requires one-to-one observation for safety. **Recommendations** • Medicaid should reevaluate and streamline its process for enrolling mental health patients. • Reimbursement for inpatient behavioral health services should be evaluated and paid based on the patient's acuity. A DRG (Diagnostic Related Group) system, rather than a daily flat fee (per diem) would cover the additional costs that hospitals experience with certain youths, such as a youth who requires one staff to one patient monitoring.

Mobile Crisis Units, Crisis Stabilization Centers and Crisis Lines	• The number of Mobile Crisis Units (MCUs) in Nevada has increased but the service is very limited throughout the state.
	• MCUs provide a needed service. A clinician, who is part of a unit, can de-escalate a situation, evaluate the individual, provide resources, and determine if the individual (youth or adult) requires an inpatient level of care. Sometimes mobile crisis units accompany law enforcement. The goal of these units is to divert a crisis in the community, avoid ER evaluations, behavioral health hospitalizations, or incarceration.
	• In some areas of the state, more Mobile Crisis Units are needed. In other areas, licensed staff are needed.
	• The barriers impeding the success of Mobile Crisis Units are:
	  ○ The lack of behavioral health services (especially after hours) that do not require an appointment. The Counties and State do not maintain after-hour psychiatric, or substance use resources.
	  ○ The lack of Crisis Stabilization Centers for MCUs to take patients to deescalate and receive referrals for community services.
	• The Mobile Crisis Program would be most effective in collaboration with a Crisis Stabilization Center or an inpatient hospital that can accommodate a psychiatric crisis.

	• A Crisis Stabilization Center is a 23-hour-or-less center (similar to urgent care) that provides further evaluation, medication, nourishment, a place to rest, and an environment to allow for additional time to de-escalate. Importantly, it provides community referrals. If a legal hold is placed on an individual or a potential medical condition exists, a medical evaluation is provided. The Crisis Stabilization Center should be staffed with nurses, clinicians, peer support specialists/counselors, and medical providers.
	• Three barriers prevent Crisis Stabilization Centers from opening and expanding:
	  ○ **Physical plant** – Spaces are needed for mobile crisis teams and police officers to take patients. The building must provide a calming environment.
	  ○ **Step down services** – Most communities lack a continuum of behavioral health services to offer patients follow up care. Centers need places to refer patients, otherwise the patient will be placed back on the street without treatment referrals. Safe discharge options are needed.
	  ○ **Funding** – Crisis Stabilization Centers cannot survive based on billing and collecting only. Medicaid rates are too low. Many patients will be uninsured, or their insurance cannot be determined. Denials and bad debt will be challenging to manage given the short length of stay at these centers.
	• The barriers impeding the success of Crisis Lines are similar to the barriers facing Mobile Crisis Units and Crisis Stabilization Centers. Nevada lacks behavioral health services to refer callers. This is especially true for callers who need help after normal business hours and do not have an appointment.
	• Additional funding is needed for citizens who are uninsured or underinsured.
	
	Recommendations
	• The State should develop behavioral health services that are available 24 hours a day, without an appointment, for individuals who have a mental health crisis.
	• Crisis Stabilization centers should be developed throughout the state.
	• Crisis Lines need places to refer callers and law enforcement needs a place to bring individuals who need to de-escalate.
	• A public report should be developed describing the revenue generated from the fee imposed on cell phones and how the proceeds from that fee will be distributed to fund services such as Crisis Stabilization Centers.

CCBHCs (Certified Community Behavioral Health Clinics)	• In 2017, Nevada was one of eight states selected to participate in a demonstration to establish the CCBHC model to reduce ER visits and admissions to psychiatric hospitals. CCBHCs provide a comprehensive range of outpatient and case management programs and serve everyone regardless of insurance status. The new model has not achieved the level of results expected. CCBHC clinicians and case managers are supposed to respond to ERs and provide in-home intervention services, but they are frequently unable to do so because of staffing issues. CCBHCs throughout the state are struggling with sustainability issues due to low Medicaid reimbursement rates and staff turnover. **Recommendations** • Counties or other governmental entities should provide additional funding for CCBHCs to care for uninsured individuals with mental health and substance use problems and assist with making all CCBHC services sustainable. • The state should address the Medicaid rate structure for services provided by the CCBHCs.
Charity and Unfunded Patients	• The State relies on the private sector to be the door to mental health services when a person experiences a crisis. The opposite should occur. The State should initially intervene. • State behavioral health hospitals have historically been designated to receive charity and unfunded adult patients to alleviate pressure on the private hospitals. Currently, many of the state's beds are consistently blocked (over 50% in northern Nevada) due to staffing and/or physician issues and in the south, state hospitals have converted beds into forensic beds. An inadequate supply of state psychiatric beds exists. • If the private sector is relied on to provide the service, counties should have the option and/or the mandate to compensate healthcare providers for unfunded patients. The private sector cannot sustain the level of charity care created by unfunded patients. • In the past, grants were awarded to groups who offered to provide various types of behavioral health services. Too many programs were created and operated under these grants. Often services were duplicated and not coordinated. When the funding ran out, the programs closed. No coordination, consistency, or sustainability existed. • Similarly, new agencies coming to Nevada are often unaware of the large gaps in the mental health system and find themselves at a financial loss, resulting in closure. This adds to instability and inconsistency in our behavioral health delivery system. **Recommendations:**

	• The State and/or County should provide funding for the care of uninsured individuals with mental health problems. • A handful of agencies should be funded to coordinate care in their communities and provide non-competing services. The State should monitor their quality and track outcomes. This model would offer consistency, accountability, and sustainability. • The state needs to create more options for outpatient mental health services. • The state hospitals should be adequately supported so they can address their staffing and physician issues to ensure all their licensed beds are operational on a consistent basis. • State hospital beds that were converted to forensic beds should be replaced.
Inpatient Bed Capacity	• A public misperception exists that Nevada has an insufficient number of behavioral inpatient and substance abuse use inpatient beds. Nevada has plenty of these beds. On an average day, an estimated 300 beds are not occupied or utilized in the state. • Low reimbursement rates and high staffing costs greatly contribute to these beds not being utilized. **Recommendations** • Adequately reimburse providers so that excess bed capacity can be used for adults, youth, and substance use inpatient and residential needs. More buildings are not the solution. Funding to maximize occupancy is the answer.
Managed Medicaid and Medicare Accountability	• Managed Care Organizations (MCOs) often focus their efforts on acute care services and pay little attention to behavioral health care. • Some MCOs contract with third-party agencies to manage the behavioral health portion of their contract with the State. These third-party agencies frequently create “related organizations” with different names. The names are different, but the owners and operators are the same. This practice creates the illusion that different companies are operating in the market and that more than one company is offering services. As a result of this practice, Medicaid behavioral health care in Nevada is moving toward a monopolistic system. • These agencies appear to lack accountability by the MCOs. Quality oversight appears to be limited. The agencies overpromise, underdeliver, and do not have the provider network to provide all the services they claim to offer. • If the practice of subcontracting continues, MCO’s should not be allowed to engage in capitated agreements with these agencies. This practice creates an incentive for the agencies to deny treatment to patients and deny provider claims to make more money.

	• If an agency and/or their related organizations work with two or more MCO's, the agency can control the market and there isn't anything behavioral health providers can do. Providers either work with the agency or they risk being eliminated from the network and losing business. This is particularly challenging for small providers. • In some cases, the agencies provide behavioral health services to their enrollees. This creates a conflict of interest because they can self-refer patients. • The network of behavioral health providers that the agencies claim to have can be misleading. For example, a housing provider of "Sober Living" may state they accept Managed Medicaid patients, but they require the Medicaid patient to have an income, which disqualifies many who need the service. This is a barrier for a large number of behavioral health patients. • The expected length of stay for an inpatient and Rehabilitation/Residential program patient is far too short to provide quality treatment and establish appropriate planning. This results in adverse outcomes such as death, injury, re-admission, or relapse. • Managed Care Organizations take too long to resolve claims and have too many clerical errors. The delay in payments causes providers to experience significant cash flow problems. Smaller providers cannot survive long without cash flow. Reasonable timeframes should be established for resolving disputes and errors. • Some Managed Care Organizations relinquish control of the claim processing to the same 3rd party agency that manages the care. The agencies have no incentive to resolve issues in a timely manner. Smaller providers who are not part of a large health system have little recourse because they cannot afford the cost of litigation. This impacts cash flow and the ability to operate for all healthcare organizations, especially smaller organizations. • Many agencies lack the bandwidth to support the behavioral health population they contract to serve. The list of services offered, such as housing, may really be a few beds at the Salvation Army. What looks good in writing when contracts are awarded may not necessarily serve the community. • Often Managed Care Organizations and their agencies change billing processes without giving providers adequate notice. Healthcare providers are unsure if the change they are told about is legitimate, and they must contact the MCO to verify. This takes time and adversely affects patient outcomes. **Recommendations** • The State should require MCOs to provide greater oversight of their agencies.

	• The State should place a limit on the size of the Medicaid market that MCO subcontractors and their related organizations control. • The State needs to ensure that managed care networks are adequate and are actively accepting behavioral health patients and providing needed services. The expectations for each organization should be clearly outlined. • The State must determine if the behavioral health providers listed in a network are fully accessible to all Medicaid patients before granting a contract. • Safeguards need to be established to hold the Managed Care Organization and their subcontractor agencies accountable. • The State should establish time frames for MCOs to resolve provider claims and denials. • MCOs and their agencies should be required to communicate a process change in writing weeks in advance of implementing a new practice or policy.
Acute Care Hospitals	• Acute care hospital emergency rooms are the gateway to behavioral health services in the state. Law enforcement, EMS, and other first responders bring behavioral health patients to the emergency room for a medical screening. An emergency room is not the appropriate environment for a patient experiencing a mental health crisis (unless they require medical help for a physical problem). Patients should be taken to other locations such as a behavioral health hospital. • An additional transport is needed to take the patient from the emergency room to the behavioral health hospital. This expense can be avoided by having patients evaluated at the behavioral health hospital, but adequate funding for behavioral health hospitals is needed. • The Medicaid rate for psychiatric care has been fixed since 2014 in Nevada. Hospital expenses have increased dramatically during that time. **Recommendations** • Encourage law enforcement and other first responders to take behavioral health patients to behavioral health hospitals for evaluation and screening (unless a physical medical condition exists) • Increase the Medicaid rate for psychiatric patients in acute care and behavioral health hospitals.
Rural Issues	• Few behavioral health services exist in rural Nevada. • Critical Access Hospitals (CAH) are not equipped to handle serious behavioral health patients. • Too often CAHs cannot transfer behavioral health patients to an appropriate setting, and the patients remain at the CAH for long periods of time (up to months at a time).

	Recommendations • Create more behavioral health services in rural Nevada and/or improve access to telehealth services for behavioral health. • Incentivize urban providers to accept patients from rural areas.
Youth Services	• Nevada's youth services are usually a "one size fits all" approach when programs are established. The State should increase funding to support various levels of care. • Appropriate step-down services for inpatient to outpatient are needed. • Few services are available for youth between the ages of 5-12. • Too many behavioral health services for youth have closed in Nevada (E.g. Never Give Up Residential Treatment Center (RTC), Montevista RTC, and BH Hospital - West Hills Hospital). Each of these facilities elected to close; their license was not terminated. Financial issues were the main reason for the closures. Profit margins are minimal for behavioral health facilities. Low reimbursement and increasing capital expenditures make it extremely difficult to remain operational. • When regulatory scrutiny increases and funding is restricted, facilities are forced to close for financial reasons. • Nevada's current payment structure for behavioral health services requires providers to maintain a high volume of patients to financially survive. Quantity becomes more important than quality. • Youth Crisis Stabilization requires a guardian to be present. At times, the guardian is not available. • Youth crisis is best served by a Mobile Crisis team or at an inpatient behavioral health facility. Our State does not have the after-hour resources to manage this population. • Autistic children pose a unique challenge. Some of the children are violent and their parents are afraid to take them home. They may not need behavioral health services, but hospitals need a safe place to discharge them. • State agencies such as the Department of Child and Family Services (DCSF), which oversees the rural counties, and the Department of Family Services (DFS) use their limited resources well. **Recommendation** • The State needs to incentivize and support the development and sustainability of various types of youth behavioral health services. • Create beds and services for children between the ages of 5-12. • Create safe places for hospitals to discharge autistic children.
Elderly Care	• Obtaining Public Guardianship for an elderly person with mental health issues is slow, costly, and time consuming. The current

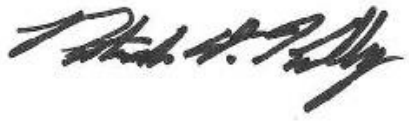
	system will not adequately serve the growing number of elderly people in our State. • It often takes 5 months for an acute care hospital to obtain guardianship for a patient. After a couple of days, the hospital is either paid a low custodial rate or nothing at all for much of the time. • Some MCOs and related organizations have not contracted with places to care for and treat elderly Nevadans. **Recommendations** • A temporary guardianship should be created to help patients move to the appropriate level of health care they need while full guardianship proceedings occur. • Acute care hospitals should be adequately reimbursed for the time patients await a guardianship order. • The State needs to monitor MCO agencies to assure they have adequate provider networks to serve the elderly. • The state should develop a streamlined process for resolving payment disputes with MCOs and for paying providers in a timely manner so that providers receive the compensation to which they are entitled and enable them to remain in operation.
Housing	• The State must increase discharge and community placement options for the homeless. A lack of housing options is the driver for overutilization of healthcare services. Sixty-three percent of readmissions to one behavioral health hospital were initially discharged to a Shelter because other options were unavailable. • In the past, states operated facilities to house individuals with long term psychiatric disabilities. After the deinstitutionalization movement occurred, long-term housing was not created for these individuals, and many are homeless. These individuals need shelter and someone to check on them daily to ensure they are taking their medications. **Recommendation** • Create special housing for individuals with long-term mental health issues that provides a minimal level of supervision and support.
Electronic Medical Records and Technology	• Behavioral health providers need help with implementing EMRs. Meaningful Use dollars were not available to Behavioral Health facilities for EMRs. All equipment and upgrades must be funded from low patient reimbursement rates. • Whenever a government agency requires a process change, new or additional forms, or any request that affects EMR utilization, it is a costly change for providers to absorb.

	Recommendation • Be mindful that legislative and regulatory changes impacting medical records are costly and must be funded.
Cost of Policy Changes	• Policy changes come with a cost to providers. Please consider the additional cost providers will incur when passing legislation. For example, Cultural Competency training is a wonderful idea, but it is extremely expensive. At one BH hospital, 400 employees had to be trained for 6 hours. Some of the employees were paid overtime because they could not leave their floor during their shift for training. The facility's cost for training these employees was $216,000 (training costs and labor/hours). Cultural competency training is in addition to other government mandated trainings, licensure trainings, company trainings, department specific trainings, and competency trainings. Cultural Competency training came with no additional funding. **Recommendation** • Provide funding for mandated training.
State Regulatory and Quality Control	• The State has a high turnover rate for key positions. New employees are unaware of the history or barriers to behavioral health care in the state. This makes changing policy very difficult. • State agencies often absorb behavioral health programs that close. It is a costly and inefficient practice. • State agencies need more funding to provide quality control, oversight, and management. **Recommendations** • Adequately compensate state employees so they remain in key positions. • When a program closes, consider contracting with private entities to provide the service rather than having the State absorb programs. Private agencies can provide services at a much lower cost and the state can oversee their activities. • Adequately fund state agencies.
Continuum of Behavioral Health Care	• Nevada needs a continuum of care that focuses on patients stepping down to a lower level of care quickly and with minimal disruption. • Many patients with behavioral health problems fall through the cracks. • Currently, law enforcement and emergency rooms are the doorway to behavioral health care in Nevada. This needs to change.

	• Individuals attempting to access behavioral health services directly are often denied by payers or do not have funding. **Recommendations** • The state needs to create a plan for a continuum of behavioral health care in the state. The plan should provide a path for people to access behavioral health services without calling the police or having to go to an emergency room. • Funds will be needed to build and support the continuum. • Health insurers must be required to accept the continuum process and not deny claims if the process is followed.

Thank you for allowing the Nevada Hospital Association to highlight and collaborate with you on these issues. We look forward to advancing the behavioral health of Nevadans.

Very truly yours,



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