

**Proposal on Managing State Hospital Utilization in Virginia**  
**From the**  
**Panel on System Structure and Finance**  
**October 26, 2016**

**Background**

Since Virginia's "last resort" legislation took effect in July of 2014, admissions to Virginia's nine state hospitals have increased 54% over FY 2013. Admissions to state hospitals of individuals under temporary detention orders (TDOs) have increased 157% over the same time period. At the same time, the proportion of temporary detention admissions going to private or community hospitals statewide has gone down significantly<sup>1</sup>. In addition, as many as 150-180 individuals on a 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 and at great expense to the Commonwealth<sup>2</sup>.

State hospitals are consistently operating at utilization levels of 95% or higher, while best practices indicate that safety of patient and staff is reduced at utilization levels over 85%<sup>3</sup>. At times, several state hospitals have been at 100% of operating capacity, causing delayed admissions for some individuals, as well as the use of temporary beds. In addition, there has been 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. The above has occurred amid declining budgets over the last decade<sup>4</sup> and has contributed to increased staff turnover.

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.<sup>5</sup> 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.<sup>6</sup> 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.<sup>7</sup>

**Managing State Hospital Utilization in Virginia**

State hospital utilization management in Virginia is primarily driven by clinical factors, but many other system variables can significantly influence admissions, discharges and length of stay. One obvious factor in the current increasing admissions in Virginia is the "last resort" statutes cited above. Another variable that is widely thought to be important is that state hospital care is free to Community Services Boards (CSBs)<sup>8</sup>. Although inpatient care is the most expensive mental health resource, there are currently no meaningful CSB performance targets or accountability objectives in place that are explicitly linked to state hospital utilization. The current situation led the System Structure and Financing Panel, as well as

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<sup>1</sup> These figures were presented by Interim Commissioner Jack Barber, MD, to the Panel, Oct. 14, 2016.

<sup>2</sup> Interim Commissioner Jack Barber, MD, statements to Panel, Sept. 9, and Oct. 14, 2016. Although EBL patients would incur some service costs in the community, EBL bed days used in FY 2015 cost approximately \$30 million.

<sup>3</sup> Interim Commissioner Jack Barber, MD, statement to Panel, Oct. 14, 2016.

<sup>4</sup> According to DBHDS, state facilities' administrative budgets have been reduced 17% over the past decade.

<sup>5</sup> Source: DBHDS and National Association of State Mental Health Directors (NASMHPD)

<sup>6</sup> Interim Commissioner Jack Barber, MD, presentation to SSF Panel, Sept. 9, 2016.

<sup>7</sup> Email correspondence from J. Barber to CSB Executive Directors, Aug. 2, 2016.

<sup>8</sup> Although not the subject of discussion here, care in DBHDS psychiatric hospitals is also free to jails.

Virginia DBHDS, to search for stronger tools, including incentives, to manage state hospital utilization more effectively.

At its July 11, 2016, meeting, the System Structure and Financing Panel heard a brief description from Dr. Mike Hogan<sup>9</sup> about Ohio's approach, in which state law gives 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 to reduce state hospital use. Ohio used this strategy as part of a long-term effort to expand community services and reduce the size of its state hospitals. 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.

Other states have financial incentives that are explicitly aligned with state hospital utilization objectives, and many have statutes, policies or other practices in place that effectively strengthen accountability of community service providers for state hospital utilization. On the basis of the above, the Panel elected to study the issue further and develop recommendations for the System Structure and Financing Work Group and SJ 47 Subcommittee.

### **State Hospital Utilization Management Practices in Other States**

To understand more completely the use of state hospital utilization management tools 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 to reduce hospital use, 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 in practice 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 the Texas DMH, Panel staff learned that there had been a financial sanction built into the state fund allocation process that penalized county 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 review process was triggered when community providers exceeded their agreed upon utilization threshold. The outcome of the peer review could require the community 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 community providers to use Crisis Stabilization Units in lieu of state hospital care;
  - Similarly, Tennessee encourages the use of less restrictive care whenever appropriate (neither CO nor TN indicated in the survey how this occurred);

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<sup>9</sup> Mike Hogan was 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).

- In Georgia, the 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 Waiver uses a capitated funding method, which creates a “natural deterrent” and 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 (SMHAs) 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 Dr. Mike Hogan, who reported 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 Department of Mental Health to negotiate a state hospital bed target with County Boards (Ohio’s local mental health authorities, or 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 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 the local mental health authorities and have primary responsibility for all 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 SMHA uses two main approaches to manage state hospital utilization. First, the state negotiates a “bed cap” with each County mental health authority. There are no penalties associated with exceeding 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 the County needs to address utilization, what challenges the County is facing, etc.). Because exceeding their bed target brings certain scrutiny by the state, Counties pay close attention to achieving their targets. Secondly, the State 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 creates a strong incentive to support individuals in community programs versus state hospitals<sup>10</sup>.

- **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 state hospital costs. Vermont’s community mental health providers are community mental health centers (CMHCs). Because the case rate cannot support more than a limited amount of hospital care for enrolled individuals, CMHCs have a strong financial incentive to minimize the use of hospitalization and more expensive services generally. In addition, the SMHA 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 for state hospital patients. Lastly, if a hospitalized individual no longer meets level of care requirements, the responsible community provider’s Medicaid payments may be reduced by Vermont’s state Medicaid authority.
- **Delaware** – Delaware’s system of care includes the SMHA and private providers. There are no local county-based mental health authorities and the system is entirely 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, creating a natural brake on hospitalization (see Texas, above).

## Discussion

In healthcare generally, it is well understood that placing clinical decision-making authority for a given population and financial accountability for care within a single organizational entity maximizes opportunities for care providers and care managers to implement the most effective care most efficiently. Short of that approach, data collected by the Panel from other states, though limited in scope, suggests that state behavioral health systems can effectively implement a variety of mechanisms to foster a strong and explicit focus on targeted state hospital utilization objectives. These strategies can create sufficient incentives for community providers to effectively manage state hospital utilization, as described above.

In May, DBHDS also began an ongoing dialogue with Virginia CSBs and state hospitals to raise awareness of the inherent risks and liabilities of the current situation, and to explore strategies that would reduce and stabilize CSBs’ state hospital utilization at safer levels (e.g., 90%), build community program capacity and assure that CSBs within each state hospital’s region would have access to acute beds when necessary. Among the strategies being implemented are;

- Focused meetings with CSB emergency services staff to strengthen their capability to avoid state hospitalization;
- Training in clinical risk management;

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<sup>10</sup> 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.

- Intensive review of data regarding individuals released at commitment hearings, current state hospital inpatients, and admissions diverted out of region;
- Meetings with private hospitals to strengthen capacity and willingness to accept admissions;
- Consultation to treatment teams to make timely discharge of discharge ready individuals;
- Mechanisms for transfer from state to private hospital when benefits are in place;
- More intensive and focused communication and data exchange between CSBs and state hospitals (re individual cases, admissions, TDOs, admission diagnoses, co-occurring medical issues, trends, etc);
- Provision of prompt transportation when needed to accomplish discharge;
- Central office participation in CSB/regional meetings with private hospitals.

DBHDS also carved out \$8.7 million in one-time funds from existing budgets to allocate to Regions and CSBs for system capacity-building. These funds will support an extensive array of service enhancements that are tailored to specific local and regional needs that will reduce state hospital utilization. Each CSB and Region-specific plan is intended to reduce state hospital utilization by 10% when service improvements are implemented.<sup>11</sup> Planning is also underway to respond to longer-term needs through performance-based contracts with private hospitals; increased community detox and sobriety centers; housing; uniform children’s crisis response services; increased Discharge Assistance Program (DAP) funding; and multi-disciplinary regional support teams to work with assisted living and nursing facilities to improve their capacity to serve individuals with behavioral health challenges.

The Panel strongly supports these DBHDS and CSB initiatives and believes that, if implemented successfully, they will help address one of Virginia’s most significant and challenging current problems, that is, the burgeoning use of state hospitals. The Panel also applauds the use of targeted interventions designed to address specific local and regional needs, as well as the use of explicit outcome objectives expressed in terms of the impact of these interventions on state hospital utilization.

The Panel also recognizes, however, that excessive demand on state hospital beds has been an ongoing challenge for the behavioral health system for decades, and that the current initiatives are limited in scope and funded with one-time dollars. The Panel is also convinced that permanent and lasting change will not be achieved without permanent and lasting support, including funds and other resources as well as leadership commitment.

Moreover, these initiatives do not address the structural incentives built into the system that are almost certainly producing or exacerbating the increased pressure on state hospitals. These structural incentives include the “last-resort” laws, the bias toward involuntary (vs. voluntary) care in the provision of short-term treatment for temporary detention and in transportation, the “free care” provided by state hospitals to CSBs, and the discretion granted to private hospitals regarding all admissions. The Panel believes that these and possibly other structural incentives warrant further study in the upcoming year, which may yield important keys to achieving in the long term a more balanced and accountable community based system of care for Virginia.

## **Recommendations**

Based upon the deliberations outlined above, the Panel makes the following recommendations:

- 1) ***That DBHDS, CSBs and state hospitals implement the agreed upon FY 2017 census reduction initiatives and periodically upon request report on the progress and impact of these initiatives on***

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<sup>11</sup> A detailed description of specific CSB and Regional initiatives, including funds allocated to each region, was presented to the Panel on October 14, 2016, by Interim Commissioner Jack Barber, MD.

*the Extraordinary Barriers List and overall state hospital use to the System Structure and Finance Panel, Work Group and SJ 47 Subcommittee.*

- 2) *That DBHDS and CSBs develop budget request(s) for FY 2018 to support continued targeted CSB and regional interventions to stabilize and maintain state hospital utilization at no more than 90% of the January 1, 2017, operating capacity of each DBHDS state hospital.*
- 3) *That the Panel and Work Group continue to study the statutory, policy, financing, and administrative elements of the current behavioral health system that are not aligned with strategic and operational objectives, or that create impediments to efficient and effective care, and recommend solutions to the Subcommittee by October 30, 2017, including the use of financial risks and incentives to achieve targeted performance objectives.*
- 4) *That DBHDS, in cooperation with the Department of Medical Assistance Services, shall study the potential use of the Involuntary Mental Commitment Fund (IMCF) 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 shall study the possible transfer of the IMCF fund from DMAS management to DBHDS, and any other strategies for improving the use of these funds.*

DRAFT