DRAFT Proposal to Use Incentives to Manage State Hospital Utilization in Virginia
From the
Panel on System Structure and Finance
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Background

Since Virginia's "last resort" legislation took effect in July of 2014, admissions to state hospitals have increased 42%, from 4,275 in FY14 to 6,082 in FY16. Admissions to state hospitals of individuals under temporary detention orders (TDOs) have increased 164%, from 1,319 in FY14 to 3,477 in FY16.[1] In addition, approximately 150 individuals on any given day are clinically ready for discharge from Virginia state hospitals but continue to occupy much needed beds, often well beyond the necessary period of hospitalization. In August 2016, Virginia's state hospital utilization averaged 98% of capacity[2] statewide. This level of utilization is causing delayed admissions for some individuals, as well as regular diversion of individuals from their home catchment areas to state hospitals much farther away, which aggravates transportation challenges for law enforcement and creates additional care coordination problems for care providers.

Nationally, states operate an average of 15 state psychiatric hospital beds per 100,000 residents. In addition, states spend an average of 23% of their state mental health expenditures on state psychiatric hospitals and 75% on community-based mental health services and supports.[3] Virginia currently has 17.3 state hospital beds per 100,000 individuals and Virginia's ratio of state hospital to community services expenditures is approximately 50/50.[4] Bringing Virginia's state hospital bed utilization down to the national average would free up approximately 165 beds in Virginia state hospitals, and would allow state hospitals to operate more safely and effectively as a regional resource within their respective catchment areas.[5]

Managing State Hospital Utilization in Virginia

State hospital utilization management in Virginia is currently driven primarily by clinical factors, but many other system variables, such as the "last resort" statutes cited above, can influence admission and discharge decisions and length of stay. One variable that is widely thought to be important is that state hospital care in Virginia is free to CSBs[6]. Inpatient care is the most expensive mental health resource, but there is currently no financial consequence for CSBs associated with state hospital utilization[7]. In addition, no other meaningful CSB performance targets or accountability objectives are currently in place that are linked to CSB state hospital utilization.

The current situation has led Virginia DBHDS to search for stronger incentives to manage state hospital utilization more effectively. The Department is now considering implementing a financial incentive to strengthen community capacity and to manage state hospital utilization by civil inpatients at lower

[1] Source: DBHDS
[2] Statement by interim Commissioner Jack Barber, MD, to SSF Panel, September 9, 2016.
[3] Source: DBHDS and National Association of State Mental Health Directors (NASMHPD)
[4] Interim Commissioner Jack Barber, MD, presentation to SSF Panel, September 9, 2016.
[5] Email correspondence from J. Barber to CSB Executive Directors, August 2, 2016.
[6] Although not the subject of discussion here, care in DBHDS psychiatric hospitals is also free to jails.
[7] State hospitals, not CSBs, are responsible for obtaining any available reimbursement from payers for state hospital care.

levels. By so doing, accountability for the use state hospitals would be shared more directly by both DBHDS and CSBs.

This concept of linking financial accountability for state hospital utilization with the local community mental health authority is not new, either for Virginia or for other states. Virginia successfully piloted several efforts in the late 1980's and 1990's that used financial incentives for CSBs to reduce their state hospital utilization.[8] Other states have used financial incentives, and many states have statutes, policies and/or practices in place that effectively assign accountability for state hospital utilization to community service providers.

At its July 11, 2016, meeting, the System Structure and Financing Panel heard a brief description from Mike Hogan[9] about Ohio's approach, in which state law gave County Boards (Ohio's local mental health authority) control of state hospital funding so that the Boards could purchase inpatient services from state facilities or use the funds to develop community based care. Ohio used this strategy as part of a long-term effort to expand community services and reduce the size of its state hospitals. Most importantly, Dr. Hogan strongly endorsed an approach for Virginia that would give more responsibility for state hospital costs to CSBs in order to create both an incentive to minimize unnecessary state hospital utilization and an opportunity to expand community services in lieu of state hospital care. On the basis of the above, the Panel elected to study the issue further and develop recommendations for the SSF Work Group and SJ 47 Subcommittee.

State Hospital Utilization Management Practices in Other States

To understand more completely the use of incentives by other states, the Panel contacted the National Association of State Mental Health Directors (NASMHPD), which sent out to all states a two-item survey asking whether the states used incentives (1) "*to encourage providers not to send patients to state psychiatric hospitals*" and (2) "*to encourage providers not to send patients to psychiatric hospitals, public or private*". Sixteen states to date (including Virginia) responded to the NASMHPD inquiry. The results are as follows:

- Seven states (CT, IL, MD, MO, NH, SC, UT) reported that they had no such incentives. Of these, Maryland and Missouri indicated that their state hospitals were for forensic patients only, with civil admissions accepted only rarely on a case-by-case basis.
- Four more states (KY, NY, OH, VA) reported a "qualified no" response. New York was implementing a risk-based purchasing approach that would bring financial incentives into play, and the three other states had been discussing such incentives. Kentucky also reported that state hospital utilization was used as a provider quality measure, but that it "has no teeth" and thus does not really function as an incentive.
- One state, Texas, reported that their fund allocation methodology encouraged providers to "moderate" their use of state hospitals. In subsequent conversation with Texas DMH, Panel staff learned that there had been a financial sanction built into the state fund allocation process that penalized providers for overuse of state hospital care, but the Texas Legislature, in its most recent Session, had replaced the financial sanction with a strong peer review process. The peer

[8] The primary objectives of these Virginia projects were to reduce CSB utilization of state hospital beds, reduce bed capacity at the participating state hospitals, and expand community services by transferring funds from state hospital budgets to local CSBs.

[9] Mike Hogan is the former Commissioner of BH in Connecticut, Ohio and New York states, and served as Chair of the President's *New Freedom Commission on Mental Health* (2002-3).

review process was triggered when providers exceeded their utilization threshold. The outcome of the peer review could require the provider to implement changes in programs or practices.

- Four states (CO, GA, ND, TN) reported other practices that helped manage state hospital utilization:
    - Colorado strongly encourages providers to use Crisis Stabilization Units in lieu of state hospital care;
    - Similarly, Tennessee encourages the use of less restrictive care whenever appropriate (neither GA nor TN indicated in the survey how this occurred);
    - Georgia's behavioral health administrative services organization ASO) that manages behavioral health care statewide acts as the gatekeeper for all acute care; and
    - North Dakota, which operates one state hospital, screens all potential state hospital admissions through a regional intervention team that serves as the gatekeeper for the state hospital.
- Only Texas responded to the second NASMHPD survey question. Texas has implemented a 1915i Medicaid Waiver that targets individuals with serious mental illness who are "high users" of services. The capitated funding method used in the program creates a "natural deterrent", or incentive, to minimize the unnecessary use of more costly services, such as inpatient care.

In addition to Texas, Panel staff also contacted state mental health authorities in Ohio, Wisconsin, Pennsylvania, Vermont, and Delaware to ascertain what methods these states used to help manage state hospital utilization. A brief synopsis of each follows.

- **Ohio -** Ohio's approach was first described to the Panel by Mike Hogan, who said that Ohio had successfully used a financial incentive to manage and reduce hospital utilization. This was begun as a consequence of the reform-oriented Ohio Mental Health Act of 1988. The Act required Ohio's State Mental Health Authority (SMHA) to negotiate a state hospital bed target with County Boards (the LMHAs). County Boards submitted an Annual Plan quantifying their use of hospital and community services. Each County Board had the option of entering into an agreement whereby the state would "allocate" a sum of dollars to the Board equal to the cost of the agreed-upon state hospital bed-days. If the Board used less than the targeted bed days, the balance of the Board's allocation would be transferred to the Board on an ongoing basis to develop community services and infrastructure. Boards that did not choose this option could continue to use the state hospital without risk, but did not have the opportunity for the reward, i.e., the allocation of unused funds to their community budget. This proved to be an effective strategy for reducing the size of Ohio's state hospitals. However, the environment has changed in Ohio, and although the Ohio MH Act is still on the books allowing this approach, it is no longer being used today because the state is no longer down-sizing its hospitals. Also under the Act, individuals are committed to the County Boards or its designated agency, not to specific facilities. In addition, the Act requires that the state hospital chief clinical officers to review all commitments, and to discharge individuals who no longer need hospital level of care.

- **Wisconsin –** Under Wisconsin's mental health statutes, Counties are primarily responsible for mental health care and treatment. Individuals are committed to the Counties, and the Counties purchase care from hospitals, including state hospitals, or from other providers. Counties authorize all admissions and seek out payer sources just like any other health care provider. There are few voluntary admissions to Wisconsin's two state hospitals, and the state pays for forensic admissions.

- **Pennsylvania –** In Pennsylvania, the state MH agency uses two main approaches to create incentives for effective state hospital utilization. First, the state negotiates a "bed cap" with each County mental health authority. There are no penalties associated with the bed cap, but the Counties are accountable for meeting their targets. The state agency keeps close tabs on utilization by each County, and if utilization begins to exceed the target, the state intervenes with the County to ascertain what is happening (i.e., what the County is doing, what does the County need to address utilization, what challenges is the County facing, etc?). Because exceeding their bed target brings certain scrutiny by the state, Counties pay close attention to achieving their targets. Secondly, the SMHA asks the legislature each year for 90 "community-hospital integration project" slots. These are dollars targeted to individuals in state hospitals, and when these individuals are discharged, the funds follow the person to the County and are used to support the individual in the community. If funds are no longer needed to support the individual directly (for example, if the person is integrated into existing services and supports), then the County may use the funds to expand services as long as the County continues to serve the individual in the community. If the individual is re-hospitalized, the funds must be used for another hospitalized individual. This structure of this program creates a strong incentive to support individuals in community programs versus state hospitals[10].

- **Vermont –** Vermont's SMHA uses several tools to manage state hospital utilization. First, Vermont enrolls individuals with serious mental illness into the state's Community Rehabilitation and Treatment program. Services to these enrollees are supported by a case rate, of which only a portion is budgeted to cover expected state hospital costs. Vermont's local MH agencies are CMHCs. The CMHC providers are aware that the case rate cannot support more than a certain amount of hospital care, so there is an incentive to minimize hospitalization. In addition, the state MH agency oversees state hospital utilization management on an ongoing basis. A care management team at the state level works with local CMHCs to make appropriate and timely discharge plans. Lastly, if a hospitalized individual no longer meets level of care requirements, the responsible community provider's Medicaid payments may be reduced by the state Medicaid authority.

- **Delaware –** Delaware's system of care includes the state MH authority and private providers but there are no local county-based mental health authorities and the system is all state supported. The state recently changed some of its payment process, and developed a capitated system of care for 100 specific individuals needing intensive services and supports. The capitated rate is intended to pay for all care and support provided to the individual, pushing providers to use the most effective and least expensive interventions. This creates a natural brake against hospitalization.

Discussion

In healthcare generally, it is well known that placing clinical decision-making authority and financial accountability for care in a single entity maximizes opportunities for care providers and managers to implement the most effective care most efficiently. Short of that approach, systems can create other

[10] This program is similar to Virginia's Discharge Assistance program (DAP). However, in Virginia's DAP program, there is no incentive to move the individual into mainstream services and supports, or into less costly care, to free up DAP funds, because those funds cannot be used for community capacity-building or service expansion. They may only be used for another hospitalized individual.

incentives that foster innovation, best practices, good management, and a focus on desired outcomes by introducing simple risks and rewards.

Regarding the use of incentives to manage state hospital usage, although the Panel has only limited information from less than half the states, and although the states are very different in terms of their organization, infrastructure, statutes, resources, etc., it is clear that states are successfully using many different methods to create incentives for community providers to effectively manage state hospital utilization[11].

In response to Virginia's current situation, DBHDS has already initiated a dialogue with Virginia CSBs about the possibility of linking some CSB funding to state hospital utilization targets. The objectives would be to create financial incentives to reduce state hospital utilization to safer levels (i.e., from the present 98% to approximately 90%), build community program capacity and assure that CSBs within each state hospital's region will have access to acute beds when necessary. The Panel supports this initiative and believes that such an approach will do much to help resolve one of Virginia's most significant and persistent problems, i.e., the high number of individuals who are ready for discharge but who remain in Virginia's state hospitals.

Recommendation

Given the current demand on Virginia's behavioral health system and its state hospitals, the Panel strongly recommends that Virginia develop and implement, by July 1, 2017, a more robust and balanced approach to accountability for state hospital utilization. Such an approach should allocate more accountability for state hospital utilization to CSBs, increase CSB responsibility for and "ownership" of state hospital use, and create the opportunity for CSBs to share financial risks and rewards based on their state hospital utilization levels and other appropriate target objectives. The Panel recommends an approach that will preserve the present bed capacity of state hospitals, and that emphasizes reducing the "Extraordinary Barriers List" (EBL) to no more than 15 individuals by June 30, 2017, and that maintains this EBL level or lower on an average basis thereafter. The approach should also encourage diversion of civil admissions to community hospitals or other community alternatives whenever possible. The Panel does not endorse any approach that includes a financial penalty that would reduce or remove funding from CSBs or state hospitals.

The Panel further recommends that the above specifications be incorporated as a language amendment into the FY 2018 Appropriations Act, and that $5,000,000 of new State General Funds be appropriated to DBHDS to support this effort in FY 2018 and thereafter.

[Optional: The Panel lastly recommends that DBHDS and DMAS be required to study the possible use of the Involuntary Mental Commitment Fund for both voluntary inpatient treatment and involuntary temporary detention, in order to create an incentive to reduce the use of involuntary treatment statewide. Secondly, the two agencies should study the possible transfer of the Fund from DMAS management to DBHDS, and any other strategies for improving the use of these funds.]

[11] This was also proven in several earlier experiments that gave Virginia's CSBs the opportunity to receive increased funding for reduced state hospital utilization.