Report of the
Joint Legislative Audit and Review Commission
To the Governor and
The General Assembly of Virginia

Availability and Cost of Licensed Psychiatric Services in Virginia

SENATE DOCUMENT NO. 19
2007

In Brief

Availability and Cost of Licensed Psychiatric Services in Virginia

SJR 185 (2006) directed JLARC to "study the use and financing of licensed inpatient psychiatric facilities in the Commonwealth." The statewide supply of psychiatric beds in Virginia appears to be adequate although a lack of data on the demand for beds hinders this assessment. Other indicators suggest that persons with behavior problems have difficulty accessing psychiatric beds. Use of psychiatric beds could be reduced by increasing the availability of community-based mental health services, but this is impeded by a statewide shortage of psychiatrists.

In 2005, licensed hospitals reported substantial unreimbursed costs from providing psychiatric services in inpatient beds and emergency departments; the largest sources of unreimbursed costs were uninsured patients and underreimbursement from commercial insurers. Furthermore, Medicaid does not pay licensed hospitals for all costs associated with psychiatric patients. Medicaid reimbursements for psychiatrists decreased by 16 to 24 percent between 2000 and 2006 when adjusted for inflation.

Finally, some groups of persons previously served by State mental hospitals are now deemed inappropriate for admission, although statutorily required admission regulations have not been issued. Also, many persons with mental illness are in jails. Statutory clarification is also needed on the role of regional partnerships of community services boards in State hospital admission decisions.

JLARC Staff for This Report

Hal Greer, Division Chief
Ashley Colvin, Project Leader
Paula Lambert
Eileen Fleck
Brad Marsh

This report is available on the JLARC website at http://jlarc.state.va.us

COMMONWEALTH of VIRGINIA

Joint Legislative Audit and Review Commission

Philip A. Leone
Director

Suite 1100, General Assembly Building, Capitol Square
Richmond, Virginia 23219

(804) 786-1258

January 9, 2008

The Honorable Thomas K. Norment, Jr.
Chairman
Joint Legislative Audit and Review Commission
General Assembly Building
Richmond, Virginia 23219

Dear Senator Norment:

Senate Joint Resolution 185 of the 2006 General Assembly directed the staff of the Joint Legislative Audit and Review Commission to evaluate the use and financing of licensed inpatient psychiatric facilities. Specifically, staff were directed to evaluate utilization trends, the Medicaid rate-setting process for psychiatric and related services, community services boards contracts with psychiatric facilities, and the adequacy of funding for psychiatric beds. Staff were also asked to identify actions that could be taken to maintain adequate licensed psychiatric services in the State.

Study findings were presented to the Commission on October 9, 2007, and are included in this report.

On behalf of the Commission staff, I would like to thank the staff at the Departments of Mental Health, Mental Retardation and Substance Abuse Services and Medical Assistance Services for their assistance during this study.

Sincerely,

Philip A. Leone
Director

Table of Contents

JLARC Report Summary:

Availability and Cost of Licensed Psychiatric Services in Virginia

Key Findings

- Statewide data suggest that the supply of psychiatric beds is adequate, but comprehensive data on demand for beds are not available. Other indicators suggest that persons with behavioral problems face difficulty accessing beds, and it appears that more beds are needed in certain localities. (Chapter 2)

- The use of psychiatric beds could be reduced by increased use of community-based services, but a shortage of psychiatrists hinders the expansion of any psychiatric service. (Chapter 3)

- Licensed hospitals reported unreimbursed costs of $25 million from providing inpatient psychiatric services in 2005 and another $45 million providing emergency department services. Uninsured patients and under-reimbursement from commercial insurers were the two largest sources of unreimbursed costs. (Chapter 4)

- Medicaid does not pay licensed hospitals for all costs associated with caring for psychiatric patients. After adjusting for inflation, Medicaid reimbursements for psychiatrists have decreased by 16 to 24 percent since 2000. (Chapter 5)

- Some persons served by State mental hospitals in previous years are now deemed inappropriate for admission, although statutorily required regulations on State hospital admission have not been issued. As a result, local departments of social services, jails, and community services boards are responsible for these persons. (Chapter 6)

- State hospital admission decisions are made by regional mental health organizations that lack a statutory basis. Moreover, State funds to purchase psychiatric services from licensed hospitals flow to these organizations from the Department of Mental Health, Mental Retardation and Substance Abuse Services without sufficient guidelines on proper use of these funds or appropriate eligibility criteria. (Chapter 7)

Senate Joint Resolution 185 (2006) directs the Joint Legislative Audit and Review Commission (JLARC) to "study the use and financing of licensed inpatient psychiatric facilities in the Commonwealth." The mandate notes that financial pressures have led licensed hospitals to close psychiatric beds and that the long-term success of Virginia's efforts to transform its mental health system depends upon the availability of these beds. The mandate also notes that payments from public sources, including Medicaid, do

not cover all costs incurred by hospitals in providing psychiatric services.

Based on national prevalence rates, about 298,000 adult Virginians have a serious mental illness at any time during a given year. Symptoms may affect these individuals' ability to work or care for themselves, and may involve a suicide attempt. Children and adolescents with mental health needs are referred to as having a serious emotional disturbance. National prevalence rates suggest that about 102,000 children and adolescents in Virginia have such a disturbance, and 65,000 of them are extremely impaired.

STATE HOSPITALS AND LICENSED HOSPITALS ARE INTERDEPENDENT

Since 1970, State mental hospitals have been closing beds through a process known as deinstitutionalization, and, to fill the gap in the provision of mental health services, community-based services have increased. Many of these services are provided by local government agencies known as community services boards (CSBs). In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) provides CSBs with funds which are used to pay for psychiatric beds in licensed hospitals (freestanding psychiatric hospitals, general hospitals with psychiatric units, and teaching hospitals).

The increased use of licensed hospitals has allowed further reductions in the number of patients served by the State hospitals. For example, in 2005, licensed hospitals served 85 percent of all persons ordered by a judge through the commitment process to receive inpatient psychiatric treatment. However, because mental illness often requires intensive or long-term treatment that licensed hospitals cannot provide, State hospitals are often used to serve people who are admitted initially to licensed hospitals.

State hospitals and licensed hospitals thus are interdependent, and a reduction in services provided by either type of hospital places a greater demand for services on the other. Alternatively, other community-based services may decrease the need for either type of hospital, but these services have never been widely available, and CSBs report waiting lists for the services they provide.

THERE APPEAR TO BE SHORTAGES OF PSYCHIATRIC BEDS IN SOME LOCALITIES AND FOR CERTAIN GROUPS

Presently, statewide data do not indicate a shortage of psychiatric beds and suggest that the existing number of beds is adequate. The statewide occupancy rates for both licensed and staffed psychiatric beds are below the level used by the Virginia Department

of Health (VDH) to indicate a need for new psychiatric beds. However, since 1991, almost 800 psychiatric beds have been closed in Virginia, a decrease of 31 percent. This is twice the rate at which other hospital beds have been closed, and these closures may hinder the State's ability to continue reducing the use of State hospital beds.

Indicators suggest that new beds are needed in some localities and that some persons have difficulty accessing existing beds. The number of beds for children and adolescents appears adequate on a statewide level, but the data reported by licensed hospitals suggest that beds are concentrated in a handful of localities and some children and adolescents face barriers to access. In addition, VDH has determined that 29 new beds for adults are needed in four planning districts, and CSB staff indicate that some persons held under a temporary detention order (TDO) have been released because a bed could not be found in time. Moreover, many mental health care professionals state that individuals with behavioral problems or aggressive behavior may be less able to find a bed. Often these individuals have been hospitalized on multiple occasions, and hospitals are reportedly unwilling to readmit them.

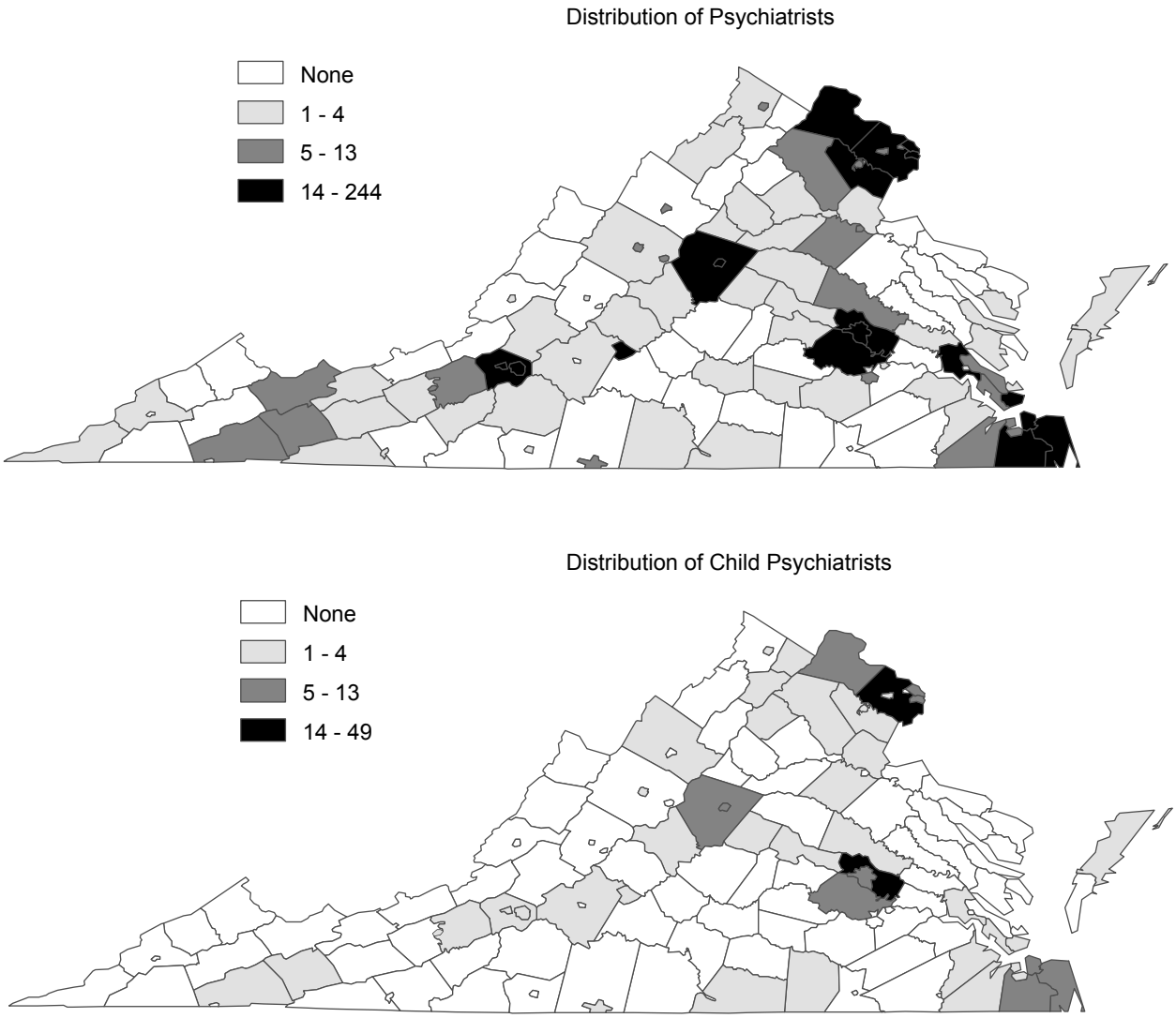
ADDITIONAL COMMUNITY SERVICES AND PSYCHIATRISTS ARE NEEDED

Licensed hospital staff report that the limited availability of community mental health services outside of the hospital limits their ability to discharge some of their existing patients. Moreover, almost one in five of all psychiatric patients in 2005 were readmitted to the hospital at least once. Hospital staff indicate that these repeat visits could be reduced if outpatient community services were available.

One category of services that could most effectively reduce the demand for inpatient psychiatric care is emergency services, which includes mobile crisis teams and crisis stabilization centers. In Virginia, the use of mobile crisis teams has been shown to reduce the use of psychiatric beds in licensed hospitals, but these services are not widely available. There are only 16 mobile crisis teams statewide, and only 12 localities have a crisis center.

In addition, the ability to expand the availability of psychiatric beds or other community services is hindered by the shortage of professional staff. Seven of Virginia's localities account for half of all psychiatrists in the State, and 47 localities do not have any psychiatrists at all. Moreover, 87 localities do not have any child psychiatrists, as shown in the map on the next page. There is also a reported shortage of other staff, including nurses and social workers. The Inspector General of DMHMRSAS has documented the

Many Localities Do Not Have Any Psychiatrists (2005)



Source: Analysis of American Medical Association data, in quartiles.

shortages of nursing staff in State hospitals, and these staffing shortages affect the ability of the State hospitals to provide services.

LICENSED HOSPITALS REPORT UNREIMBURSED COSTS BECAUSE OF UNINSURED PATIENTS AND LOSSES FROM COMMERCIAL INSURERS

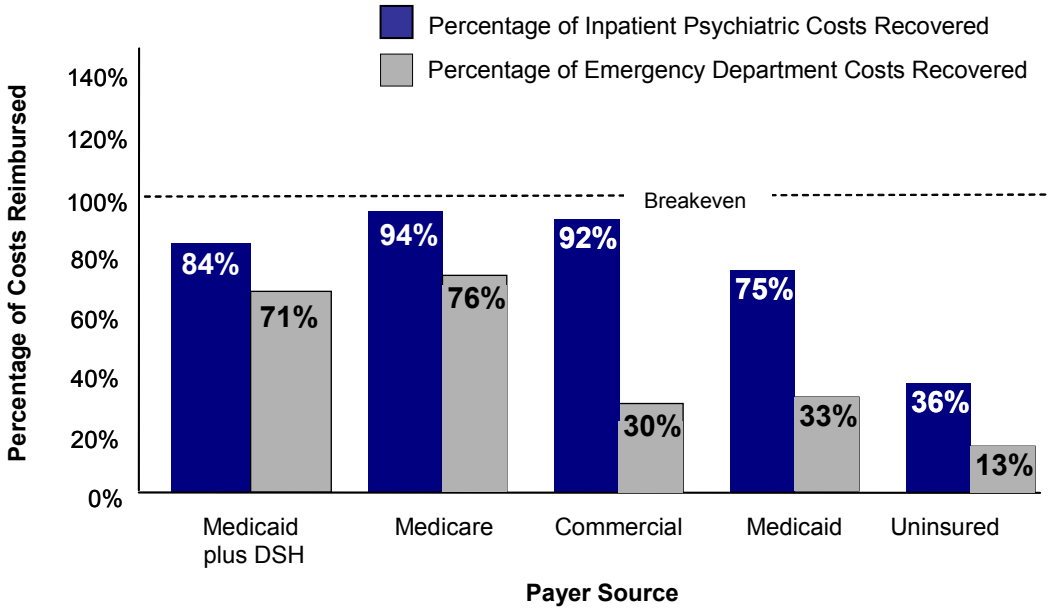
Some licensed hospitals are not fully reimbursed for the costs of psychiatric services. The overall extent of unreimbursed costs was $25 million from inpatient services and $45 million from emergency department services. Uninsured patients accounted for 29 percent of these unreimbursed costs, and under-reimbursements

from commercial insurance accounted for 16 percent. As seen in the figure below, commercial insurers reimbursed hospitals for 92 percent of the costs incurred providing inpatient services, on average. However, because the largest group of patients has commercial insurance, these under-reimbursements have a large cumulative effect.

Not all licensed hospitals had unreimbursed costs, however. Specifically, freestanding psychiatric hospitals were fully reimbursed for their costs of providing psychiatric services in 2005. In contrast, teaching and general hospitals had unreimbursed costs overall. One explanation for the difference in reimbursements is that some hospitals served a large volume of Medicaid recipients and therefore received additional Medicaid payments. These payments, known as Disproportionate Share Hospital (DSH) payments, can be used to offset losses associated with the costs of serving Medicaid recipients or uninsured patients.

Although the majority of licensed hospitals report unreimbursed costs, most of which are from uninsured patients, hospitals are obliged to provide some charity care as a condition of licensure. Moreover, some hospitals appear to negotiate with commercial insurers for a hospital-wide level of reimbursement, and psychiatric services may not be fully reimbursed as a result of these overall negotiations. However, if licensed hospitals determine that they

Some Payers Reimburse a Higher Percentage of Costs for Psychiatric Services



Source: Analysis of psychiatric facilities financial survey data (2005).

are not recovering a sufficient percentage of costs, then they may respond by reducing the number of inpatient psychiatric beds.

CHANGES TO THE MEDICAID RATE-SETTING PROCESS MAY BE WARRANTED

The process used by the Department of Medical Assistance Services (DMAS) to set Medicaid rates appears to be reasonable overall, but some changes may better reflect the costs incurred in treating individual patients and address the shortage of psychiatrists. These steps may assist in the State's efforts to ensure an adequate supply of psychiatric beds.

Unlike most other inpatient hospital rates, the rates for psychiatric services are per diem rates, meaning that each hospital gets a set daily payment for each psychiatric patient regardless of his or her medical needs. DMAS sets new rates every three years and adjusts the rates for inflation in the intervening years. The rates only reimburse licensed hospitals for a portion of the costs they incur treating Medicaid patients because a rate adjustment factor is used to artificially lower rates, and only 80 percent of capital costs are reimbursed. The adoption of a weighted per diem rate like that used by Medicare may better reflect variation in costs between different patients, and it is recommended that DMAS study this option and report to the General Assembly.

DMAS also uses the Involuntary Mental Commitment Fund to pay licensed hospitals for services rendered to persons who are held under a TDO. The TDO payment rate is tied to the Medicaid rate for inpatient psychiatric services; therefore, licensed hospitals are only reimbursed for a portion of their costs. Licensed hospitals express concern that DMAS does not pay for all of the services they render during a TDO because DMAS may determine that some services were not medically necessary. Some of these concerns could be addressed through the regulatory process, but the Board of Medical Assistance Services has not adopted statutorily required regulations concerning the rate for services rendered during a TDO. It is recommended that the Board adopt these regulations and use this process to clarify which services DMAS will reimburse during a TDO.

It has been reported that Virginia's shortage of psychiatrists may be exacerbated by the insufficiency of Medicaid rates for psychiatric services. Since 2000, Medicaid rates (unadjusted for inflation) have generally decreased or remained flat and are lower than rates paid by other insurers, including Medicare. After adjusting for inflation, overall Medicaid rates have decreased by about 16 to 24 percent. If the General Assembly wished to adjust the rates for psychiatric services for inflation, it may need to first direct DMAS

to create a rate-setting process for psychiatric services. This step was taken in 2005 to create specific rate-setting processes for other services.

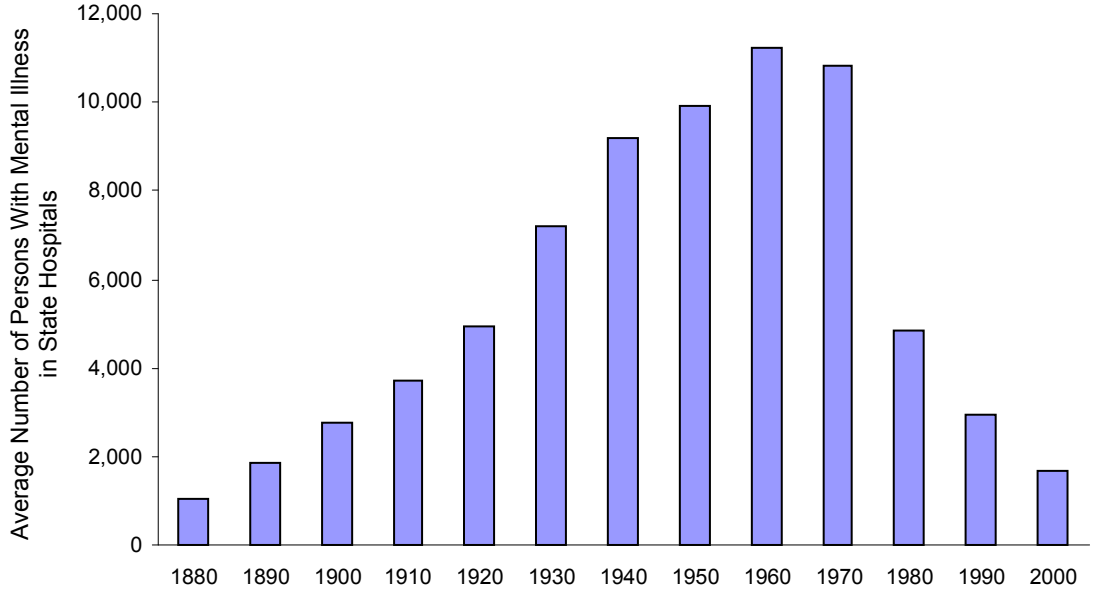
SOME PERSONS ARE NOT ADMITTED TO STATE HOSPITALS, AND PATIENTS IN CUSTODY OF CRIMINAL JUSTICE SYSTEM REDUCE THE AVAILABILITY OF BEDS

Since Virginia's first State hospital for the mentally ill was opened in 1773, these institutions have been responsible for serving most of Virginia's mentally ill citizens. As shown in the figure below, State hospital beds have decreased in number to less than one-fifth of their 1970 levels; this decrease resulted from an effort to provide care in a less restrictive and less costly environment. As a result, many of the persons who would have been admitted to State hospitals in previous years are now being served by licensed hospitals.

Some groups of individuals that the State hospitals used to serve, such as those with dementia, substance use disorders, and major medical conditions, are now deemed by DMHMRSAS to be inappropriate for State hospital care. By statute, it would appear that local departments of social services are responsible for serving these persons.

Licensed hospitals are concerned that the State is shifting responsibility to them without a clear rationale for its current admission

Institutionalization Began in About 1920 and Deinstitutionalization Began In 1970



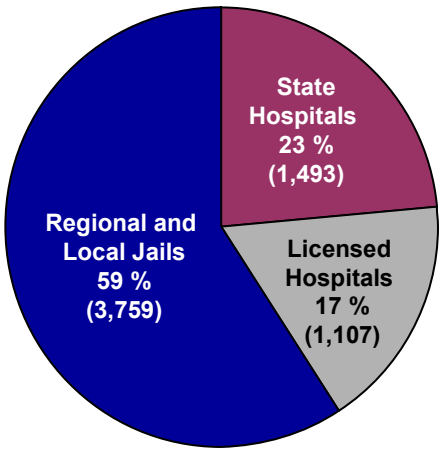
Source: Analysis of data from the Department of Mental Health, Mental Retardation and Substance Abuse Services, and archival data from the State Department of Public Welfare.

criteria. Because the role of the State hospitals in relation to licensed hospitals has changed, there is a need to clarify the current role of the State hospitals in terms of what types of individuals they serve. However, the State Mental Health, Mental Retardation and Substance Abuse Services Board has not adopted statutorily required regulations on admission criteria for State hospitals. The State Board should adopt these regulations, and this action may help ensure that licensed hospitals continue to serve persons who are involuntarily committed, because a private provider cannot be legally compelled to serve these persons.

State hospitals serve both civil patients, who enter either voluntarily or through the involuntary commitment process, and forensic patients, who are committed to a State hospital through the criminal justice system. While DMHMRSAS controls admissions of civil patients, forensic admissions are outside of the department's control. There are also a large number of mentally ill individuals in jails who may be referred to State hospitals for inpatient care. As shown in the figure below, data indicate that on a given day, regional and local jails care for about 60 percent of mentally ill persons, more than those served by State hospitals and licensed hospitals combined.

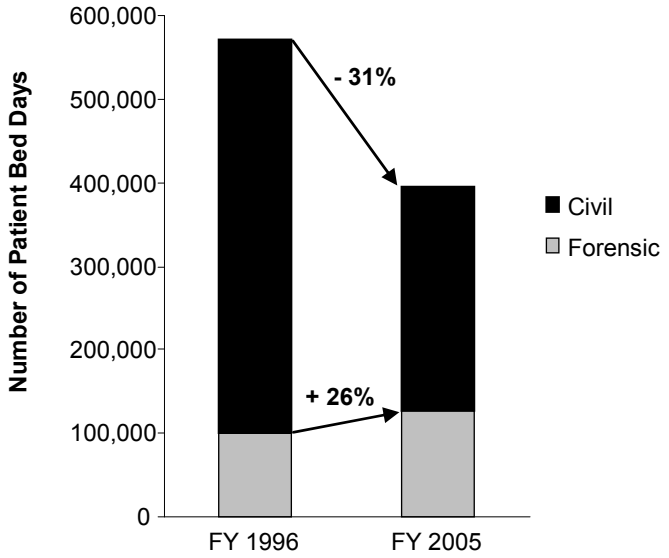
As can be seen in the figure on the following page, although the availability of State hospital beds is decreasing (as measured by the number of "bed days"), an increasing proportion of the bed days

One-Day Snapshot Shows That Jails Serve More Mentally Ill Persons Than State Hospitals or Licensed Hospitals



Source: Analysis of data from Virginia Health Information, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Compensation Board for September 13, 2005.

Forensic Patients Are Using an Increasing Proportion of State Hospital Bed Days



Source: Analysis of data from the Department of Mental Health, Mental Retardation and Substance Abuse Services.

is being used by forensic patients. From FY 1996 to FY 2005, the number of bed days used by forensic patients increased by 26 percent, while the overall number of bed days decreased by 31 percent. As a result, there are fewer State hospital beds available to accept patients transferred from licensed hospitals.

Although significant changes have occurred in the number and type of individuals served in State hospitals, DMHMRSAS is not planning for or projecting the number of State hospital beds that will be needed in the future. It is recommended that DMHMRSAS undertake these planning activities.

REGIONAL ORGANIZATIONS PROVIDE SOME MENTAL HEALTH SERVICES WITHOUT CLEAR STATUTORY BASIS

In 2003, DMHMRSAS promoted regional partnerships of CSBs in order to continue reducing the number of State hospital beds. CSBs in each region have entered into memoranda of understanding (MOU) with the State hospital in their assigned region, and regional committees now determine whom to admit to the State hospital. The CSBs in these regional partnerships also expend State funds to purchase beds for eligible patients in licensed hospitals through a Local Inpatient Purchase of Services (LIPOS) program.

The regional MOUs establish the requirements patients must meet in order for their hospital stay to be paid for with LIPOS funds. The regional partnerships also contract with licensed hospitals to establish per diem rates for LIPOS-funded hospital stays and other program requirements. At the present time, the use of LIPOS contracts and the relationships they establish with licensed hospitals are in different stages in different parts of the State. This results from the variation both in LIPOS funding and in the regional availability of licensed hospital beds.

Licensed hospital staff have three concerns about the LIPOS program which affect the willingness of the hospitals to continue to contract with the regional partnerships. First, licensed hospital staff indicate that there are no clear guidelines on the appropriate use of LIPOS funding, making it difficult to determine if the funds are being spent appropriately. For example, it is unclear whether a CSB could use these funds to provide services outside of a licensed hospital. Second, there are also no clear eligibility criteria, making the variation between regions appear arbitrary. For example, some regions will not pay for individuals who are admitted to a licensed hospital without assistance by CSB staff. Third, LIPOS per diem rates are reported to be insufficient to cover hospital costs.

Resolution of these concerns would be in the best interest of the State because licensed hospital beds are vital to the success of current initiatives designed to reduce the use of State hospitals. As the agency that distributes LIPOS funds, DMHMRSAS should issue guidelines that clarify how they can be used and who is eligible.

There is also lack of clarity regarding the authority of the regional partnerships. The annual performance contract executed between DMHMRSAS and each CSB appears to require the CSBs to form and participate in regional partnerships. However, there is no clear statutory basis for their creation, which appears to undercut efforts to increase the accountability of CSBs to the local governments that created those partnerships. Moreover, although these regional efforts appear to have many beneficial aspects, there is no clear statutory basis for delegating to them responsibilities for State hospital admission that are assigned by statute to other entities. For example, the regional partnerships are approving transfers to State hospitals, a responsibility assigned in statute to the Commissioner of DMHMRSAS. If the regional partnerships are to continue to perform these statutory duties, these organizations should be established in statute as the appropriate vehicle for performing these duties.

Chapter 1

Overview of Virginia's Mental Health System

In Summary

National estimates of the number of persons with mental illness suggest that about six percent of Virginia's population has a serious mental illness. A mental illness, such as bipolar disorder or schizophrenia, may affect the ability of these individuals to work, limit their ability to care for themselves, and may lead to a suicide attempt. Mental illness typically affects people at an early age, and most people develop symptoms by their mid-twenties. Some of these individuals will need mental health care services, which are provided by public agencies and private providers including hospitals with licensed psychiatric beds. People can seek mental health services voluntarily. If they are unwilling to seek needed care, Virginia's civil commitment process provides a mechanism for determining if care is needed. In keeping with legal requirements, this process must protect individual liberties and provide care in the least restrictive setting. The costs of mental health services may be paid by commercial insurance, and some persons may qualify for Medicare or Medicaid.

Virginia is noteworthy for having the first public mental health hospital in the Western Hemisphere, Eastern State Hospital in Williamsburg, which opened in 1773. This was followed by Western State Hospital in 1828, which was built in the geographic center of the State (Staunton), and another hospital in what is today West Virginia. Over many decades, these and other State hospitals were the primary source of public mental health services in Virginia, and few community-based services were available. This began to change in 1970 when services provided in State hospitals were reduced through a process known as deinstitutionalization. Funding began to shift from State institutions to community-based providers, and community mental health services began to grow. Since then, these services have been provided by a combination of local government agencies and licensed hospitals (freestanding psychiatric hospitals and general hospitals).

Nationally, there is a renewed effort to "transform" the public mental health system. This effort was embraced in 2003 by the President's New Freedom Commission on Mental Health. As part of these transformation efforts, states are restructuring their mental health system to shift additional funding from State hospitals to community-based services, including licensed hospitals. This has resulted in reductions nationwide in the number of State hospital beds.

Inpatient beds in licensed hospitals play an important role in the mental health system as alternatives to State hospital beds. However, the number of inpatient psychiatric beds in licensed hospitals has also been decreasing, and 35 states reported a shortage of psychiatric beds in 2004. If this decrease in inpatient psychiatric beds continues, the availability of psychiatric services could be limited.

Senate Joint Resolution 185 (2006) directs the Joint Legislative Audit and Review Commission (JLARC) to "study the use and financing of licensed inpatient psychiatric facilities." (Appendix A contains the complete text of the study mandate.) The study mandate ties the decrease in the number of psychiatric beds to underpayment by Medicaid and other public payers, and states that these funding sources do not cover all of the costs incurred by hospitals. JLARC is also directed to examine trends in the use of psychiatric beds, and to determine what steps can be taken to maintain a sufficient number of psychiatric beds.

To answer these questions, JLARC staff used several research activities, which are discussed in more detail in Appendix B. To analyze the extent to which licensed hospitals had unreimbursed costs resulting from the provision of psychiatric services, JLARC staff obtained patient-level financial and demographic data for calendar year 2005. JLARC staff also analyzed patient-level data from Virginia Health Information (VHI) for calendar years 2001 through 2005. Lastly, JLARC staff conducted structured interviews with mental health professionals at State agencies and licensed hospitals, reviewed the mental health literature, and reviewed contracts executed between licensed psychiatric hospitals and community services boards (CSB).

MANY VIRGINIANS REQUIRE MENTAL HEALTH SERVICES

Estimates of the number of Virginians with mental health care needs suggest that about one of every four Virginians has a diagnosable mental disorder at some point during a given year. Persons with more serious needs comprise a much smaller group.

About Six Percent of Virginians Have a Serious Mental Illness

In part because of the stigma that has long been associated with mental illness, there is no precise estimate of the number of people who need mental health care. According to a national survey conducted by the National Institute of Mental Health (NIMH) in 2005, about 26 percent of the general American population has some type of mental disorder. This percentage includes all disorders, including substance abuse disorders, cognitive impairments (such as Alzheimer's disease), and mood disorders (such as depression).

However, for most persons these disorders are usually mild, infrequent, and do not need formal treatment.

The population most in need of services are those persons with a serious mental illness (SMI), such as schizophrenia or bipolar disorder (also known as manic depression). The NIMH study estimates that about six percent of Americans have a serious mental illness, as indicated by symptoms that affect their ability to work, limit their ability to care for themselves, and may lead to a suicide attempt.

Using national prevalence rates, it is estimated that about 298,000 adult Virginians have a serious mental illness at any time during a given year. Children and adolescents with mental illness are referred to by the term "serious emotional disturbance." National prevalence rates suggest that about 102,000 children and adolescents in Virginia have a serious emotional disturbance, and 65,000 of them are extremely impaired.

Mental Health Needs and Services Typically Vary with Age

In 2005, VHI data indicate that 81 percent of psychiatric patients were adults (ages 18 to 64), but adults comprised only 65 percent of Virginia's population. In contrast, children and adolescents comprised 25 percent of the State's population but only 10 percent of all psychiatric patients. There are two possible explanations for the differences in age distribution between psychiatric patients and other Virginians.

First, the initial symptoms of mental illness typically occur in late teens and early 20s. According to a 2005 study in the *Archives of General Psychiatry*, half of all mental disorders are identifiable by age 14, and 75 percent by age 24. For example, anxiety disorders often begin in late childhood, and mood disorders begin in late adolescence. Severe cognitive impairments that usually occur later in life, such as Alzheimer's disease, are often not considered to be a mental illness.

Persons with serious mental illness live 25 years less, on average, than the general American population.

Second, persons with SMI now live 25 years less, on average, than the general American population. According to the National Association of State Mental Health Program Directors (NASMHPD), in 1990 persons with SMI lived, on average, only 10 years less than the general American population. This suggests that the life expectancy of persons with SMI has decreased by 15 years since 1990. According to NASMHPD, the decrease in lifespan results from medical conditions such as cardiovascular, pulmonary, and infectious diseases. These conditions result from a combination of factors, but a notable change has been the use since 1991 of "second-generation" antipsychotic drugs, which have "become more highly

associated with weight gain, diabetes, dyslipidemia, insulin resistance and the metabolic syndrome."

Types of Mental Disorders Among Hospital Patients in Virginia

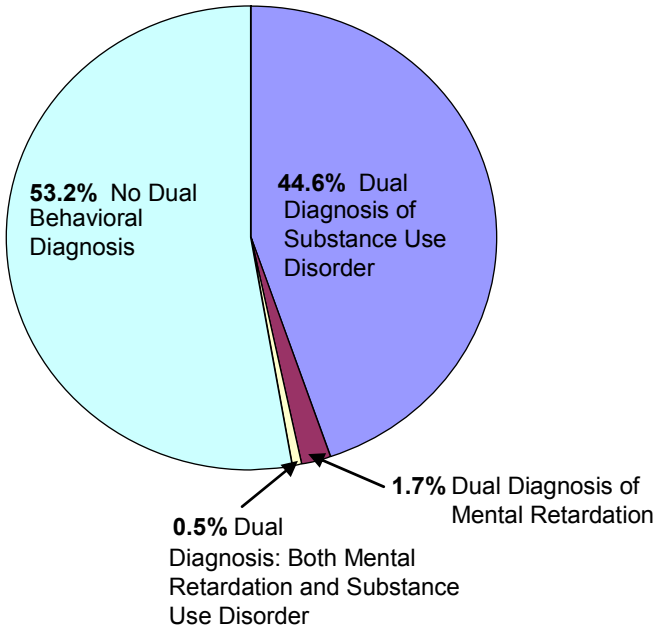
Between 2001 and 2005, VHI data indicate that there was no change in the five most frequent types of mental disorders among psychiatric patients in licensed hospitals. However, there has been an increase in the number of patients with bipolar disorders, and recent research suggests the number of veterans seeking psychiatric services may increase.

Mood Disorders Are the Most Prevalent Diagnosis for Psychiatric Patients. In 2005, the most common diagnosis for psychiatric patients was a mood disorder (47 percent), followed by schizophrenia (18 percent), substance abuse (15 percent), and depression (6 percent). The *New England Journal of Medicine* reported in 2005 that the prevalence of mental disorders among adults did not change between 1990 and 2003. However, there are indications that these trends may change. A July 2007 article in *Biological Psychiatry* concluded that from 1990 to 2003 the rate of bipolar disorder among children increased sevenfold. In Virginia, the number of psychiatric patients with a bipolar diagnosis increased by nine percent among children and adolescents (102 discharges), and by 19 percent among adults (1,196 discharges).

Secondary Diagnosis of Substance Use Disorders Increased. Although half of all psychiatric patients do not have a secondary behavioral health diagnosis, some psychiatric patients also have a diagnosis of substance use or of mental retardation (Figure 1). The percentage of psychiatric patients with a secondary diagnosis of substance abuse increased since 2001, from 35 to 45 percent. However, there was also an increase in the percentage of all hospital patients with a secondary substance abuse diagnosis (from 10.4 to 13.2 percent). In contrast, the percentage of psychiatric patients with a secondary diagnosis of mental retardation decreased, from 2.8 to 2.2 percent.

Demand for Psychiatric Services by Veterans May Increase. A 2007 article in the *Journal of the American Medical Association* found that 31 percent of Iraq veterans seeking treatment at Veteran's Administration facilities had a mental health disorder, and 56 percent of this group had more than one disorder. A frequently occurring condition, post-traumatic stress disorder, is reported by one in eight Iraq veterans, according to a 2004 article in the *New England Journal of Medicine*. Although some federally supported services are available, local agency staff in the Hampton and Newport News area stated that the local Veteran's Administration hospital is unable to provide services to all persons seeking care.

Figure 1: Forty-Five Percent of Psychiatric Patients Had a Secondary Diagnosis of Substance Abuse (2005)



Source: Analysis of data from Virginia Health Information.

Mental Disorders Affect Health and Well-Being

Suicide and homicide are the fourth and fifth leading causes of death for persons aged 10 to 60 years in the United States, and both of these causes of violent death are associated with mental illness. The *Journal of the American Medical Association* reports that more than 80 percent of persons with suicidal behaviors met diagnostic criteria for a mental illness, including diagnoses of mood disorders, anxiety disorders, impulse-control disorders, and substance use disorders. In addition, Americans with substance use disorders are 12 to 16 times more likely than other Americans to engage in violent behavior. This association is stronger among persons with co-occurring personality disorders (such as antisocial personality disorder) or SMI.

The research conducted by NIMH indicates that in a given year, persons with SMI are unable to carry out normal daily activities for a period of 90 days (on average) because of their mental illness or substance abuse problems. The director of NIMH has characterized mental illness "as a chronic disorder of the young." Adolescents and young adults who have an untreated mental illness often encounter delays in treatment, and may suffer debilitating symptoms during their most productive years. This can affect educational attainment, career development, and family building. More-

over, many persons with mental illness may develop a more severe mental illness or substance use disorders.

MENTAL HEALTH SERVICES ARE PROVIDED BY BOTH THE PUBLIC AND PRIVATE SECTORS

Until the 1950s, mental health care services in Virginia were primarily provided by a system of public mental health hospitals (State hospitals) and a small number of private psychiatric hospitals (freestanding hospitals) for paying clients. Since that time, federal grant funds and the advent of commercial insurance coverage for mental illness spurred the development of acute care psychiatric units in general hospitals, as well as additional freestanding hospitals. Simultaneously, the State hospitals have been downsizing through deinstitutionalization.

Public Agencies Provide, License, and Fund Services

The public mental health system in Virginia consists of three primary organizations, but other agencies play an important role.

State Mental Health, Mental Retardation and Substance Abuse Services Board (State Board). The State Board is a nine member policy board that oversees the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). The State Board is statutorily responsible for creating programmatic and fiscal policies, long-range planning, adopting regulations, and monitoring the performance of DMHMRSAS. The responsibilities of the State Board are contained in the *Code of Virginia* (§ 37.2-203).

Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). DMHMRSAS has a broad mission to provide leadership, accountability, oversight and support to the CSBs, State institutions, and other groups. To further this mission, DMHMRSAS promotes partnerships between State, local, and private sector agencies and also has responsibility for providing direct care and treatment in the nine State mental health hospitals. Persons who are admitted to the State hospitals generally receive long-term care; the institutions appear to have generally ceased to provide acute care (30 days or less). DMHMRSAS also licenses all mental health providers, both public and private, except for the State hospitals. The responsibilities of the Commissioner of DMHMRSAS are contained in the *Code of Virginia* (§ 37.2-300, et seq.).

State Hospitals. While DMHMRSAS holds titular control of State hospitals, it appears that much of the day-to-day operations are handled by the institutions themselves. DMHMRSAS does not have a contractual relationship with the institutions, and instead,

the director of each institution has a performance agreement with the Commissioner of DMHMRSAS. In addition to Eastern and Western State Hospitals, the other eight State hospitals are located in the Cities of Danville, Petersburg, and Staunton, and in the Counties of Fairfax, Roanoke, Smyth, and Prince Edward (Figure 2).

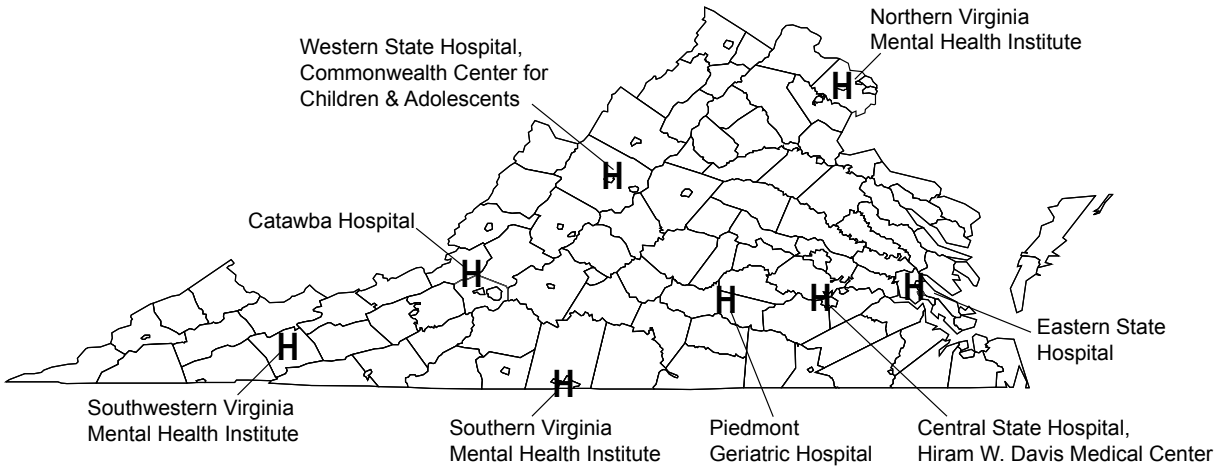
Since its peak in 1962, the average number of people in State hospitals has been reduced by 87 percent, from 11,532 to 1,452.

As a result of efforts to move Virginia's mental health system toward the use of the least restrictive and least costly services, the number of beds in State mental hospitals has been reduced. Since its peak in 1962, the average number of people in State hospitals has been reduced by 87 percent, from 11,532 to 1,452. This represents an average biennial reduction of 7.7 percent from 1962 to 2006.

Community Services Boards (CSB). CSBs are local government agencies that operate under a contract with DMHMRSAS to provide mental health, mental retardation, and substance abuse services to their communities. One or more local governments can be represented by a single CSB, and these governments oversee and fund the CSBs. Thirty-nine CSBs (and one behavioral health authority) currently exist in Virginia, and all localities are members of one of these CSBs. The responsibilities of the CSBs are contained in the *Code of Virginia* (§ 37.2-500, et seq.). CSBs are required by statute to provide only four specific services:

- emergency services, which are available 24 hours a day and include crisis stabilization;
- prescreening evaluations and written reports for individuals seeking admission to State hospitals as part of the civil commitment process;

Figure 2: Locations of State Hospitals



Source: JLARC staff.

- discharge planning for anyone identified by State hospital staff as ready to be discharged to the community; and

- case management "subject to the availability of funds." CSBs report that 76 percent of their case management services are funded by fees, mostly Medicaid funds.

These services are necessary for CSBs to effectively execute their role as the "single point of entry into publicly-funded mental health, mental retardation, and substance abuse services."

Statewide, CSBs rely on three major sources of funding for the mental health services that they provide. In fiscal year (FY) 2005, State funding accounted for the largest proportion (34 percent). Medicaid fees accounted for 32 percent, an increase from 15 percent in FY 1992. Local funds comprised 25 percent of CSB funding for mental health services, but this statewide percentage is driven by five CSBs (Alexandria, Arlington, Fairfax-Falls Church, Loudoun, and Prince William) who get most of their overall funding (for all services) from their local governments. In contrast, 29 CSBs rely on local government funding for less than ten percent of their overall funding.

Department of Medical Assistance Services (DMAS). As the State's Medicaid agency, DMAS is responsible for funding many of the mental health services provided in Virginia. These services include

- outpatient services, including psychiatric services and psychological testing;

- inpatient services, including hospitalization for children under age 21, short-term inpatient care for persons of all ages, and long-term care for persons age 65 and older; and

- community mental health rehabilitative services, including crisis intervention, case management, and day treatment.

These services are regulated under the State's Medicaid Plan, which is in the *Virginia Administrative Code* (12 VAC 30-10 et seq.).

Virginia Department of Health (VDH). VDH licenses hospitals and approves the creation of new medical facilities, including the addition of new beds. Approval of new construction occurs through a process known as the Certificate of Public Need (COPN), which was instituted in 1973 to control health care costs by limiting construction of new facilities. The COPN process covers all medical facilities, including psychiatric and substance abuse providers. Although the COPN process can be used to disallow new

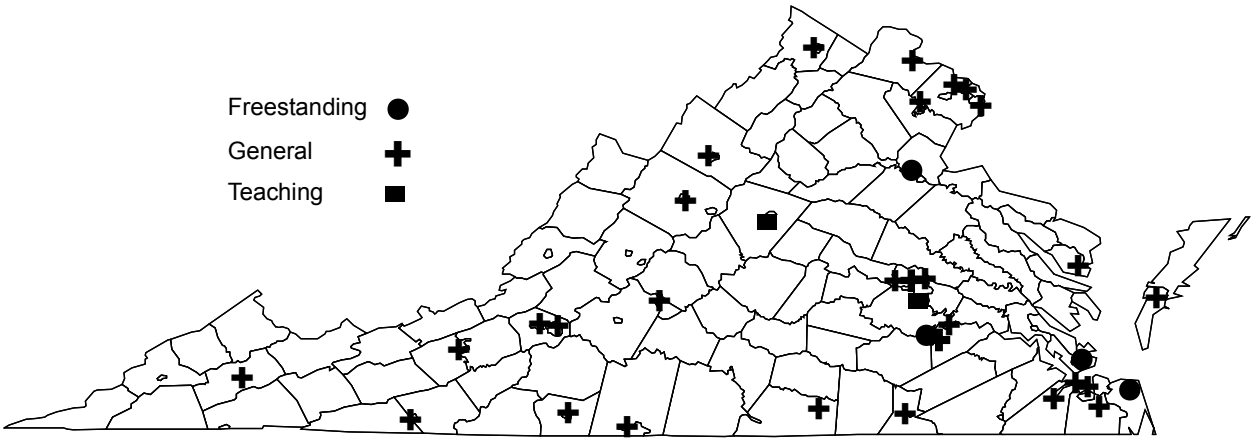
construction, the State has no ability to compel a private provider to continue providing services. The COPN process is outlined in the State Medical Facilities Plan (12 VAC 5-230 through 12 VAC 5-360).

Deinstitutionalization Led to Increased Growth in the Private Sector

In response to the reduction in State hospital beds and the advent of public and private funding for mental health care, community-based services were expanded or developed. These services include nursing homes, assisted living facilities, licensed hospitals, and other providers. For the purposes of this report, the most important of these service providers is licensed hospitals (The term "licensed hospitals" refers to general and freestanding hospitals that have licensed psychiatric beds, but does not refer to State hospitals.) Two of the general hospitals are State-owned (the University of Virginia and Virginia Commonwealth University), and are referred to in this report as teaching hospitals. In 2005, there were 1,794 licensed psychiatric beds in the 38 hospitals that were licensed to provide this service. The location of these licensed hospitals is shown in Figure 3.

As indicated in Table 1, hospitals vary according to their tax status and configuration. Although only two hospitals with licensed psychiatric beds are State-owned—the University of Virginia Medical Center and the Virginia Commonwealth University Health System—some hospitals are political subdivisions of the Commonwealth, such as Chesapeake General. The distribution of beds var-

Figure 3: Locations of Hospitals With Licensed Psychiatric Beds



Source: Analysis of Virginia Health Information data.

ies across these types, and 41 percent of licensed psychiatric beds are located in not-for-profit general hospitals. The next largest concentration of beds (32 percent) are in the proprietary freestanding hospitals, followed by the proprietary general hospitals (20 percent) and the teaching hospitals (7 percent).

Table 1: Number of Licensed Psychiatric Beds Varies According to Type of Hospital (2005)

	Tax Status	
Configuration	**Proprietary**	**Not-For-Profit**
Teaching Hospital	0	2
General Hospital	7	24
Freestanding Hospital	5	0

Source: Analysis of data from Virginia Health Information.

General Hospitals. As of 2005, Virginia had 94 general hospitals, of which 33 had licensed psychiatric beds. There were a total of 1,092 licensed psychiatric beds, which represented 61 percent of all licensed beds. These beds are contained in psychiatric units and focus on acute care (a patient stay of seven to 30 days). The size of these units varies, ranging from ten beds to 145 beds, with an average size of 37 beds.

These inpatient psychiatric units fit within the acute care model that dominates hospital care in the United States. This model focuses on episodes of treatment associated with the acute occurrence of a disease, in which an appropriate diagnosis is made, a treatment approach is developed, and symptoms are stabilized. Acute care differs from long-term care, which focuses on recovery and rehabilitation over a longer period of time, and is the primary model used in State hospitals.

Freestanding Hospitals. Virginia had five freestanding psychiatric hospitals in 2005, and these hospitals had 32 percent of all licensed psychiatric beds (570). The freestanding hospitals range in size from 30 to 187 beds, with an average size of 114 beds. These hospitals specialize in acute and long-term psychiatric care, and are concentrated in the "urban crescent" (Falls Church, Fredericksburg, Petersburg, Hampton, and Virginia Beach.) One important distinction between general and freestanding hospitals is that the latter are considered by the federal government to be Institutions for Mental Disease (IMD). Just like the State hospitals, which are also IMDs, the freestanding facilities are not eligible to receive Medicaid payments for persons between the ages of 21 and 64.

The ownership and tax status of the licensed hospitals varies. All five of the freestanding hospitals are for-profit (proprietary), as are

seven of the general hospitals. The other 24 general hospitals are not-for-profit (excluding the two teaching hospitals). Fifty-two percent of all licensed psychiatric beds are in proprietary hospitals, 41 percent are in not-for-profit hospitals, and seven percent are in the teaching hospitals.

Emergency Departments (ED). Hospital EDs play a central role in the mental health care system. Although none of the freestanding hospitals have an ED, all of the general hospitals with licensed psychiatric beds have an ED. Most of the other hospitals in Virginia also have an ED. Although DMHMRSAS licenses the inpatient psychiatric beds (for those hospitals that have them), the hospital's ED falls under the license issued by VDH.

Every hospital that accepts Medicare patients and has an ED is required by federal law to stabilize every patient. Because of this law, the Emergency Medical Treatment and Labor Act (EMTALA), ERs must be capable of providing psychiatric services 24 hours a day, even if the hospital does not have any licensed psychiatric beds. If the person needs to be admitted to an inpatient psychiatric bed, those hospitals without psychiatric beds must find a hospital that is willing and able to accept the transfer.

PERSONS CAN BE INVOLUNTARILY COMMITTED IF THEY POSE A DANGER OR CANNOT CARE FOR THEMSELVES

Persons receiving inpatient psychiatric services, whether through State hospitals or licensed hospitals, obtain these services through voluntary and involuntary means. Most persons obtaining services do so voluntarily, and enter a licensed psychiatric bed through a hospital ED or via a physician referral. Other persons are involuntarily committed, if they are found to have a mental illness to a degree that warrants involuntary treatment. Because of definitional language in the statute, this process applies equally to persons with substance use disorders.

Commitment Process May Begin With an Emergency Custody Order

The statutory process allows for the issuance of an emergency custody order (ECO) by a magistrate. There are four criteria that must be met before an ECO can be issued (§ 37.2-808). The magistrate must have probable cause to believe that the individual (1) has mental illness; (2) presents an imminent danger to himself or others as a result of mental illness, or is so seriously mentally ill as to be substantially unable to care for himself; (3) needs hospitalization or treatment; and (4) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. Notably, the section also allows a law enforcement officer to take a person into cus-

tody without an ECO if the officer has probable cause to believe that a person meets the criteria for emergency custody.

A person for whom an ECO is issued is taken into custody by a law enforcement officer and "transported to a convenient location to be evaluated to assess the need for hospitalization or treatment." The CSB, or a person designated by the CSB, is required to perform the evaluation. If the individual requires "emergency medical evaluation or treatment," the law enforcement officer is allowed to take the individual to a medical facility. Under either avenue, an ECO lasts for no more than four hours.

Temporary Detention Order Is Required Before Proceeding to a Commitment Hearing

In order to proceed to a commitment hearing, a temporary detention order (TDO) is first required. (An ECO, however, is not required.) The four criteria for obtaining a TDO are the same as for an ECO, but there are some other differences. If these criteria are not met, the person is no longer detained.

Community Services Board Must Conduct a Preadmission Screening. Before the magistrate can issue a TDO, an employee or designee of the CSB must first complete an in-person evaluation (§ 37.2-809), which is referred to as a pre-admission screening. This evaluation is intended to determine whether the individual presents an imminent danger to himself or others as a result of mental illness (or substance abuse), or is substantially unable to care for himself and requires involuntary inpatient treatment. The CSB is also charged with determining the facility where the person will be temporarily detained and whether there is a less restrictive alternative to inpatient treatment. The CSB's recommendations are also required to designate "a specific course of treatment and programs for the provision of involuntary outpatient treatment." State law also requires that an independent evaluation be conducted by a psychiatrist or psychologist (§ 37.2-815).

Medical Screening Is Conducted, Although Not Required by Statute. A third evaluation also appears to be conducted during ECOs and TDOs, although it is not required by statute. This evaluation, referred to as a medical screening, is conducted by staff at the licensed hospital to determine whether the apparently psychotic behavior is actually the result of an underlying medical problem (such as diabetes, drug interaction or reaction, or heart-related issues).

As documented in medical literature, persons with mental illness are more likely to have untreated medical problems than the general population. This is an important factor to consider during a

psychiatric evaluation because many serious or life threatening illnesses can create or exacerbate psychiatric symptoms. Therefore, if the behavior which warranted custody is actually medical in nature, then the individual should not be admitted to a psychiatric setting. The screening may also indicate that the person requires emergency medical or psychiatric care, which § 37.2-809 allows the hospital to perform.

Although this screening is not clearly required by statute, it appears to be anticipated in § 37.2-808, which states that a person held under an ECO may be taken "to a medical facility as may be necessary to obtain emergency medical evaluation or treatment that shall be conducted immediately in accordance with state and federal law" (emphasis added). Although the statute does not specify which federal law is referenced, it is likely that it is the federal Emergency Medical Treatment and Labor Act (EMTALA). As a result of EMTALA, Medicare-participating hospitals that offer emergency services must stabilize a person who visits the emergency room and has an emergency medical condition. Therefore, it appears that a medical screening is a regular part of the process.

Costs Incurred by Licensed Hospitals Are Paid Through Involuntary Mental Commitment Fund

During the ECO or TDO period, the licensed hospital is reimbursed for the costs of medical and psychiatric care by either the person's insurance or, if no other source of funds is available, from the Involuntary Mental Commitment Fund (IMCF). The IMCF is also used to cover the costs of the uninsured. (More information on the IMCF is provided in Chapter 5.) According to § 37.2-809, "the costs incurred . . . by the facility in providing services during the period of temporary detention shall be paid and recovered pursuant to § 37.2-804." This referenced section, insofar as it pertains to licensed hospitals, states that "all expenses incurred . . . shall be paid by the Commonwealth."

Commitment Hearing May Result in Inpatient or Outpatient Treatment

Within 48 hours of the issuance of the TDO (unless a weekend or holiday intervenes), a commitment hearing is required to be held before a district court judge or special justice.

At the commitment hearing, one of three outcomes can occur:

- The person can be released after the hearing if the commitment criteria are not met;

- The person may apply for voluntary admission and treatment (§ 37.2-814); or

- The person is involuntarily committed to an inpatient hospital or is ordered to receive mandatory outpatient treatment (§ 37.2-817).

If an individual is deemed by a judge or justice to be capable and willing to accept voluntary treatment, then that individual can go into inpatient treatment as a court-ordered voluntary patient. Though these individuals enter treatment voluntarily, they must give 48 hours notice to the hospital in which they are being treated.

For either involuntary inpatient commitment or mandatory outpatient treatment to occur, the judge or justice must find that the person presents "an imminent danger to himself or others as a result of mental illness or has been proven to be so seriously mentally ill as to be substantially unable to care for himself" (§ 37.2-817).

An involuntary commitment is made to either a State hospital or a licensed hospital, and can last no longer than 180 days. Prior to that limit, a patient may be released if certain conditions are met (§§ 37.2-837 and 838). In contrast, State law does not set a time limit for outpatient treatment.

Civil Patients Differ From Forensic Patients

Two types of patients are housed in State hospitals. "Civil" patients enter State hospitals either voluntarily or through the involuntary civil commitment process. "Forensic" patients are in the custody of the criminal justice system and include persons who have been acquitted by reason of insanity or found incompetent to stand trial. Additionally, some persons are transferred from jails in order to receive psychiatric treatment. (The forensic commitment process is outlined in Chapters 11 and 11.1 of Title 19.2 of the *Code of Virginia*.)

MOST INPATIENT MENTAL HEALTH CARE IS REIMBURSED BY INSURANCE

More than 90 percent of the persons who were admitted or committed to a psychiatric bed in a licensed hospital had some form of health insurance. The largest group was persons with commercial insurance, followed by Medicare and Medicaid.

Some Persons With Mental Illnesses Qualify for Medicare

Workers who become severely disabled before age 65 and can no longer work are eligible for Social Security Disability Insurance (SSDI) payments after five months of unemployment (substance use is not a qualifying condition). SSDI recipients are subsequently eligible for Medicare after they receive SSDI benefits for 24 months. About nine percent of Medicare beneficiaries have a severe mental disorder, and since 1987, both the number and proportion of disability awards due to mental illness have increased dramatically. In fact, mental disorders were the leading reason disabled workers received SSDI in 2004. Because of the early onset of mental illness, half of those Medicare beneficiaries who were classified as severely mentally ill are under age 45.

Some Persons With Mental Illness Qualify for Medicaid

Many low-income beneficiaries who qualify for Medicare due to a disability also qualify for Medicaid. In addition to these "dual eligibles," some disabled people are ineligible for SSDI and Medicare because they do not have a sufficient work history. These individuals may be eligible for Medicaid and Supplemental Security Income (SSI) from the Social Security Administration. Nationally, about 40 percent of all disabled adults with mental disorders are eligible for Medicaid but not Medicare.

Virginia is one of 11 states where eligibility for SSI does not automatically lead to eligibility for Medicaid. Although automatic eligibility does not exist, SSI recipients who apply and meet Virginia's more restrictive resource requirements may be eligible for Medicaid coverage as an SSI recipient. Additionally, individuals not eligible for SSI or SSDI, but who claim to be disabled, may apply for Medicaid and request that a Medicaid Disability Determination be completed. (Medicaid uses the same definition of disability as does the Social Security Administration.)

To qualify for Medicaid, a disabled individual must also have income less than or equal to 80 percent of the federal poverty level. In 2007, that equates to $681 per month for a single individual and $913 per month for a couple. According to the Virginia Association of Community Services Boards, about half of their consumers are eligible for Medicaid. If the income threshold was raised to 100 percent of the poverty line, the association estimates that about 85 percent of CSB consumers would be eligible for Medicaid.

Some Persons With Mental Illness Will Not Qualify for Either Program

Some disabled people will not qualify for Medicaid or Medicare. This group includes those in the process of fulfilling the two-year waiting period, as well as those who do not meet the criteria for disability determination. Nationally, approximately 22 percent of disabled adults with mental disorders are ineligible for either Medicare or Medicaid. In addition to Medicare and Medicaid, many other types of payers reimburse licensed hospitals for psychiatric services. Table 2 lists the payer categories reported by licensed hospitals on the JLARC staff survey of psychiatric facilities, along with the corresponding total payment amount in 2005. (More information on this topic is provided in Chapter 4.)

Table 2: Licensed Hospitals Reported $165 Million in Total Reimbursements for Inpatient Psychiatric Services in 2005

Payer Source	Total Reimbursement
Medicare	$62,198,707
Commercial	50,466,629
Medicaid	31,936,393
Other (a hospital-defined category)	8,419,625
Self-pay	4,477,243
Community Service Board Per Diem	3,050,168
Temporary Detention Order Per Diem	2,869,043
CHAMPUS/Tricare	1,662,510
Worker's Compensation	151,666
TOTAL	**$165,231,984**

Source: Analysis of psychiatric facility financial survey data (2005).

MENTAL HEALTH SERVICES EXIST ON A CONTINUUM, AND THE LEAST RESTRICTIVE TREATMENT SHOULD BE USED

Mental health services range from the most restrictive institutional services (State and licensed hospital inpatient beds), to passive walk-in services that rely on an individual to seek help. Decisions by the U.S. Supreme Court, other federal and State laws, and efforts by the mental health community, have led to the concept that persons with mental illness should be served in the least restrictive environment possible.

Individuals Are Entitled to Refuse Treatment

In addition to the concept of least restrictive available treatment, individuals cannot be forced into treatment unless they are deemed dangerous to themselves or others. In the 1975 decision of *O'Connor v. Donaldson* (422 U.S. 563), the U.S. Supreme Court held that there is no constitutional basis to confine persons with mental illness if they are dangerous to no one and can live safely

in freedom. Subsequently, the Court's 1980 decision of *Vitek v. Jones* (445 U.S. 480) held that individuals have a substantive liberty interest under the 14th Amendment to the U.S. Constitution in avoiding confinement in a mental hospital, and that confinement cannot occur without affording an individual due process. Thus, an individual cannot be confined for mental health treatment involuntarily unless he or she is committed pursuant to the State's civil or forensic commitment statutes.

Recovery Model Advocates Personal Responsibility

There is a nationwide effort to "transform" public mental health care. One tenet of transformation is the concept of "recovery," which the federal Substance Abuse and Mental Health Services Administration has identified as the "single most important goal" for the mental health service delivery system. The strategic planning efforts of DMHMRSAS embrace system transformation and seek to support the recovery model.

The recovery model of mental health treatment, which is referred to in DMHMRSAS's Integrated Strategic Plan, is described as both a conceptual framework for understanding mental illness, and a "system of care" that supports the individual. Four tenets of this model appear to be important in understanding the mental health system that Virginia is trying to achieve:

- Recovery from severe psychiatric disabilities is achievable. This tenet is aided by new medicines that can treat mental illness in an outpatient setting, but also appears to stand in opposition to the use of long-term care services, such as State hospitals.

- Recovery can occur even though symptoms may reoccur. A person may have recovered sufficiently to live in the community, but will still need to interact with the mental health system to a degree.

- Individuals are responsible for the solution, not the problem. This tenet places the responsibility for accessing services with the individual, which is in consonance with the description of the Transformation Initiative as "person-centered" and "consumer-directed."

- Recovery requires a well-organized support system. Individuals with mental illness need to be able to access the care they need, when they need it.

Olmstead Decision Reinforced the Shift to Less Restrictive Services

The nationwide transformation of mental health care has been accompanied by other drivers that affect how and why the system is transformed. One of the most important drivers has been a 1999 U.S. Supreme Court decision, *Olmstead v. L.C.* In this case, the Court held that Title II of the Americans with Disabilities Act (ADA) requires that states provide community-based treatment to persons with mental disabilities when (1) a professional deems such placement appropriate, (2) the affected person does not object, and (3) placement in the community can be reasonably accommodated.

The Court further stated that nothing in the ADA or its implementing regulations requires community placements for persons unable to handle or benefit from community settings. In practice, the opinion means that individuals should be served in the least restrictive environment practicable.

Chapter 2

There Appear to Be Shortages of Psychiatric Beds in Some Localities and for Certain Groups

In Summary

Since 2001, the number of licensed psychiatric beds has decreased, and the occupancy rate has increased. Despite these changes, based on thresholds used by the Virginia Department of Health to determine if new beds are needed, the current number of beds appears adequate statewide. However, data indicate that some localities need additional psychiatric beds. In parts of the State, patients have to travel more than one hour to access a psychiatric bed, a circumstance that hinders family and community support. Statewide, the number of licensed acute beds for children and adolescents appears to be sufficient, but the beds are located in a very few localities and some children and adolescents face barriers to access. Persons of all ages who exhibit behavioral problems are reported to have difficulty finding a bed. Moreover, community services boards report that some persons detained under a temporary detention order have been released because no bed could be found. Any assessment of adequacy is limited because barriers to access to inpatient psychiatric care make it difficult to determine the true demand for psychiatric beds.

All of Virginia's freestanding psychiatric hospitals and 38 of the 86 general hospitals have beds that are licensed for the provision of psychiatric services. These psychiatric beds are an important part of the continuum of mental health care, because they serve some persons who would otherwise be in a State hospital bed.

CERTAIN CHARACTERISTICS OF PSYCHIATRIC PATIENTS AFFECT THE USE OF BEDS

The use of psychiatric beds is affected by the number of psychiatric patients and the length of time they stay in a bed. On an annual basis, licensed hospitals report data to Virginia Health Information (VHI) on the patients who are discharged from their facility. This patient data is a duplicated count of the actual number of persons who were treated because some persons are admitted to a hospital more than once in a given year. In this report, "patients" refers to the duplicated number unless otherwise indicated.

Number of Psychiatric Patients Has Been Decreasing

In 2005, psychiatric patients accounted for seven percent of all hospital patients. As indicated in Table 3, this percentage remained relatively constant between 2001 and 2005 but decreased by about one percentage point over the five year period. (This percentage is based on a subset of all patients, as discussed in Appendix C.)

Table 3: Number of Psychiatric Patients Has Been Decreasing

	Psychiatric Patients (Duplicated Count)	Percentage of All Patients (Duplicated Count)
2001	52,811	8.4%
2002	52,042	8.1
2003	50,631	7.7
2004	49,749	7.5
2005	50,819	7.3

Note: These "patient" data represent a duplicated count of the actual number of individuals because some persons are admitted to a hospital more than once in a given year.

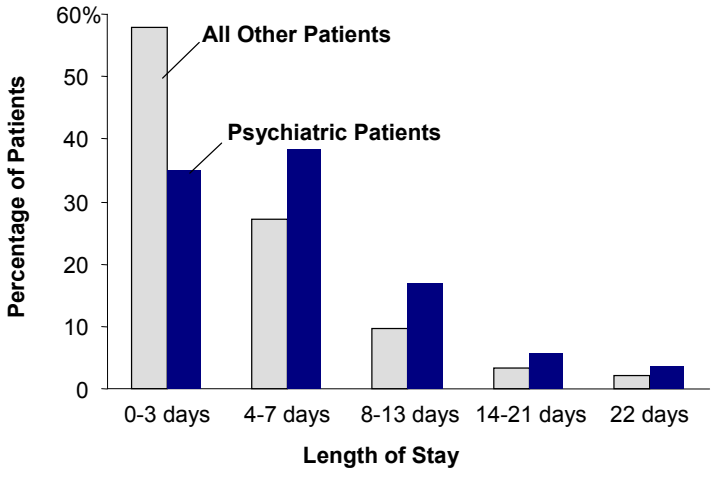
Source: Analysis of Virginia Health Information data.

Average Length of Stay Is Seven Days

In 2005, a typical length of stay (LOS) for a psychiatric patient was seven days, on average. Recent decades have seen a decrease in the average LOS, because of managed care and the increasing effectiveness of medications which allow patients to be discharged more quickly. Nationwide, the average length of stay decreased from 33 days in 1986 to 24 days in 1991. Since 2001, the average LOS in Virginia has increased slightly from 6.1 days to 6.5 days. For adults, the average LOS was 5.9 days in 2005, a slight increase from 5.5 days in 2001. The average LOS was 8 days for children and adolescents (up from 6.7 days), and stayed the same at about 10 days for geriatric patients.

Psychiatric patients tend to have a longer LOS than other hospital patients, who had an average LOS in 2005 of 4.8 days (Figure 4).

Figure 4: Psychiatric Patients Typically Have a Longer Length of Stay (2005)



Source: Analysis of Virginia Health Information data.

In 2005, about 35 percent of psychiatric patients had a LOS of three or fewer days, compared to 58 percent of all other hospital patients.

NUMBER OF PSYCHIATRIC BEDS STATEWIDE IN LICENSED HOSPITALS HAS DECREASED, BUT APPEARS ADEQUATE

At a statewide level, the number of psychiatric beds in licensed hospitals appears to be adequate. Although the number of beds in licensed hospitals has decreased in recent years, the occupancy rates do not indicate that a shortage exists. However, an assessment of the adequacy of beds is limited by the lack of demand data on persons who could not access a psychiatric bed.

Since 1990, Virginia Has Lost Almost 900 Psychiatric Beds in Licensed Hospitals

Since 1990, a total of 873 psychiatric beds have been closed, as shown in Table 4. However, the number of psychiatric beds in 1990 was close to an all-time high. Reductions in the number of psychiatric beds since then have been consistent with reductions in the number of all hospital beds. More information on the number of hospital beds is provided in Appendix D.

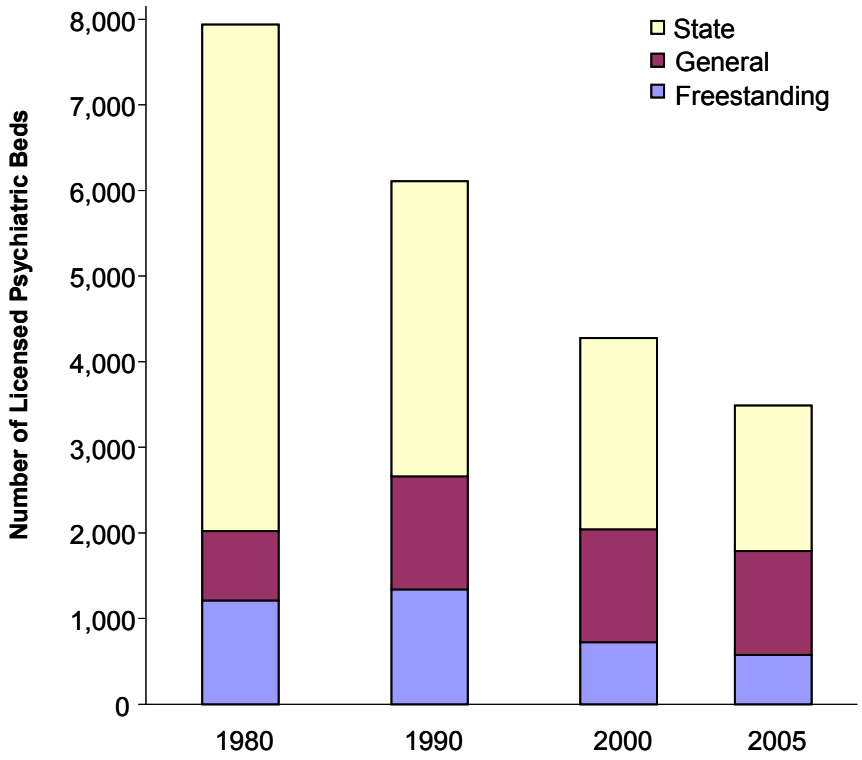
1980s Was a Growth Period for All Licensed Hospital Beds. The number of psychiatric beds increased during the 1980s. A survey conducted in 1986 by the National Institute of Mental Health indicated that Virginia had the fifth largest number of beds in freestanding hospitals (1,517), behind Pennsylvania, Florida, Texas, and California. General hospitals were adding psychiatric beds, which increased as a percentage of all beds in general hospitals. As indicated by Figure 5, as general hospitals added psychiatric beds the relative proportion of psychiatric beds in general and freestanding hospitals changed. The number of State hospital beds, in contrast, decreased from 5,922 in 1980, to 3,441 in 1990.

Table 4: Decreasing Number of Psychiatric Beds Reflects Changes in the Hospital Sector

	General Hospitals			Freestanding Psychiatric Hospitals	All Licensed Hospitals	
	Total Number of Beds	Total Number of Psychiatric Beds	Psychiatric Beds as Percent of Total Beds	Total Number of Beds	All Psychiatric Beds	Psychiatric Beds Per 10,000 People
1980	21,562	816	3.8%	1,206	2,022	3.8
1990	21,947	1,332	6.1	1,335	2,667	4.7
2000	18,058	1,319	7.3	726	2,045	2.9
2005	17,957	1,224	6.8	570	1,794	2.4

Source: Analysis of Virginia Health Information data.

Figure 5: The 1980s Saw a Historic Shift in the Relative Number of Psychiatric Beds in Freestanding and General Hospitals



Source: Analysis of data from the Virginia Department of Health (Center for Health Statistics), Virginia Health Information, and DMHMRSAS.

Historic Shift in the Composition of Psychiatric Beds Occurred in the 1990s. Starting in 1991, the number of general hospital psychiatric beds was for the first time greater than the number of freestanding beds. The historic nature of this shift can be seen by looking at the role of freestanding and general hospitals in 1947, the year after the first federal Hill-Burton funds were provided to spur the growth of general hospitals. According to a report by the State Health Department, Virginia had three freestanding hospitals and two general hospitals with psychiatric beds, the University of Virginia and the Medical College of Virginia (39 and 48 beds, respectively). Although the number of beds in those three freestanding hospitals was not reported, a 1959 publication by the State Board of Mental Health indicated that these three facilities had a total of 345 beds.

This change has historical significance for two reasons. First, freestanding hospitals and general hospitals have been traditional competitors. Prior to deinstitutionalization, almost all non-State psychiatric beds were in freestanding hospitals and a person could be committed to a freestanding hospital in lieu of a State hospital

if they had sufficient financial resources. Second, freestanding hospitals are considered Institutions of Mental Disease (IMD), and Medicaid will not pay for adult patients in these facilities. As a result, the decrease in the proportion of freestanding beds may increase access to psychiatric beds by persons who are Medicaid recipients.

The recent decrease in the number of freestanding beds results partially from mergers and consolidations. For example, in 1995 the 62-bed Norfolk Psychiatric Center and the 61-bed Tidewater Psychiatric Institute were purchased and then closed by the owners of the newly built Virginia Beach Psychiatric Center, removing a net of 62 freestanding beds. In 2001, the owners of the Virginia Beach Psychiatric Center delicensed 41 acute beds at another facility and then re-licensed them as child and adolescent residential treatment beds, removing another 41 freestanding beds.

Number of Psychiatric Beds Has Decreased Since 2000. Although general hospitals added psychiatric beds in the 1990s, this trend has reversed, and the number of psychiatric beds in general hospitals decreased between 2000 and 2005. In contrast, general hospitals have added other types of beds since 2000. These changes indicate the declining role of psychiatric beds in general hospitals.

The number of beds in freestanding hospitals has also decreased, and most of the statewide reduction in the number of psychiatric beds between 2000 and 2005 (62 percent) occurred at freestanding hospitals. State hospital beds have also decreased since 2000. As noted above, there were 3,441 State hospital beds in 1990. This decreased to 2,235 in 2000, and 1,686 in 2005.

As a result of these changes, on a per capita basis there were 2.4 psychiatric beds (in both freestanding and general hospitals) for every 10,000 people in 2005. This was a decrease from the 3.8 psychiatric beds in licensed hospitals for every 10,000 people in 1980. State hospitals had also decreased on a per capita basis, from 11.1 per 10,000 in 1980, to 2.3 per 10,000 in 2005.

Only Three-Quarters of All Licensed Psychiatric Beds Are Staffed

Some licensed psychiatric beds are not staffed, which means that these beds are not used. In 2005 about three-quarters of all licensed psychiatric beds were staffed and in use (1,397 beds). If all licensed beds had been in use, another 397 beds would have been available.

In 2005, five licensed hospitals staffed half or less of their licensed beds. This accounted for 61 percent of all unstaffed beds. Several reasons have been offered for the number of unstaffed beds. Some

hospital administrators reported that fewer beds were staffed because of the difficulty of finding psychiatrists and other staff for inpatient work. Hospital administrators also indicated that some psychiatric patients require one-on-one or even two-to-one staffing. These high ratios reportedly drive up costs, creating a situation in which the decision to staff additional beds results in greater financial losses. Staff at one hospital also cited poor reimbursement generally as a reason why not all licensed beds were staffed. By not staffing all beds, it was reported, a hospital can minimize its overall financial losses from the provision of psychiatric services.

Number of Licensed Psychiatric Beds Appears Adequate Based on the Occupancy Rate

In the 1980s, when the increase in hospital expenditures led to managed care reforms, the average length of stay decreased. Since 2001, the average LOS in Virginia increased slightly and the number of psychiatric patients decreased, as discussed earlier. These changes, in conjunction with the decrease in the number of psychiatric beds, have led to an increase in the occupancy rate.

Licensed Occupancy Rates Are Used to Assess Need for More Beds. Consistently high occupancy rates are one indication that a bed shortage exists. Indeed, this measure is regarded as a critical measure of capacity, and many states regard an average occupancy rate in excess of 75 to 85 percent as the threshold for approving a hospital's request to open new beds. In Virginia, a threshold of 90 percent is used by the Virginia Department of Health (VDH), which licenses hospital beds, as an indication that more psychiatric beds are needed in a given region of the State.

VDH is responsible for approving requests to build additional medical facilities. This is conducted by means of the Certificate of Public Need (COPN) process, which was created by the State in 1973 to control the escalating costs of medical care by limiting the number of hospital beds. As part of the COPN process, VDH determines the need for additional licensed bed capacity by comparing existing licensed occupancy rates to the 90 percent threshold. If an area in which a hospital proposes to build a bed has an occupancy rate of less than 90 percent, then VDH staff recommend that the Health Commissioner disapprove the hospital's request.

Presently, Licensed Occupancy Rates Are Under the Threshold of 90 Percent. Since 2001, the occupancy rate for licensed psychiatric beds has increased by six percent, and as of 2005 it was 58 percent (Table 5). In contrast, the occupancy rate for all hospital beds increased by only 2.5 percent, and was 53 percent in 2005. Although the statewide occupancy rate for licensed psychiatric beds has increased, it is well below the existing threshold of 90 percent.

Table 5: Occupancy Rates Have Increased Since 2001

	All Hospital Beds		Psychiatric Beds	
	Licensed Occupancy Rate	Staffed Occupancy Rate	Licensed Occupancy Rate	Staffed Occupancy Rate
2001	51.9	64.6	54.7	68.9
2002	52.8	66.0	56.8	68.2
2003	54.8	66.6	56.3	68.7
2004	55.2	59.0	58.5	70.3
2005	53.2	56.4	58.1	70.5

Source: Analysis of data from Virginia Health Information.

Statewide Occupancy Rates for Staffed Psychiatric Beds Are Higher but Still Under the 90 Percent Threshold. Since 2001, the occupancy rate for staffed psychiatric beds has increased by 2.3 percent, and as of 2005 it was 71 percent. However, this rate remains below the 90 percent threshold used by VDH in the COPN process. If more beds are needed for a particular service, such as psychiatry, VDH tries to encourage hospitals to convert existing beds into that use. As indicated in Table 5, the occupancy rate in 2005 for all staffed hospital beds (56.4 percent) was lower than the rate for staffed psychiatric beds.

When not all licensed beds are staffed, VDH staff note that the hospital may have overestimated the demand for beds during the COPN process, with the result that it has too many licensed beds. However, VDH staff add that a hospital could choose to use unstaffed beds as a barrier to entry into the marketplace. Because the licensed occupancy rate is used to measure the threshold, per VDH regulations, a hospital could decide to not staff all of its beds in areas where it wished to prevent competitors from receiving their own certificate to build new beds.

Staffed Occupancy Rates in Some Health Planning Regions Are Approaching the 90 Percent Threshold. In planning for medical facility needs, VDH has divided the State into five Health Planning Regions (HPR). Staffed occupancy rates are higher than the statewide average in some HPRs, but still appear to be reasonable based on the 90 percent threshold (Table 6). However, since the staffed occupancy rate may be a better measure of the actual availability of beds, the fact that two regions of the State have a staffed occupancy rate of about 80 percent may indicate that shortages could occur. In addition, although 90 percent is the present threshold, VDH indicates that it is considering a decrease in the threshold to 75 percent. Using 2005 data on staffed beds, this would indicate a need for more beds in HPRs 4 and 5.

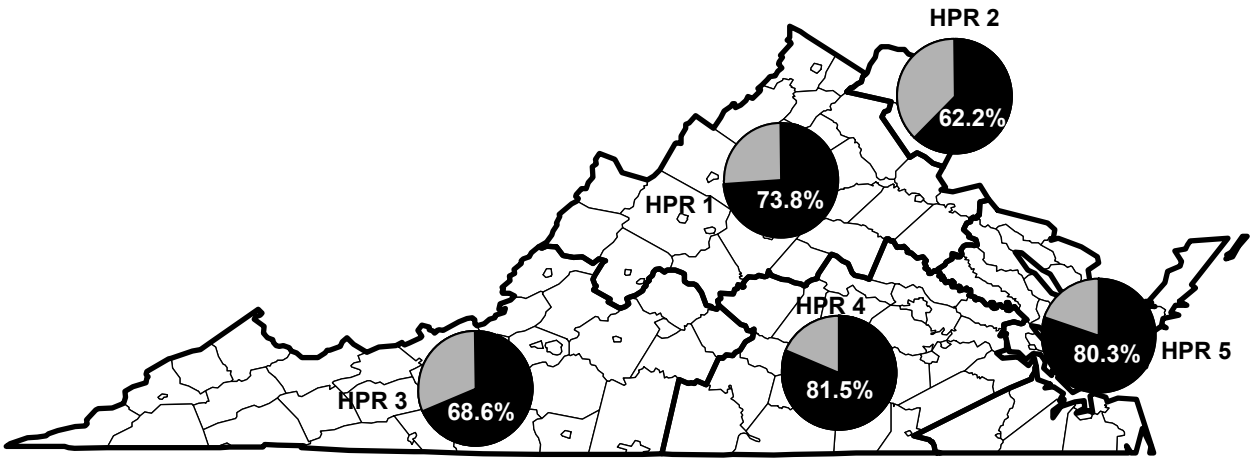
Table 6: Staffed Occupancy Rate for Psychiatric Beds Varies by Health Planning Region (HPR)

	HPR 1	HPR 2	HPR 3	HPR 4	HPR 5
2001	70.6	62.0	61.4	84.4	68.0
2002	59.5	58.7	65.9	84.9	66.6
2003	62.3	58.5	66.9	70.7	68.6
2004	65.9	58.7	70.3	77.1	76.8
2005	73.8	62.2	68.6	81.5	80.3

Source: Analysis of data from Virginia Health Information.

The staffed occupancy rates have fluctuated in each region since 2001. Therefore, if staffed occupancy rates are used as a guide, then it appears that the need for beds may be greater in some years than in others. In other words, a determination of whether a sufficient number of beds existed must take into consideration where in the State the beds may be needed, and in what year the need is assessed. Presently, however, no HPR has an occupancy rate higher than 82 percent (Figure 6).

Figure 6: Staffed Occupancy Rates Vary by Health Planning Region (2005)



Source: Analysis of data from Virginia Health Information.

ADDITIONAL BEDS APPEAR NEEDED IN SOME PARTS OF THE STATE AND FOR SOME GROUPS

Certain parts of the State appear to need more psychiatric beds, and certain groups of people appear to have difficulty accessing existing beds. Some parts of Virginia are more than one hour away from a psychiatric bed, and particular planning districts need more beds. Additionally, although statewide numbers indicate that there is an adequate number of beds, staff at some licensed hospitals and community services boards (CSB) indicate that it is difficult to find a bed for persons with behavioral problems. Also, because beds for

children and adolescents are concentrated in a few localities, some children and adolescents have difficulty finding a bed.

Virginia Department of Health Reports Need for Additional Psychiatric Beds Based Upon Occupancy Rate

According to calculations performed by VDH and an analysis of proximity to existing psychiatric beds, there is a need for additional beds in some parts of the State. However, the need is relatively small in comparison to the number of beds that are currently licensed but not staffed. The additional beds that these analyses indicate are needed are concentrated in certain parts of the State.

Another 29 Psychiatric Beds Are Needed. In 2006, VDH issued its *Annual Report on the Status of Virginia's Medical Care Facilities Certificate of Public Need Program*. In this report, VDH staff reported on the methodology contained in the State Medical Facilities Plan (SMFP). Based on the SMFP methodology, VDH determined that there are four planning districts with a total need for 29 additional acute inpatient psychiatric beds (Table 7). These planning districts are in the Middle Peninsula, Northern Neck, Charlottesville, and Farmville areas. These 29 beds comprise seven percent of the unstaffed beds that are currently licensed but not used statewide.

Table 7: Planning Districts Where Additional Psychiatric Beds Appear to Be Needed, Based on the State Medical Facilities Plan

Planning District Commission (PDC)	Number of Beds Needed According to SMFP Methodology
Thomas Jefferson (PDC 10)	1
Commonwealth Regional Council (PDC 14)	10
Northern Neck (PDC 17)	7
Middle Peninsula (PDC 18)	11

Source: Virginia Department of Health.

Some Planning Districts Are Outside of the 60 Minute Travel Time Threshold. The SMFP also contains another mechanism for determining if additional beds are needed, based upon proximity to services. According to the proximity threshold, acute psychiatric services "should be available within a maximum driving time, under normal conditions, of 60 minutes one-way for 95 percent of the population" (12 VAC 5-290-30). VDH notes that the majority of the population of the four planning districts in Table 7 live within one hour of psychiatric services, although pockets within the planning districts may not. VDH has noted that if psychiatric services are located more than one hour away, then family members and CSB

staff cannot interact with the patient to coordinate the services they will need after discharge.

However, it appears that the 60 minute travel time was an approximation based upon the assumption that anyone within 35 miles of a hospital was within a 60 minute travel time. A more refined estimate using geographic information system (GIS) analysis indicates that there may be a need for additional psychiatric beds in five other planning districts of the State, based upon travel time. As indicated in Table 8, in six planning districts more than five percent of the population is outside of a 60 minute travel time radius from a licensed psychiatric bed. These planning districts are largely in Southwest Virginia, in the areas surrounding the cities of Norton, Bristol, Galax, and Roanoke, plus the Danville and Farmville areas. However, the SMFP methodology that looks at occupancy rates does not indicate an additional need for beds in these areas, with the exception of planning district 14, despite the fact that the existing beds are more than one hour away. Appendix E contains additional information on the GIS analysis.

Table 8: Planning Districts Where More Than 5 Percent of the Population Is More Than 60 Minutes From a Psychiatric Bed

Planning District Commission (PDC)	Percentage of Population More Than One Hour From a Psychiatric Bed
LENOWISCO (PDC 1)	68.2%
Cumberland Plateau (PDC 2)	40.1
Mount Rogers (PDC 3)	9.9
Roanoke Valley-Alleghany (PDC 5)	8.7
Southside (PDC 13)	17.5
Commonwealth Regional Council (PDC 14)	49.7

Source: Analysis of data provided by the Virginia Department of Health and the Virginia Geographic Information Network.

Recommendation (1). The Virginia Department of Health should begin using geographic information system (GIS) software to determine the extent to which 95 percent of the population lives within one hour of the medical service under consideration as part of the department's analysis of the need for medical services in reviewing requests for Certificates of Public Need.

Concerns Expressed About Extensive Travel to Find a Psychiatric Bed Appear Unfounded. In almost every interview conducted by JLARC staff with representatives of licensed hospitals and CSBs, concern was expressed over the number of persons who travel great distances to access a psychiatric bed. Examples given included Northern Virginia residents traveling to Virginia Beach, and Richmond residents traveling to Danville. However, a GIS

analysis conducted by JLARC staff indicates that less than six percent traveled 50 miles or more. However, this analysis did not examine the ages of persons traveling, nor does it account for persons who did not receive inpatient services because of the need to travel. Appendix F contains detailed information for the licensed hospitals surveyed by JLARC staff.

Similar findings are indicated by the preliminary results from a survey of CSB staff conducted by the University of Virginia. The survey found that 3,003 individuals were evaluated by CSB clinicians for crisis services during June 2007. An inpatient psychiatric bed was sought for about half of this group (1,586 people). CSB staff found a bed within four hours for 95 percent of people seeking a bed, and 88 percent of people seeking a bed were placed within the CSB's catchment area.

Demand for Beds Is Affected by the Civil Commitment Process

As discussed in Chapter 1, persons in need of psychiatric services may be held under a temporary detention order (TDO), and some of these persons may be required to receive inpatient psychiatric services under an involuntary commitment order (ICO). Persons who are the subject of a TDO or ICO are treated in State hospitals or licensed hospitals, and 85 percent of all involuntary civil commitments were made to licensed hospitals in 2005.

Bed Shortage Is Reported to Result in Release of Persons Held Under Temporary Detention Orders. According to CSB staff, it has become more difficult to locate beds in licensed hospitals for individuals held under a TDO, as indicated by the increased use of State hospitals for TDOs. This is especially true in Southwest Virginia, where 72 percent of admissions to the Southwestern Virginia Mental Health Institute (SWVMHI) are TDOs. Staff at the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) state that the high rate of TDO admissions to SWVMHI results from a general lack of psychiatric beds in that region. Although there may be psychiatric beds available in nearby states that the residents of Southwest Virginia can use, a judge cannot send a temporarily detained person out of state.

An indication that there may not be enough psychiatric beds is the reported release of individuals held on TDOs. A survey of CSBs conducted by DMHMRSAS indicated that a total of 68 people were released during September and October 2004 because a psychiatric bed could not be found for them. However, the reason for the inability to find a bed is not known. For example, a bed may have been available, but that particular person was not able to access it. The preliminary results from the survey conducted by the Univer-

sity of Virginia indicate that of the 1,586 people for whom an inpatient psychiatric bed was sought, a bed could not be found for 117 individuals. Of this group, 11 people were released with no further treatment.

Although the lack of access to a psychiatric bed during a TDO is an important indicator of adequacy, no systematic data are regularly collected on the number of TDOs, whether a bed could be found, and whether the TDO expired because of an inability to find a bed. Moreover, if a person is released, it does not appear that any systematic tracking is conducted to determine if they receive other services.

Increasing Number of Involuntary Commitment Orders Suggests That Need for Inpatient Beds May Increase. Although historical data on the number of TDOs are not available, data collected by the Virginia Department of State Police on the number and location of involuntary commitment orders indicate that the number of ICOs is increasing. Between 1998 and 2006, the annual number of ICOs increased by 35 percent (Table 9). This existing trend suggests that the demand for psychiatric beds in licensed hospitals may increase. Moreover, if the use of inpatient commitments increases as an alternative to mandatory outpatient services, the demand for beds may increase even faster.

Between 1998 and 2006, the annual number of involuntary commitment orders increased by 35 percent.

Table 9: Number of Involuntary Inpatient Commitment Orders Increased by 35 Percent Since 1998

Year	Number of Involuntary Commitment Orders	Number of Involuntary Commitment Orders to State Hospitals	Percentage of Involuntary Commitment Orders to State Hospitals
1998	5,308	N/A	N/A
1999	4,493	N/A	N/A
2000	4,313	1,280	30%
2001	5,403	1,452	27
2002	5,835	1,316	23
2003	6,618	1,597	24
2004	7,004	1,206	17
2005	7,056	1,282	18
2006	7,159	1,056	15

Note: N/A, data not available.

Source: Analysis of data provided by the Virginia Department of State Police and the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Certain localities have much higher concentrations of ICOs. In 2006, the City of Richmond had the highest number (755), followed by Smyth County (736) and the City of Hampton (601). The high number in Smyth County may be attributable to the location of

SWVMHI. Appendix G contains historical data on the number of ICOs by the locality where the orders were issued.

Personal Characteristics and Behavioral Problems May Limit a Person's Ability To Access a Bed

State and local agency staff reported that it can be especially difficult to find a psychiatric bed for persons of any gender, age, or diagnosis who exhibit certain characteristics. Often these individuals have been hospitalized on multiple occasions, and hospitals are reportedly unwilling to readmit them because of personal characteristics or behavioral issues. For example, one State official noted that licensed hospitals are reluctant to admit homeless persons, not because of any aggressive behavior, but because of personal characteristics that may be disagreeable to other patients.

Staff at several CSBs reported that individuals with known histories of behavioral problems, such as aggressive behavior, are sometimes "blacklisted" by hospitals. For example, staff at the Rappahannock CSB stated that they cannot get violent persons held on a TDO into licensed hospitals and that they admit them into Western State Hospital instead. Licensed hospital staff report that their facilities are ill-equipped to provide the required services. This ability has recently been reduced as a result of guidelines issued by clinical and regulatory bodies (such as the American Psychiatric Association and the Joint Commission on Accreditation of Healthcare Organizations) to limit the use of seclusion rooms and physical restraints. Yet when a patient becomes aggressive, it affects the hospital's ability to adequately serve their other patients.

Statewide, the Number of Licensed Acute Beds for Children Appears to Be Sufficient, but Children Face Access Barriers

Similar to the statewide data on the total number of psychiatric beds, data on those beds that are licensed for use by children and adolescents suggest that the overall number is adequate. However, the data are not consistently reported, and the existing data suggest that the beds are located in a handful of localities.

Statewide Data Suggest the Number of Beds Is Adequate. A relatively large number of beds for children and adolescents appear to be available, as indicated by comparing the number of beds to the number of patients (Table 10). Although limited historical data on the number of child and adolescent beds are available, the number of beds for children and adolescents is growing, and the number of patients is decreasing.

These data are consistent with the conclusions reached by DMHMRSAS, which licenses psychiatric services, including psy-

chiatric beds. In the agency's most recent *Quarterly Report on the Youth and Adolescent Health Services*, it states that there are no data indicating a need for acute or residential beds for children and adolescents. In 2006, as part of a review of the COPN regulations, DMHMRSAS stated that "although state agencies have complained that there is a shortage of children and adolescent beds, we have no information to substantiate the complaint."

Table 10: Statewide Number of Psychiatric Beds for Children and Adolescents Appears Adequate

	Number of Licensed Beds	Child/Adolescent Beds as a Percent of All Beds	Child/Adolescent Patients as a Percent of All Patients	Number of Patients (Duplicated)
2001	N/A	N/A	10.4%	5,455
2002	N/A	N/A	10.3	5,636
2003	223	11.3%	10.8	5,446
2004	221	11.2	10.7	5,323
2005	237	13.4	9.8	4,949
2006	250	N/A	N/A	N/A

Note: N/A, data not available. Beds in State hospitals are not included.

Source: Analysis of data from Virginia Health Information and the Department of Mental Health, Mental Retardation and Substance Abuse Services.

In Hampton Roads, CSB staff and hospital staff agree that there are sufficient acute inpatient beds. Staff at the Hampton-Newport News CSB described the beds at one local acute care facility for children as never being full, because the availability of Medicaid coverage for residential beds has increased the number of these beds. As a result, children who historically would have used an acute bed now use residential beds, thereby freeing up the acute beds. Northern Virginia CSB staff made the same observation.

Children and adolescents also face barriers when attempting to access existing beds. For youth, psychiatric hospitalization is a last resort and is used as a temporary measure until residential treatment or community services are arranged. Although there is no indication in the statewide data of a need for more acute care inpatient beds for children and adolescents, based on the number of licensed beds statewide, there are far fewer staffed beds than licensed beds.

Only 83 Percent of Acute Psychiatric Beds for Children and Adolescents Are Reported to Be Staffed. Based upon data reported by State and licensed hospitals to DMHMRSAS, not all licensed beds for children and adolescents are staffed. However, as seen in Table 11, not all hospitals report data on the number of staffed beds, nor are data reported consistently on the number of beds for children. For adolescents there are 236 licensed beds, but only 186 are re-

ported to be staffed. These beds are located in 12 localities (Table 11). There are 51 licensed beds for children, of which all are reported to be staffed. However, these beds are located in just three localities—the Cities of Falls Church, Salem, and Staunton.

Table 11: Not All Acute Psychiatric Beds for Children and Adolescents Are Reported to Be Staffed (2007)

Facility Name	Location	Beds for Children (Ages Birth–13) Licensed	Staffed	Beds for Adolescents (Ages 14–17) Licensed	Staffed
Bon Secours Maryview	Portsmouth			12	12
Centra Virginia Baptist Hospital	Lynchburg			14	14
Commonwealth Center for Children and Adolescents[a]	Staunton	24	24	24	24
HCA Dominion Hospital	Falls Church	21	21	30	30
HCA Lewis-Gale Medical Center	Salem	6	6	18	18
HCA Tucker Pavilion at Chippenham	Richmond			18	18
Inova Fairfax	Falls Church			6	
Inova Mount Vernon	Alexandria			3	0
Psychiatric Solutions, Poplar Springs	Petersburg			23	23
Psychiatric Solutions, Virginia Beach Psychiatric Center	Virginia Beach			20	20
Riverside Behavioral	Hampton			10	
Snowden Hospital	Fredericksburg			16	
Southwestern Va. Mental Health Inst.[a]	Marion			16	16
Virginia Treatment Ctr for Children, VCU	Richmond			26	11
	TOTAL	**51**	**51**	**236**	**186**

[a] Facility operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). Blank cells indicate that the facility did not report data to DMHMRSAS.

Source: Analysis of September 2007 data provided by DMHMRSAS.

Difficulty Using Existing Beds Is Reported. Staff at CSBs and licensed hospitals in some parts of the State have noted difficulty finding beds for children and adolescents. This has been reported, for example, by the Director of the Southside CSB (serving Brunswick, Halifax, and Mecklenburg Counties) and by staff at Community Memorial Hospital in South Hill. Staff at the Valley CSB in Staunton and the Danville-Pittsylvania CSB noted that they attempt to place children in many of the facilities listed in Table 11, but that these facilities are usually full.

According to a 2005 report issued by CSBs in Northern Virginia, "although most children receive inpatient care locally, a small number of youth are sent to Commonwealth Center for Children and Adolescents in Staunton and sometimes out of state for inpatient services." The report states that even if additional community services were available, another 43 beds are needed in Northern Virginia. In addition to the Center in Staunton, children and adolescents are sent to the Virginia Treatment Center for Children (VTCC) in Richmond, which is operated by Virginia Commonwealth University.

The need to travel outside of one's locality to access services may be especially difficult for children and their parents. This is likely heightened by the fact that family separations occur as a result, and it is difficult for the child's teachers to participate meaningfully in the child's treatment. According to data maintained by VTCC, a total of 175 children were turned away from their facility between July 2006 and January 2007. Many of these calls were referred to other locations, but the final outcome is not known.

Staff at VTCC stated that they would generally not admit adolescents who are nearing their 18th birthday, or children or adolescents who will not agree to treatment. VTTC staff also provided several examples of children and adolescents that they have had to refer elsewhere because of

- a history of acting out sexually, so double-occupancy rooms could not be used;
- a history of severe and repetitive violence;
- pending felony charges;
- a significant history of substance abuse; or
- autism spectrum disorders or mental retardation.

It seems reasonable to assume that these characteristics are similar to the characteristics of adults who face difficulty accessing an available psychiatric bed, although no data appear to be tracked on this issue for adults.

In contrast, staff at the Hampton-Newport News CSB report that there is a broad array of children's services and that the CSB has four child psychiatrists. However, they added that it may not be possible to get a bed for certain children and adolescents. For example, a pregnant teenager who needs psychiatric treatment probably would not be admitted because they would need a medical/surgical bed. CSB staff in North Virginia made the same observation. In addition, CSB and hospital staff frequently noted that there is a critical lack of outpatient services for children, including a shortage of child psychiatrists, and stated that if more community services were available then the current need for acute beds would decrease.

Older Virginians With Dementia Are Reported to Face Access Barriers

Older Virginians who exhibit aggressive behavior as a result of dementia have also been reported to face difficulty accessing a psychiatric bed. As reported in the 2005 JLARC study, *Impact of an Aging Population on State Agencies*, licensed hospitals are reluctant to accept older Virginians with aggressive dementia because

of discharge problems. As that study noted, these individuals have often "burned bridges" with family or other care providers, including nursing homes and assisted living facilities. As a result, hospital staff reportedly may not admit a person they feel will be difficult to discharge.

Staff at some licensed hospitals questioned what the proper role of nursing homes should be, and whether they should serve these patients. However, as noted in the 2005 JLARC study, the Virginia Health Care Association reported that nursing homes cannot serve persons who have behavioral problems. As a result, both CSB and licensed hospital staff indicated that older Virginians with behavioral problems often remain in hospital beds long after inpatient treatment is no longer needed.

Determining What Constitutes an Adequate Number of Beds Depends on Multiple Factors

Some areas of the State appear to need additional inpatient psychiatric beds and certain persons, notably anyone with a behavioral issue at any age, have difficulty accessing a bed.

However, while it appears that there are some areas of the State that may need additional inpatient psychiatric beds and certain categories of individuals who have difficulty accessing psychiatric beds, it is difficult to conclusively determine whether overall there is an adequate supply of psychiatric beds.

Any assessment of adequacy is limited by the lack of comprehensive demand data on persons who are in need of inpatient psychiatric services but do not obtain them due to barriers to access or other factors. For example, the lack of an inpatient facility within close proximity may result in services not being sought despite the need for them. In addition, interviews with mental health professionals during this study and previous studies have indicated that some individuals who need services are denied access to them because of their personal characteristics, diagnosis, or behavior. Data on individuals who are in need of inpatient psychiatric services but not able to access them due to these types of barriers is not tracked and therefore cannot be factored into the demand when assessing the issue of adequacy.

To some extent, the answer to the question "Are there enough psychiatric beds?" is a policy decision that reflects society's values and standards. For example, should individuals have to travel outside of their community to find a psychiatric bed? If the answer is yes, then how often should this occur, and for whom? The answer must also consider the availability of alternatives to psychiatric beds, such as community services. A lack of community services may re-

sult in a greater need for psychiatric beds, but the reverse may not be true. This is because if additional community services are provided to reduce the use of psychiatric beds, then these services may also be used by people who have never been admitted to a psychiatric bed. The ability to supply additional services—whether inpatient or in the community—also depends on the availability of trained personnel, whether psychiatrists, social workers, nurses, or other professionals.

Chapter 1 also indicated that the demand for psychiatric services may change in future years, and this may increase the need for inpatient beds if other services are not available. Furthermore, based upon the information provided by mental health professionals in the private and public sectors, it is also clear that the supply of beds varies around the State, and by the time of the year. More beds are available in the summer than in the winter, especially for children. Another factor is the continuing decline in the number of State hospital beds. If this number continues to decline as presently anticipated, then additional services—whether inpatient psychiatric beds or community services—will be required. These factors complicate any effort to determine the appropriate number of psychiatric beds.

Chapter 3

Additional Community Services Appear Needed and Could Reduce the Need for Psychiatric Beds

In Summary

The data discussed in Chapter 2 suggest there is an adequate number of psychiatric beds on a statewide basis, but that certain persons have difficulty accessing psychiatric beds. There appears to be widespread agreement that additional community services, such as crisis stabilization centers, would improve the availability of beds. Another community service, mobile crisis teams, has been demonstrated to reduce the use of State and licensed hospital beds in Virginia. Licensed hospital staff assert that more of these services are needed, and that greater availability would decrease unnecessary use of their emergency departments and ensure that inpatient beds are available to persons in need of that level of care. However, there is a widespread shortage of psychiatrists which limits the availability of any psychiatric services. Forty-seven localities do not have any psychiatrists at all, and 87 do not have any child psychiatrists.

Although the data on licensed beds presented in Chapter 2 indicate a need for additional psychiatric beds, some of these needs could be met through the provision of additional community services outside of hospitals. Certain community services, such as crisis stabilization centers or mobile crisis units, may not only reduce the need for additional inpatient psychiatric beds but also provide a way of serving persons with behavioral problems for whom a psychiatric bed is reportedly difficult to find. By addressing existing gaps in the continuum of mental health services, crisis services would respond to the concerns of licensed hospital staff and allow their facilities to focus on the care of patients with medical and psychiatric needs.

CERTAIN COMMUNITY SERVICES MAY REDUCE THE USE OF PSYCHIATRIC BEDS AND EMERGENCY DEPARTMENTS

Staff from the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and many of the community services board (CSB) and licensed hospital staff interviewed by JLARC have stated that if the availability of community services increased, then the need for psychiatric beds would decrease. The Commissioner of DMHMRSAS has stated that there is an adequate number of psychiatric beds, but that they are overused because community services are insufficient.

Several community services were mentioned by staff at DMHMRSAS, the CSBs, and at licensed hospitals as having the

potential to reduce the use of inpatient psychiatric beds. These services include crisis stabilization centers, mobile crisis teams, and assertive community treatment (ACT) teams. The latter service may be one means of reducing the use of beds by persons with multiple readmissions who use a disproportionate amount of psychiatric beds.

Discharge Barriers Faced by Certain Patients Limit the Availability of Beds to New Patients

In addition to the difficulty that certain groups of patients may face accessing a psychiatric bed, other patients are reported to face difficulty being released. The inability of hospitals to discharge some patients reduces bed availability, and hospitals and physicians cannot simply discharge patients without ensuring their safety upon release.

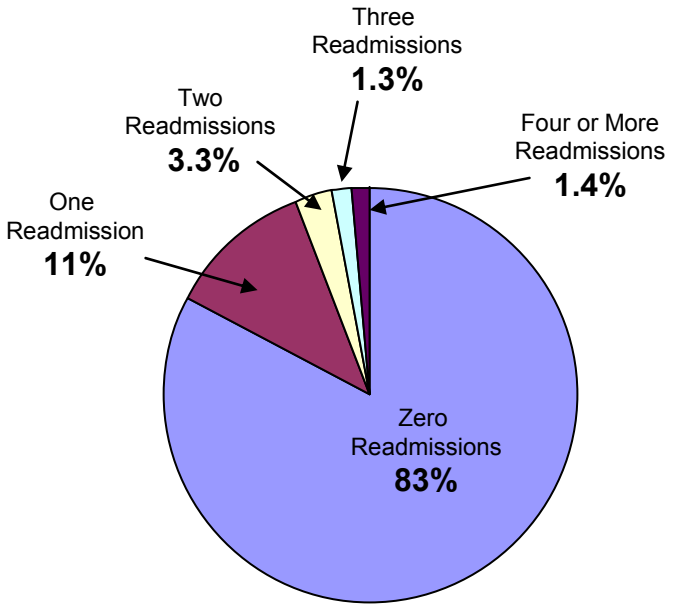
Staff at licensed hospitals and CSBs most frequently identified a lack of appropriate housing as a major discharge barrier. A lack of housing also affects the ability of State hospitals to discharge patients, and thereby reduces their ability to accept patients from licensed hospitals. Appropriate housing can include housing with supportive services, assisted living facilities, or nursing homes. Although these providers are an integral part of the continuum of mental health care, they are not obligated to accept patients. This issue has been examined by other organizations and was outside the scope of the present study, but appears to deserve further consideration.

In addition to a general shortage of appropriate housing, persons with certain diagnoses—notably Huntingdon's disease and traumatic brain injury—reportedly face difficulty accessing post-discharge services. For example, licensed hospital staff report that State hospitals will not accept these individuals. (This issue is discussed in Chapter 6.)

Patients Who Frequently Visit the Hospital Use a Disproportionate Amount of Resources

During interviews with staff of licensed hospitals, concern was frequently expressed about the impact of persons who are discharged and then are readmitted to their hospital. In 2005, there were 35,718 individual psychiatric patients. (This is an unduplicated count based on Virginia Health Information data. In contrast, there were 50,819 duplicated patients, as discussed in Chapter 2.) Of this group, 17 percent were discharged from a licensed hospital and then readmitted at least once within a 90 day period (Figure 7).

Figure 7: Seventeen Percent of Psychiatric Patients Were Readmitted At Least Once Within a 90-Day Period (2005)



Source: Analysis of Virginia Health Information data.

Although licensed hospital staff describe incidents where individuals will return to their hospital on a weekly basis, the data indicate that this occurs infrequently. Eleven percent of psychiatric patients were readmitted once within a 90-day period (4,036 patients). Another 3.3 percent had two readmissions (1,161 patients). An additional 1.3 percent (459 patients) had three readmissions, and 1.4 percent (503 patients) had four or more readmissions.

While few individual psychiatric patients are readmitted more than once, as a whole this group has a disproportionate impact upon the use of psychiatric beds. This is measured by calculating the percentage of "bed days" they use. (If a hospital had one bed, and it was used every day of the year, this would equal 365 bed days.) Although patients with multiple readmissions accounted for only 17 percent of all psychiatric patients, they accounted for 36 percent of all psychiatric bed days in 2005.

Assertive Community Treatment Teams May Reduce Use of Beds by Persons With Multiple Readmissions

ACT teams have been used in Virginia since 1997 and analysis conducted by DMHMRSAS staff demonstrates that ACT teams reduce the need for inpatient psychiatric beds in both State and licensed hospitals.

ACT teams provide long-term intensive "wrap-around" services to a limited number of consumers who are difficult to engage with a more traditional approach to treatment. The recipients may be frequent users of high intensity services (such as emergency departments, acute inpatient psychiatric services, and intensive crisis intervention services), and may be at a high risk of involvement with the criminal justice system.

The services are provided by a multi-disciplinary team which can respond quickly to the needs of a person with serious mental illness by going to where they live. The teams are available 24 hours a day and seven days a week and provide long-term rehabilitative treatment and support as well as crisis response to persons enrolled with the team. DMHMRSAS staff provided an illustrative case study of a typical person served by an ACT team.

Case Study

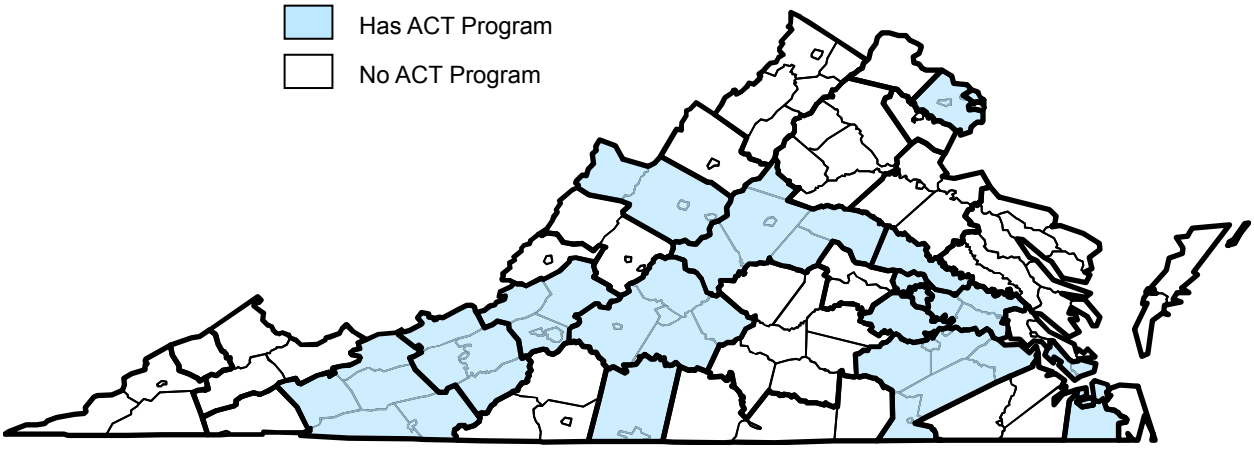
"M" is a 28-year-old man who is bright and creative, but has little employment history and often stops taking his medication, resulting in auditory hallucinations and bizarre and aggressive behavior. During one six month period, M did not show up for repeated psychiatric appointments, was hospitalized 3 times, became homeless, and was incarcerated for assaulting another homeless shelter resident. M was referred to an ACT team, which met with him twice a day, every day (including weekends and holidays) to help him manage his medications. The team also located suitable housing and a part-time job at a local auto repair shop. Occasionally, M would still experience symptoms severe enough to warrant crisis intervention and the team psychiatrist would then visit M at his home.

In Virginia, ACT teams usually have five to 12 full-time staff and an enrolled caseload of 85 persons. Each team has an average annual cost of $1.1 million. Medicaid will pay for some of these costs, depending upon the person's eligibility. There are currently 18 ACT teams in Virginia (Figure 8). Although the entire area of each CSB that has a team is shown, many teams serve individuals in a smaller area that is more centrally located to the CSB's office.

Additional Crisis Stabilization and Response Services May Reduce Use of Inpatient Psychiatric Beds

Through the use of additional crisis centers and mobile crisis teams, it may be possible to reduce the use of existing psychiatric beds so the beds will be more readily available for persons in need of inpatient care. Residential crisis centers that provide short-term crisis beds as well as mobile crisis teams are important components of a continuum of crisis stabilization and response services.

Figure 8: Location of CSBs With Assertive Community Treatment (ACT) Teams (2007)



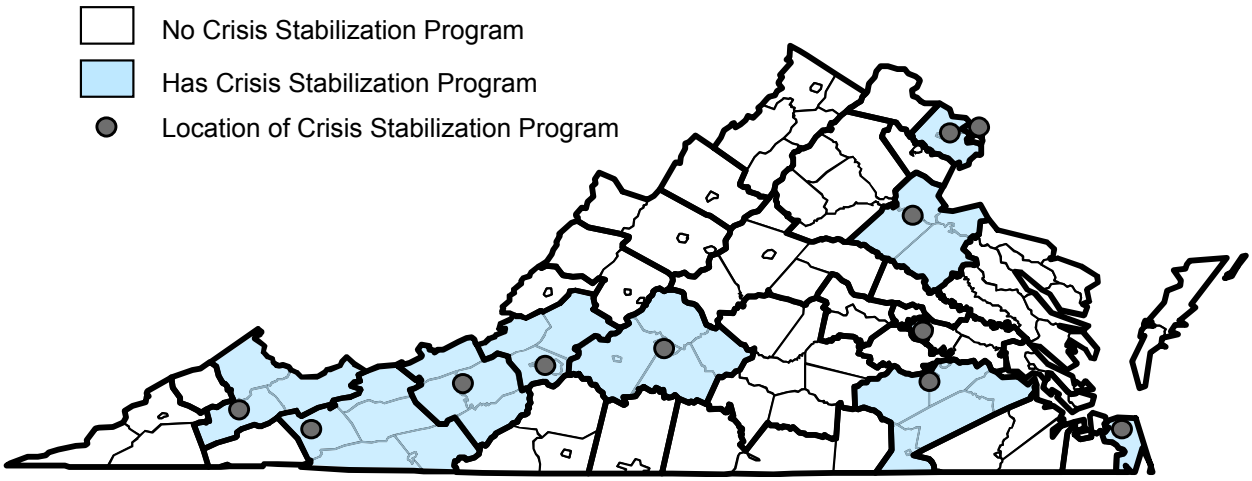
Source: Analysis of Department of Mental Health, Mental Retardation and Substance Abuse Services data.

Crisis Centers Were Noted by CSB and Hospital Staff as Having the Potential to Reduce the Use of Inpatient Psychiatric Beds. According to staff at the Rappahannock CSB, the availability of a new crisis stabilization unit has reduced the use of licensed hospital beds by "diverting" patients from licensed hospitals, thereby making it easier to admit individuals to hospitals when necessary. In the other regions with crisis stabilization units, such as the Tidewater area, DMHMRSAS staff note that access to acute psychiatric beds has improved.

The Inspector General of DMHMRSAS, in his report on the *Investigation of the April 16, 2007 Critical Incident At Virginia Tech*, recommends that "the number and capacity of secure crisis stabilization programs be expanded statewide in order to address the challenges frequently faced by prescreeners in securing a willing temporary detention facility in a timely manner." Presently, there are 12 crisis stabilization centers in Virginia, with a total capacity of 105 beds (Figure 9). Although the map shows that these centers are provided by a CSB, each center is physically located in one locality and the time and distance required to access the center may limit its effectiveness for the CSB as a whole.

Mobile Crisis Teams Have Reduced the Use of Inpatient Beds in Virginia. Mobile crisis teams were also reported by CSB and DMHMRSAS staff to be effective at resolving emergency situations and reducing the use of hospital emergency departments and inpatient beds. This conclusion is consistent with studies in peer-reviewed literature. For example, studies in *Psychiatric Services*, which is published by the American Psychiatric Association, have shown that mobile crisis teams are effective. One of these studies

Figure 9: Location of CSB Crisis Stabilization Programs (2007)



Source: Analysis of Department of Mental Health, Mental Retardation and Substance Abuse Services data.

found that 55 percent of emergencies handled by mobile crisis teams could be managed without psychiatric hospitalization, compared to 28 percent of emergencies handled by regular police intervention.

A mobile crisis team is able to provide on-site assessment, crisis management, medication and treatment, and referrals to consumers, their families, and law enforcement officers. Mobile crisis teams provide access to immediate intensive mental health care, but unlike Virginia's existing ACT teams the service can be used by any individual in need and is for a shorter time period. The Inspector General's 2005 *Review of the Community Services Board Emergency Services Programs* reported that nine CSBs offer mobile outreach crisis team services where emergency services clinicians assess and serve persons in crisis wherever they may be, but that "some have limited availability, are frequently unavailable, or are restricted to current CSB consumers."

Responsibility for Providing Some Crisis Stabilization Services May Rest With Local Governments

Staff at many licensed hospitals stated that the existing array of crisis stabilization services in their locality is not sufficient. As a result, licensed hospitals believe that they are the de facto "single point of entry" for public mental health care. This is said to result from the effects of the federal Emergency Medical Treatment and Labor Act, which requires all hospitals with an emergency room to stabilize any person seeking care. Because many emergency rooms are open 24 hours a day, and are located in closer proximity to most Virginians than public crisis centers, many mentally ill per-

sons seek services from the licensed hospitals. Licensed hospitals do not dispute that they have a role in providing care, but maintain that local governments are not providing the services they are required to provide by law.

Although local governments do not appear to have a legal responsibility to provide inpatient services, they are statutorily required through their CSB to provide emergency services:

> The core of services provided by community services boards within the cities and counties that they serve shall include emergency services and, subject to the availability of funds appropriated for them, case management services (§§ 37.2-500 and 600).

The State Board has adopted regulations in the *Virginia Administrative Code* (VAC) which define emergency services as being

> available 24 hours a day and seven days per week that provide crisis intervention, stabilization, and referral assistance over the telephone or face-to-face for individuals seeking services.

Crisis stabilization is further defined as

> direct, intensive intervention to individuals who are experiencing serious psychiatric or behavioral problems, or both, that jeopardize their current community living situation. This service shall include temporary intensive services and supports to avert emergency psychiatric hospitalization or institutional placement (12 VAC 35-105-20).

The Inspector General's 2005 review of CSB emergency services found that all CSBs offer some form of telephone-based crisis services, and about two–thirds offer face-to-face crisis counseling. This kind of crisis response is sufficient to meet the definition of emergency services quoted above. However, very few CSBs offer residential programs, such as crisis stabilization centers, which the Inspector General noted are "critical" services. The Inspector General stated that because these residential services are lacking, there is a greater dependence on more costly and restrictive inpatient hospital care.

In order to address the concerns of licensed hospitals, it would appear that the provision of emergency services is primarily a local responsibility. However, it may be reasonable to have the State assist localities in the provision of services by providing State aid through DMHMRSAS.

Recommendation (2). The General Assembly may wish to provide additional funding for crisis stabilization centers, mobile crisis treatment teams, and assertive community treatment teams.

SHORTAGE OF PSYCHIATRISTS IS REPORTED

Widespread concern expressed by staff of licensed hospitals and CSBs is that Virginia has too few psychiatrists. The lack of psychiatrists is reported to affect the availability of services in many ways. On the inpatient side, additional psychiatric beds cannot be opened unless there are psychiatrists available and willing to staff them. On the outpatient side, it has been reported that a lack of psychiatrists affects licensed hospitals because individuals in need of psychiatric services cannot find them in the community and therefore turn to emergency departments.

There is also a reported shortage of many other kinds of direct care staff, including nurses and social workers. The Inspector General has documented the shortages of nursing staff in State hospitals, and these staffing shortages affect the ability of the State hospitals to provide services. Lastly, it appears that some services which are performed by psychiatrists could be performed by other types of personnel, including nurses and psychologists, but an assessment of these possibilities is beyond the scope of the present study.

Recent Data Indicate That Persons Have a Long Wait Before Seeing a CSB Psychiatrist

In June 2007, the Inspector General surveyed all 40 CSBs, and one question asked about the length of time that a CSB consumer would have to wait before seeing a psychiatrist. The survey results revealed that, on average, an adult would have to wait 24 days to see a psychiatrist, while a child would have to wait almost 30 days. If the consumer had received emergency services and then needed to see a psychiatrist, the wait time was less but still substantial, 14 days for adults, and 16 days for children.

To put these wait times in perspective, when a CSB consumer is discharged from a licensed hospital they receive a 14 day supply of medication. To have their prescription refilled, the consumer must see a psychiatrist, which is typically at the CSB. Failure to receive medication in a timely manner is reported to lead to repeat admissions.

The longer wait time for children reflects the reported shortage of child psychiatrists. Many reasons have been offered for this shortage, and most reflect the same issues identified for other psychiatrists—low reimbursements, and a desire to avoid "on call" work.

But it has been reported that many psychiatrists avoid treating children because doing so takes substantially more time and effort. Treating the psychiatric needs of children usually involves family therapy, and may also involve interactions with school officials. This extra work is not reflected in Medicare and Medicaid rates.

Difficulty Accessing Medication After Discharge Was Noted as a Concern

Without regular, affordable access to medication, some patients will be readmitted to hospitals more often than they otherwise would be. In some cases the barrier to obtaining medication may be financial. But in other cases, such as patients with Medicaid coverage, it may be difficult to find a psychiatrist to prescribe and monitor medication. CSB and hospital staff reported that few psychiatrists are willing to take Medicaid patients due to low reimbursement (discussed in Chapter 5).

Many Localities Do Not Have Any Psychiatrists

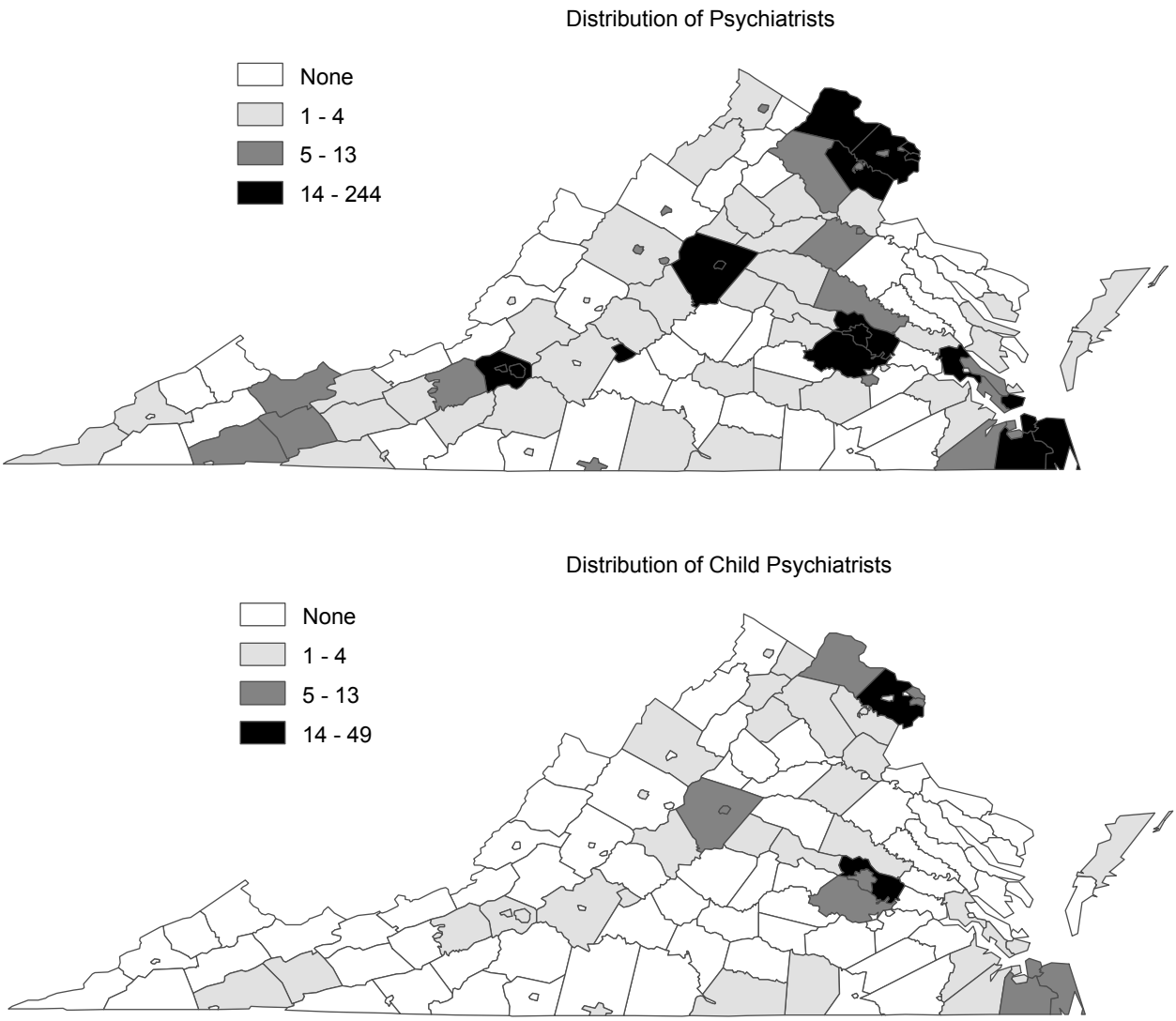
According to data collated by the American Medical Association (AMA), as of December 2005 there were 1,261 psychiatrists in Virginia. (These data are based on self-reported specialty areas.) This equates to 2.6 psychiatrists per 10,000 people statewide.

The AMA data also reported that there were 216 child psychiatrists, but it is not known if these data are duplicated. Using the AMA data, there is one child psychiatrist for every 10,000 children statewide. The AMA data indicate that there are more psychiatrists than are reported by the Psychiatric Association of Virginia. The Psychiatric Association estimates that there are 190 child psychiatrists. They also note that all child psychiatrists are also general psychiatrists, and so many psychiatrists have practices in which they see adults as well as children. Therefore, the Psychiatric Association believes that the effective number of child psychiatrists is lower than the AMA data.

Seven of Virginia's localities account for half of all psychiatrists.

The distribution of psychiatrists is a concern. Based on the AMA data, 47 localities do not have any psychiatrists and 87 localities do not have any child psychiatrists (Figure 10). Analysis of these data reveals that seven of Virginia's localities account for half of all psychiatrists: the Counties of Fairfax, Henrico, and Albemarle, and the Cities of Richmond, Virginia Beach, Charlottesville, and Norfolk. In combination, the County of Fairfax and the Cities of Fairfax and Falls Church account for one of every five psychiatrists.

Figure 10: Many Localities Do Not Have Any Psychiatrists



Source: Analysis of data from the American Medical Association.

One step that may deserve consideration is the use of locality-based Medicaid fees. Presently, DMAS does not adjust physician rates by region or locality. This derives from the fact that the regulations adopted by the Board of Medical Assistance Services prevent fees from being adjusted by locality (12VAC30-80-190 (B)(4)). In contrast, rates for inpatient psychiatric services are adjusted to reflect the cost of labor in different parts of the State, with urban areas receiving a higher rate. (More information on these rates is provided in Chapter 5.)

However, because a locality-based fee differential would need to be designed to attract providers to *rural* areas, where wage costs are

lower, it would be necessary to design a wage index that paid a bonus to providers in certain designated areas, many of which would be rural. This is similar to the method used by the Medicare Incentive Payment program, which is designed to encourage providers to serve designated areas. For example, a provider who practices in a designated area will automatically receive a five percent bonus from Medicare on a quarterly basis.

One way of designating these areas would be to use the Mental Health Professional Shortage Areas (MHPSA). Virginia has 65 localities with this federal designation. According to the Virginia Department of Health, which administers the Health Professional Shortage Area program, there are several programs which already use these designations, including

- Virginia Loan Repayment Program;
- Conrad 30 J-1 Visa Waiver Program;
- National Health Service Corps;
- Rural Health Clinic Act; and
- Area Health Education Center Programs.

The use of incentive fees, targeted at the MHPSAs, may provide a sufficient incentive for psychiatrists to practice in areas that are presently underserved. Unlike loan repayment programs, which only are available to persons graduating from a Virginia institution, incentive payments may attract providers who have been trained elsewhere, and also increase the State's ability to retain psychiatrists already practicing in the State.

Recommendation (3). The General Assembly may wish to direct the Department of Medical Assistance Services to study and report back to the House Appropriations and Senate Finance Committees prior to the 2009 General Assembly Session on the advisability of adopting regional adjustments in the rates for physician services in order to attract psychiatrists to medically underserved areas.

Chapter 4

Most Licensed Hospitals in Virginia Had Unreimbursed Costs From Providing Psychiatric Services in 2005

In Summary

Most hospitals with licensed inpatient psychiatric beds in Virginia reported unreimbursed costs in 2005 as a result of providing psychiatric services. However, the extent of unreimbursed costs varied widely across facilities. The extent of unreimbursed cost was largely affected by the payer mix, because some payers reimbursed more than others for psychiatric services. The two largest sources of unreimbursed cost were uninsured psychiatric patients and under-reimbursements by commercial insurers. However, hospitals have an obligation to provide some charity care as a condition of licensure, and under-reimbursement from commercial insurers is a consequence of marketplace negotiations. The extent of unreimbursed costs also varied by the type of facility. Freestanding psychiatric hospitals were able to recover their costs. In contrast, teaching hospitals and acute care psychiatric units within general hospitals had unreimbursed costs. Moreover, psychiatric patients with an extended length of stay (beyond 14 days) or secondary (non-psychiatric) medical conditions appear to pose the largest financial burden for hospitals. Finally, nearly all emergency departments within licensed hospitals also had unreimbursed costs from providing psychiatric services in 2005.

Unreimbursed costs resulting from the provision of inpatient psychiatric services have been cited as a potential reason for the declining number of psychiatric beds in licensed hospitals. As business entities, whether for-profit or not-for-profit, licensed hospitals must generate enough revenue to earn a profit or at least break even. An analysis of the extent to which licensed hospitals were able to recover the costs they incurred in providing psychiatric services in 2005 indicates that almost all Virginia hospitals with licensed acute inpatient psychiatric beds had unreimbursed costs.

The patient-level financial and demographic data analyzed in this chapter were obtained through a JLARC staff survey of all 35 Virginia hospitals with licensed inpatient psychiatric beds. JLARC staff requested cost and reimbursement data of licensed hospitals for all patients assigned to a licensed psychiatric bed and discharged during calendar year 2005. In addition, JLARC staff also surveyed the emergency departments (EDs) within licensed hospitals for similar financial data associated with all psychiatric patients seen in the ED regardless of whether they were admitted to the hospital. The findings presented in this chapter and Appendix I are based on a financial analysis of 26 survey submissions. The hospitals responding to the survey served 76 percent of all psychiatric patients in 2005. Appendix B provides a more complete description of the information collected through the JLARC financial

surveys, the financial analysis performed on these data, and the other data reported in this chapter.

THREE LICENSED HOSPITALS ACCOUNTED FOR NEARLY 60 PERCENT OF ALL UNREIMBURSED INPATIENT COSTS

Overall, 24 of the 26 licensed hospitals reported unreimbursed costs resulting from providing inpatient psychiatric services in 2005. Specifically, licensed hospitals reported $217.1 million in total costs and $155.8 million in total reimbursements. Of the 24 licensed hospitals with unreimbursed costs, three hospitals accounted for 59 percent of the total net unreimbursed cost amount of $61.3 million, but accounted for only 10 percent of all psychiatric bed days. The decision was made to exclude these three "outlier" hospitals from the analysis in this chapter because of the concern that the data from these hospitals would distort the overall results given the substantial difference between them and the "typical" hospitals. Appendix H contains a detailed description and analysis of these three hospitals. Appendix I provides some additional analysis and shows the differences if the three outliers are included.

Two Types of Uninsured Patients

Self-pay patients are individuals without insurance who are determined by the hospital to be able to pay for the cost of their care. These patients are billed and expected to pay within a certain timeframe to avoid collection referrals. Payments not collected are considered bad debt.

Uninsured indigent patients qualify for charity care because they fall below a certain poverty threshold, as defined by the hospital (typically between 100 and 200 percent of the federal poverty level). They are not expected to pay for their care, and the hospital does not receive any reimbursement for the care provided to these patients.

PAYER MIX AFFECTS THE EXTENT OF UNREIMBURSED COSTS

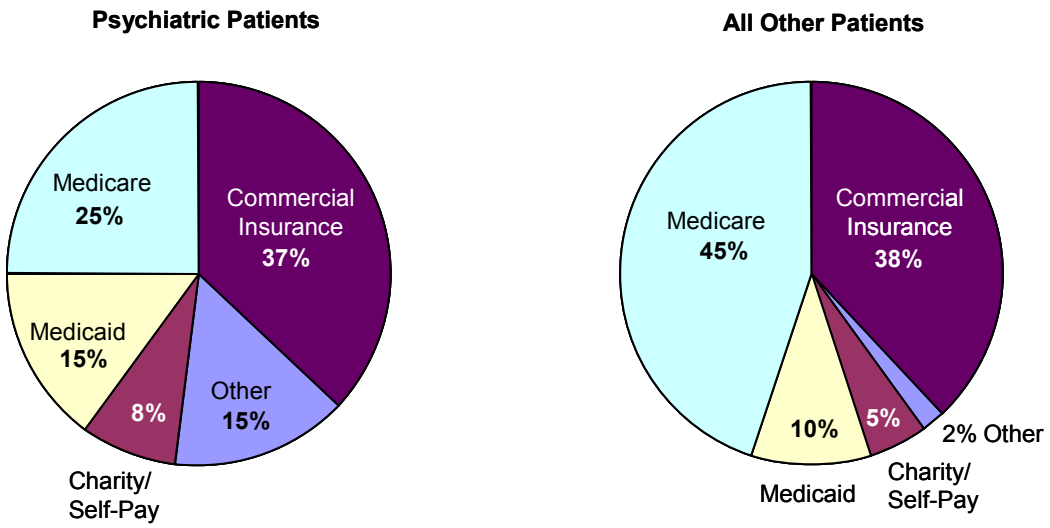
The extent of the unreimbursed costs was largely affected by the mix of different payment sources that reimbursed hospitals for the costs incurred in providing psychiatric services. Some psychiatric patients have commercial insurance, whereas others are uninsured or are Medicare recipients. Each type of payer reimburses a different percentage of total cost. Moreover, some of the payers, like Medicaid and Medicare, vary their reimbursement rate for inpatient services between hospitals.

Psychiatric Patients in Inpatient Psychiatric Beds Are More Likely to Have Medicaid or Be Uninsured Than Other Patients

According to data from Virginia Health Information (VHI), in 2005 psychiatric patients were more likely to be covered by Medicaid or be uninsured than other patients (Figure 11). (Uninsured patients either receive charity care, or "self-pay" for their own care.) Between 2001 and 2005, almost twice as many psychiatric patients were uninsured as other hospital patients.

Overall, the mix of payer sources for psychiatric patients remained relatively constant between 2001 and 2005. One of the biggest changes was the percentage of psychiatric patients with commercial (private) insurance, which declined from 42 percent in 2001 to 37 percent in 2005. Also, the percentage of psychiatric patients with Medicaid increased from 13 to 15 percent over the period.

Figure 11: Compared to Other Patients, Psychiatric Patients Were More Likely To Have Medicaid or Be Uninsured (Charity/Self-Pay) in 2005



Source: Analysis of Virginia Health Information data.

Some Payers Reimburse More Than Others for Inpatient Psychiatric Services

Two Types of Medicaid

Virginia has two types of Medicaid that reimburse hospitals. Medicaid fee-for-service (FFS) is "traditional" Medicaid, and payments are made to hospitals by the Department of Medical Assistance Services (DMAS) based upon rates set by the agency.

The other kind of Medicaid uses commercial insurers which are referred to as health maintenance organizations (HMO) or managed care organizations. DMAS contracts with the HMOs and pays them a capitated (fixed) amount for all services they provide to enrollees, based on a set per-person fee.

The mix of different payers adversely affected the amount of unreimbursed costs of some facilities. The largest source of unreimbursed costs in 2005 was uninsured psychiatric patients, who represented 29 percent of unreimbursed costs but only nine percent of psychiatric patients reported on the JLARC staff survey of psychiatric facilities (Table 12). The second largest source of unreimbursed costs stemmed from under-reimbursement by commercial insurers. As seen in Table 12, 36 percent of psychiatric patients had commercial insurance. Therefore, the cumulative effect of a relatively small under-reimbursement was significant enough for this payer source to be the second largest source of unreimbursed costs.

The next largest sources of unreimbursed costs (excluding the hospital-defined "other" payer source category) were Medicare and "Medicaid plus DSH." The latter category includes the hospitals that received Medicaid Disproportionate Share Hospital (DSH) payments. DSH payments are intended to help offset unreimbursed costs resulting from treating Medicaid recipients or uninsured patients. Psychiatric patients are included when determining the amount of DSH payments paid to each hospital. Because only some hospitals received DSH, JLARC staff analyzed the unreimbursed costs for these hospitals separately. If a hospital received

Table 12: Uninsured Patients Had a Disproportionate Effect on Unreimbursed Costs for Inpatient Psychiatric Services in 2005

Payer Type	Percent of Unreimbursed Costs	Percent of Psychiatric Patients	Average Daily Cost	Average Daily Reimbursement
Uninsured	29%	9%	$809	$295
Commercial	16	36	687	629
Medicare	13	25	722	681
Other (a hospital-defined category)	11	7	801	591
Medicaid plus DSH	11	8	728	614
Medicaid HMO	10	4	808	502
Medicaid FFS	6	4	734	549
Community Service Board (LIPOS)	3	3	679	548
Temporary Detention Order	1	2	584	547
CHAMPUS	1	1	679	605
Worker's Compensation	<1	<1	805	698
TOTAL / OVERALL AVERAGE	**100%**	**100%**	**$722**	**$612**

Note: DSH, disproportionate share hospital; HMO, health maintenance organization; FFS, fee for service; LIPOS (local inpatient purchase of services). The total number of patients in non-outlier hospitals was 33,213.

Source: Analysis of psychiatric facility financial survey data (2005) for non-outlier hospitals.

DSH then the payer source is labeled as "Medicaid plus DSH." (For more information regarding which hospitals received these payments and how this funding was analyzed to assess its effect on unreimbursed costs, see Appendix B.)

As seen in Table 12, the three categories of Medicaid payments—Medicaid HMO, Medicaid fee for service (FFS), and Medicaid plus DSH—accounted for 27 percent of the unreimbursed costs. The fifth largest source of unreimbursed costs (excluding the hospital-defined "other" payer source category) was Medicaid HMO patients who represented only four percent of all psychiatric patients but accounted for 10 percent of unreimbursed costs. Similar to commercial insurers, Medicaid HMOs negotiate rates with licensed hospitals within a capitated per-person funding amount provided by the Department of Medical Assistance Services (DMAS). The sixth largest source of unreimbursed costs was Medicaid FFS patients, who also represented only four percent of all psychiatric patients, but accounted for six percent of unreimbursed costs.

The other payer categories represented small percentages of both psychiatric patients and unreimbursed costs. Payments that licensed hospitals received from community services boards (CSB), which include the Local Inpatient Purchase of Services (LIPOS) funds discussed in Chapter 7, represented only three percent of patients and three percent of unreimbursed costs. Payments made for services rendered during a Temporary Detention Order (TDO) were made on behalf of only two percent of patients, and this represented only one percent of unreimbursed costs.

Cost Recovery Ratio

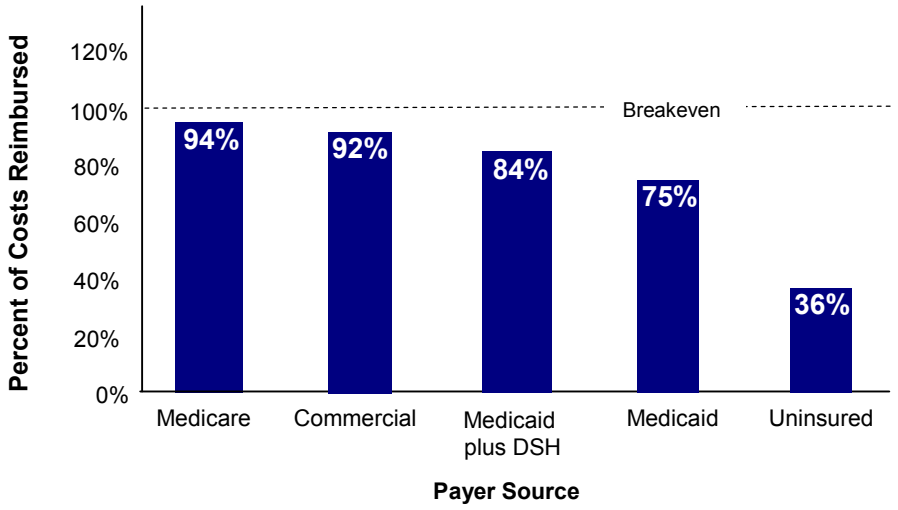
CRR = Total Revenue / Total Costs

As shown in Table 12, each payer source category had a different average daily cost and average daily reimbursement amount. A summary measure of the extent to which a hospital had unreimbursed costs can be determined by using a cost recovery ratio (CRR). The CRR, which is referred to throughout this chapter, measures the total amount of revenue received by a hospital as a percentage of its total costs. Therefore, a CRR of 1.0 (or 100 percent) indicates that a hospital broke even, or earned just enough revenue to cover its costs.

Excluding the three outlier hospitals, the remaining 23 hospitals reported an overall net amount of $25 million in unreimbursed costs. Of these 23 hospitals, two hospitals fully recovered their costs of providing inpatient psychiatric services, and the remaining 21 hospitals reported a total of $29.1 million in unreimbursed costs. This equates to a CRR of 79 percent, which likely represents the most accurate overall financial picture of those facilities which had unreimbursed costs.

Although this indicates the overall picture regardless of payer source, the CRR varied widely between the different primary payer sources. As illustrated in Figure 12, Medicare and commercial insurers covered 94 percent and 92 percent of total costs, respectively. Conversely, the CRR for uninsured psychiatric patients was by far the lowest at 36 percent, meaning that hospitals were only reimbursed for 36 percent of the total costs of uninsured patients.

Figure 12: Some Payers Reimburse More Than Others for Inpatient Psychiatric Services



Note: Does not include the three outlier hospitals. Includes only the most common primary payer sources among psychiatric patients in 2005.

Source: Analysis of psychiatric facility financial survey data (2005).

CSB payments made to hospitals pursuant to the LIPOS program covered 81 percent of the costs of these patients. Payments made by DMAS from the Involuntary Mental Commitment Fund, for costs incurred in treating patients held under a TDO, covered 94 percent of the cost to hospitals. (TDO and Medicaid FFS rates are discussed in Chapter 5).

UNINSURED PSYCHIATRIC PATIENTS ACCOUNTED FOR NEARLY 30 PERCENT OF UNREIMBURSED COSTS

Overall, a small percentage of psychiatric patients in inpatient beds were uninsured in 2005, but these patients created a disproportionate financial burden for licensed hospitals because the majority of these patients were not able to pay for the care provided to them. Public funding is available to help offset some of these losses, but some licensed hospitals are required to provide charity care which may include unreimbursed services to uninsured patients. In addition, not-for-profit facilities receive State tax exemptions to assist with the provision of health care.

Uninsured Psychiatric Patients Had a Disproportionate Effect on Unreimbursed Costs

As indicated in Table 12 (page 52), uninsured psychiatric patients represented only nine percent of all psychiatric patients reported on the survey but accounted for 29 percent of the unreimbursed costs across all licensed hospitals. In 2005, most uninsured psychiatric patients (81 percent) were indigent and were deemed by the hospital as unable to pay for their care. Of the $7.1 million in unreimbursed costs for uninsured patients, 96 percent of this loss ($6.8 million) resulted from charity care provided to indigent psychiatric patients. The remaining uninsured patients were deemed to be able to pay for their care (based upon the extent to which their income was above the federal poverty line) and are known as self-pay patients. The State may need to give greater consideration to the amount of charity care that licensed hospitals should be required to provide, and then determine what manner of financial assistance for unreimbursed costs, if any, is appropriate.

Funding Is Available to Hospitals to Partially Offset the Cost of Uncompensated Care Provided to Uninsured Patients

In Virginia, three programs are currently in place to mitigate the amount of uncompensated care provided by hospitals. The Disproportionate Share Hospital program assists hospitals with unreimbursed care provided to Medicaid recipients and uninsured patients. The other two programs, the State and Local Hospitalization program and the Indigent Health Care Trust

Fund, are intended to cover persons who are not eligible for Medicaid. Although these funds are not given to hospitals to specifically offset unreimbursed costs from treating psychiatric patients, hospitals could use these funds for that purpose. All of these programs are administered by DMAS.

Disproportionate Share Hospital (DSH). DSH is given to hospitals on the basis of the overall amount of care they provide to Medicaid recipients. DSH was created as a federal program in 1981 and both Medicare and Medicaid make DSH payments. The basis for determining which hospitals are eligible for Medicaid DSH payments is defined in State regulations which are based upon federal guidelines (these guidelines are in the Omnibus Reconciliation Act of 1987, P.L. 100-203, 101 Stat. 1330-149). DMAS has chosen to base a hospital's eligibility for DSH upon the volume of Medicaid recipients the hospital serves. Federal law also allows states to base eligibility upon the volume of low-income patients. Presently, a hospital receives DSH if the entire hospital serves a high volume of Medicaid patients. DMAS staff indicate that hospitals may allocate DSH to particular units within a hospital, such as an acute care psychiatric unit. In fiscal year (FY) 2006, about $136.2 million in DSH payments were made to licensed hospitals, of which two-thirds went to the two teaching hospitals.

State and Local Hospitalization (SLH). SLH was created in 1946 as State aid to localities. The SLH program was created at a time when there were few general hospitals, and local governments were considered to be responsible for ensuring that their citizens had sufficient access to hospitals, nursing homes, and district homes (a precursor of assisted living facilities). Originally, local participation in SLH was voluntary and the State matched local expenditures at a rate of 50 percent. Presently, the SLH program is financed entirely by State general funds (85 percent) and local funds. Funds allocated to a locality are only for residents of that locality. SLH is designed to cover inpatient and outpatient hospital care, excluding freestanding psychiatric hospitals. Coverage for SLH health care services is only available to low-income people who are not eligible for Medicaid.

Since 1989, as the result of a JLARC recommendation, all localities have been required to participate in SLH, which is intended to act as a payer of first resort for Virginians who are not eligible for Medicaid. However, SLH is not an entitlement program and payments cease once funds are exhausted. Individuals then become responsible for the balance of their medical bill. In FY 2006, total SLH expenditures were $12.6 million. DMAS estimates that a total of $66.4 million would have been needed in FY 2006 to satisfy all claims on the fund. DMAS notes that 5,393 Virginians were assisted by the SLH program in FY 2006, a 13 percent decrease from

the previous year. This is the fewest number of SLH recipients since FY 1990. DMAS attributes this in part to a change in the way DMAS calculated hospital rates (which increased costs) and a fixed level of funding.

Indigent Health Care Trust Fund (IHCTF). The IHCTF was created in 1990 after a study that involved the Virginia Hospital and Health Care Association and other parties. The IHCTF was created as a public-private partnership to address the needs of the indigent that were not met by SLH payments. In effect, the IHCTF acts as a payer of last resort for persons whose needs are not met by the SLH program. Funds are provided to the IHCTF from State general funds (60 percent) and hospital contributions (40 percent). In-state hospitals either make payments to the fund, or are paid by the fund, depending on the volume of charity care they provide. In FY 2006, total payments of $6.9 million were made to Virginia hospitals by DMAS from the IHCTF.

Licensed Hospitals May Have a Responsibility to Provide Unreimbursed Charity Care

Since 1973, Virginia has regulated the provision of new or expanded healthcare facilities through the certificate of public need program (COPN). As a result of this process, some hospitals are required to provide a specified amount of charity care as a condition of approval to build a new facility or add beds. Some other licensed hospitals provide charity care even though they are not required to by the State.

Certificate of Public Need Program Often Entails Specific Charity Care Conditions. The COPN program requires healthcare providers to obtain a certificate from the Commissioner of the Virginia Department of Health (VDH) prior to opening or expanding a medical care facility. The *Code of Virginia* authorizes the State Board of Health to adopt regulations allowing the Commissioner to place a condition on the approval of a certificate. Specifically, a healthcare provider can be required to provide care "at a reduced rate to indigents" or to "accept patients requiring specialized care" (§32.1-102.2). As part of the State Medical Facilities Plan (SMFP), the State Board of Health has adopted regulations to implement these statutory criteria which state that "acute psychiatric . . . services should be accessible to all patients in need of services without regard to their ability to pay or the payment source" (12 VAC 5-290-30).

Although charity care per se is not referred to in statute, VDH appears to have interpreted the statutory reference to providing care "at a reduced rate to indigents" to refer to charity care. The SMFP is currently being revised, and as an interim guidance to health-

care providers VDH has defined "indigent" to be persons whose income is at or below 200 percent of the federal poverty level. VDH has also defined charity care to mean "health care services delivered for which it was determined at the time of service provision that no payment was expected." This excludes under-reimbursement from Medicaid or bad debt (uncollected payments) from self-pay patients. Licensed hospitals, in contrast, assert that charity care should be defined more broadly, to include under-reimbursement from Medicaid, tax payments made by for-profit hospitals, and care provided to persons with incomes greater than 200 percent of the federal poverty level.

As part of its review of COPN applications, VDH assesses whether the applicant has demonstrated a historical commitment to charity care which is consistent with other providers in their health planning region (HPR). Typically, VDH requires applicants to provide a level of charity care that is at or above the average level provided by other hospitals in their HPR, which ranged from 2.3 to 3.1 percent of total gross patient revenue in 2005. (These figures exclude the teaching hospitals, which provide a very high amount of charity care, and freestanding hospitals, for which VHI data do not report charity care.) The *Code of Virginia* directs the Commissioner to condition any license issued to a hospital or license renewal upon the hospital meeting the conditions of its certificate (§ 32.1 – 102.2 C).

VDH Reports That Charity Care Conditions Are Difficult to Enforce. As part of the COPN process, licensed hospitals are required to submit plans that detail the type and extent of charity care they will provide, but VDH staff report that these plans are rarely submitted and that enforcing hospital compliance with charity care conditions is difficult. The charity care plans are required to include, at a minimum, the number of unreimbursed patient days to be provided to indigent patients and to CSB consumers. However, in at least four of the seven COPN reviews for new psychiatric beds conducted since 2003, VDH staff noted that the application did not contain these plans.

According to VDH, "Compliance with the conditions to provide indigent care remains relatively poor but has improved considerably." Many hospitals that are required to provide charity care as a condition of the COPN process have either not reported their compliance with conditions or have reported that they have been unable to provide the required level of charity care. VDH reports that the interim guidance has improved compliance, by giving hospitals an option to make a direct monetary contribution to a safety net health care provider, but that the current fine of $100 per day is often less than the required amount of charity care.

COPN Process May Benefit Licensed Hospitals by Limiting Competition. The Department of Planning and Budget (DPB) conducts economic impact analyses as part of its regulatory review responsibilities. As part of previous reviews, DPB has asserted that the COPN process makes "entry into the inpatient hospital industry difficult, thus providing an umbrella for incumbents against competition." DPB adds that this protection allows hospitals to shift their losses onto patients with more generous reimbursements. Therefore, a consideration of the extent of the State's responsibility to compensate licensed hospitals for unreimbursed charity care costs must consider the benefit derived from this protection against competition.

Nonprofit Hospitals Are Exempt From State Sales and Income Taxes. In addition to the DSH, SLH, and IHCTF programs, the State provides indirect support to not-for-profit hospitals through State sales and use tax exemptions. According to the Virginia Department of Taxation, Virginia has a longstanding policy of providing an exemption from the retail sales and use tax for not-for-profit entities and governmental agencies. These organizations are also exempt from federal and State income taxes. Of the eight licensed hospitals that provided psychiatric charity care to a level that was at or above the average in their HPR, six were not-for-profit hospitals.

Extent of Licensed Hospital Responsibility for Charity Care May Need Greater Clarification

The State may need to give greater consideration to the amount of charity care that licensed hospitals should be required to provide, and then determine what manner of financial assistance with unreimbursed costs, if any, is appropriate. Although VDH has defined charity care to include only those costs for which no payment was expected, licensed hospital staff assert that underreimbursement from Medicaid constitutes charity care. (As discussed in Chapter 5, in 2007 the General Assembly provided $4.9 million to increase Medicaid FFS rates for psychiatric services.) Additionally, DPB has asserted that licensed hospitals benefit from protection against competition, which is a form of indirect State support. However, because all payers reimburse less than the reported cost for psychiatric services, it appears that licensed hospitals may have less ability to cross-subsidize unreimbursed costs than may be the case for non-psychiatric services.

Overall, most licensed hospitals appear to cover all of their costs on a hospital-wide basis, but not all licensed hospitals meet the average level of charity care. Based on the unreimbursed charity care costs reported on the JLARC staff survey, of the 19 licensed hospitals with unreimbursed costs (excluding the two teaching

hospitals), eight provided psychiatric charity care that was at or higher than the average for their HPR (which ranged from 3.5 to 14.8 percent of total revenues). Turning to VHI data for 2005, nine of the 19 licensed hospitals provided *overall* charity care for the entire hospital that exceeded the average level in their HPR (2.3 to 3.1 percent of gross patient revenues). Four hospitals provided an above-average level of charity care according to both the survey data and the VHI data.

Most of the 19 licensed hospitals which reported unreimbursed costs for psychiatric services made an overall profit for the entire hospital. VHI data for 2005 indicate that 17 of the hospitals reported a profit margin of 0.1 percent to 23 percent (total revenue as a percent of total operating expenses). Only two of the 19 hospitals had a negative profit margin, and both hospitals provided a below-average level of charity care.

The above analysis represents a rough estimate of whether licensed hospitals are providing sufficient charity care. It suggests that some licensed hospitals are not providing a sufficient amount of charity care and thus may not be appropriate candidates for additional State assistance. However, licensed hospitals are an important component of the mental health continuum, and the State has an interest in assuring that a sufficient supply of psychiatric beds is available.

The availability of licensed psychiatric beds is important to the State's ability to continue decreasing the role of State hospitals and to serve persons held under a temporary detention order. If further reductions in the number of licensed hospital beds continue, then this would need to be offset by either additional State hospital beds or by new community-based services. In recent years, the number of licensed psychiatric beds has decreased, and licensed hospitals do not appear to be opening new beds with the same frequency as other types of hospital services. Of the 927 COPN applications received by VDH from 2000 through 2006, only 20 involved the addition of inpatient psychiatric beds.

If the State decides to provide further assistance with the unreimbursed costs of uninsured patients to licensed hospitals, this assistance could be provided through a re-allocation of DSH payments based on low-income patients rather than Medicaid recipients (in lieu of an increase in overall DSH payments), or through additional funding for SLH or the IHCTF. A joint consideration of the responsibility of licensed hospitals for charity care and the State's responsibility for the costs of the uninsured would help ensure a more balanced approach to the issue, and help assure that a sufficient number of psychiatric beds are available.

UNREIMBURSED COSTS FROM COMMERCIAL INSURERS AND BED REDUCTIONS MAY RESULT FROM MARKET FACTORS

More than one-third of psychiatric patients had commercial insurance in 2005. Overall, psychiatric patients with commercial insurance accounted for 16 percent of the unreimbursed costs ($4.1 million). A third-party administrator of a commercial insurance company reported that some mental health benefits are not covered for any days beyond the average length of stay of their patients, which may be a primary reason for this portion of the unreimbursed costs. The State does not appear to have a direct responsibility to reimburse licensed hospitals for these losses, and it appears that some of the unreimbursed costs incurred by licensed hospitals are the result of competitive forces in the marketplace.

The reason for under-reimbursement from commercial insurers is not known; however, JLARC staff were told that it may result from the negotiations between a hospital and the individual insurance companies. It appears that many hospitals negotiate with insurance companies every three years, and the rates are in effect for that time period. Moreover, the hospital's ability to negotiate a higher reimbursement depends in part upon the market power of that hospital. Many of the proprietary and not-for-profit hospitals in Virginia belong to larger organizations, some of which operate in several other states and countries.

However, the overall market power of hospitals vis-à-vis the insurance companies depends in part upon the number of beds in that hospital's area. Hospitals appear to gain negotiating leverage if fewer beds are available, and can refuse to participate in one carrier's network if it fails to offer attractive rates. The carrier would then incur higher out-of-network costs. In other situations, including instances in which too many beds are available, a hospital may decide to accept a lower rate for one service in exchange for a higher rate for another service. This is because many negotiations between hospitals and insurance carriers appear to involve an overall package of rates, and the hospital focuses on the overall profit from all of the services it provides. Such negotiations may result in a psychiatric rate that is below cost.

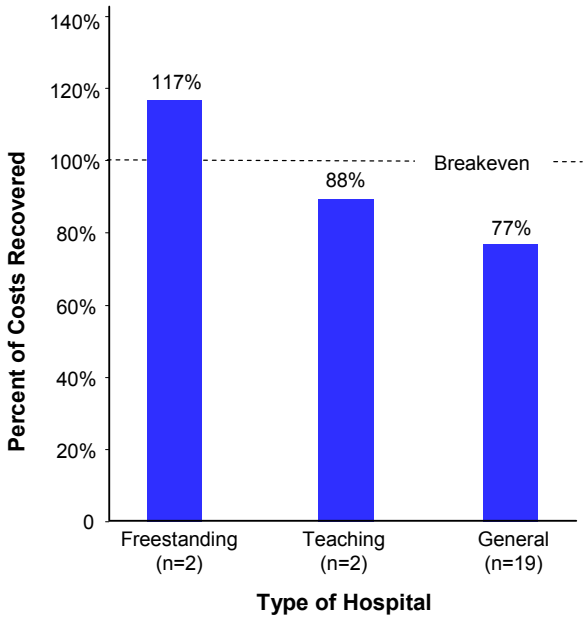
EXTENT OF UNREIMBURSED COSTS VARIES BY TYPE OF PSYCHIATRIC FACILITY

Reimbursements fell short of total costs for the majority of psychiatric facilities, while freestanding hospitals were fully reimbursed for all costs. One reason for the difference between these levels of reimbursed costs may be a result of higher than typical costs of providing psychiatric services.

Freestanding Hospitals Recovered Their Costs of Providing Inpatient Psychiatric Services in 2005

Overall, freestanding hospitals were able to recover their costs of providing psychiatric services in 2005 (Figure 13). The CRR for freestanding hospitals in 2005 was 117 percent, indicating that they were more than fully reimbursed for all of their costs. Although teaching hospitals received the highest amount of additional Medicaid payments (Medicaid plus DSH) compared to other hospitals, which helped offset their Medicaid losses and uncompensated care provided to uninsured psychiatric patients, they were still only reimbursed for 88 percent of their total costs. In contrast, freestanding hospitals did not receive DSH payments, but they were still able to fully recover their costs in 2005 as a result of being fully reimbursed by all payer sources, including uninsured patients. Appendix I includes a more detailed analysis of the percent of costs recovered by type of hospital and payer source.

Figure 13: Extent of Cost Recovery for Inpatient Psychiatric Services Varied by Type of Hospital in 2005



Source: Analysis of psychiatric facility financial survey data (2005).

Four Hospitals Accounted for Almost Half of the Unreimbursed Costs From Providing Inpatient Psychiatric Services

Among the non-outlier hospitals, a total of $29.1 million in unreimbursed costs from providing psychiatric services in 2005 was reported. Four of the 21 facilities accounted for 48 percent of this loss, and 32 percent of bed days. The unreimbursed costs resulted

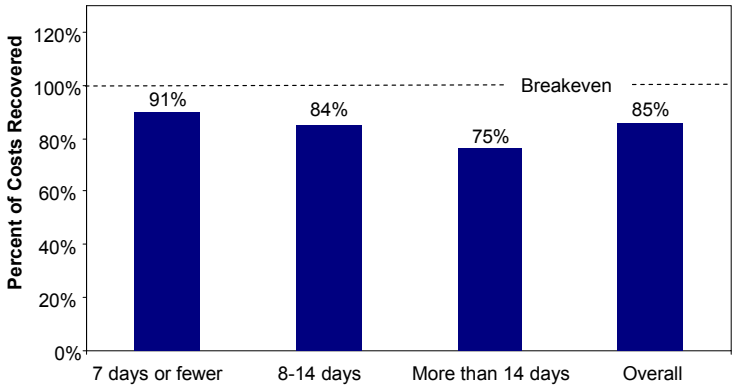
from the fact that these four hospitals were reimbursed for only 68 percent of their total costs. Hospitals with larger amounts of unreimbursed costs generally had the following characteristics:

- were located in urban areas,
- had more than 50 licensed inpatient psychiatric beds,
- had more uninsured patients, on average,
- received a small amount of additional Medicaid payments compared to teaching hospitals,
- had more adult psychiatric patients with at least one co-occurring medical condition,
- had more psychiatric patients with an extended length of stay (beyond 14 days).

NEARLY HALF OF UNREIMBURSED COSTS RESULTED FROM PSYCHIATRIC PATIENTS WHO STAYED BEYOND 14 DAYS

Only eight percent of the psychiatric patients reported on the JLARC staff survey had an extended length of stay (LOS), which JLARC staff defined as an LOS of more than 14 days. However, these patients accounted for nearly half of the unreimbursed costs in 2005 across all licensed hospitals. Facilities that had a higher number of patients with an extended LOS tended to have more than 50 licensed inpatient psychiatric beds and treated a higher percentage of adult patients. These facilities also tend to be located

Figure 14: Cost Recovery Ratio Was Lower for Patients With an Extended Length of Stay



Note: Excludes 33 admissions with a length of stay of 100 days or more, the majority of which were admitted at VCU, covered by Medicaid, and had a cost recovery ratio of more than 300%.

Source: Analysis of psychiatric facility financial survey data (2005).

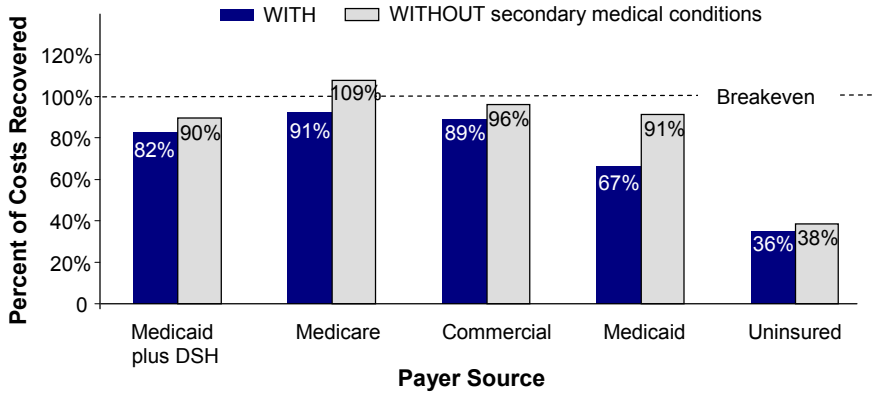
within general hospitals in urban localities. Although most psychiatric patients with an extended LOS were insured, only 75 percent of costs were reimbursed. Additionally, as shown in Figure 14 the CRR varied with length of stay.

REIMBURSEMENTS FELL SHORT OF TOTAL COSTS OF TREATING SECONDARY MEDICAL CONDITIONS

Psychiatric facility administrators also expressed concern regarding the lack of reimbursement for the additional costs incurred treating psychiatric patients with secondary medical conditions. For example, a psychiatric patient might have both a mental health disorder and diabetes. Psychiatric facilities reported they incur additional costs because these patients often require medical consultations and treatment throughout their hospital stay.

Hospitals were reimbursed proportionately less for their costs of patients with a secondary medical condition. Psychiatric patients with a secondary medical condition accounted for about 60 percent of all psychiatric patients in 2005, but also accounted for 82 percent ($20.5 million) of the total amount of unreimbursed cost. The proportion of reimbursements for these patients varied between payers. If examined by payer source, hospitals received a lower proportion of reimbursements from almost all payers for psychiatric patients with a secondary medical condition (Figure 15).

Figure 15: All Major Payers Reimbursed Hospitals a Lower Proportion of Costs for Patients With Secondary Medical Conditions



Source: Analysis of psychiatric facility financial survey data (2005).

NEARLY ALL EMERGENCY DEPARTMENTS WITHIN LICENSED HOSPITALS ALSO REPORTED UNREIMBURSED COSTS

In addition to unreimbursed costs within inpatient acute care psychiatric units, most emergency departments (EDs) within the licensed hospitals surveyed by JLARC staff reported unreimbursed costs for psychiatric services. Hospital EDs provide psychiatric services to patients regardless of whether they are admitted to one of the hospital's inpatient psychiatric beds. The federal Emergency Medical Treatment and Labor Act (EMTALA) requires EDs to stabilize all persons with an emergency medical or psychiatric condition regardless of whether or not they have insurance. Based on the results of the 22 surveys submitted by these EDs, emergency departments in licensed hospitals reported $45 million in unreimbursed costs in 2005 as a result of providing psychiatric services.

DMAS staff raised concerns regarding the low level of reimbursement by Medicaid and other payers indicated by the analysis of hospital survey data. DMAS staff stated that a potential explanation may be that the emergency departments did not report all reimbursements received, particularly for persons subsequently admitted to an inpatient bed. In these cases, the psychiatric unit, not the emergency department, would be reimbursed for the costs incurred. However, the Virginia Hospital and Healthcare Association (VHHA) conferred with the major hospital organizations and submitted a letter to JLARC staff indicating that the data received from the emergency departments are reliable and reflect an accurate picture of the financial losses incurred (Appendix K). Although there is disagreement between DMAS and VHHA, on the basis of the Association's confirmation that the data are reliable and accurate, the emergency department analysis is included in this report.

Uninsured Psychiatric Patients and Under-Reimbursement From Commercial Insurers Contribute to Uncovered Costs of EDs

The two primary sources of unreimbursed costs reported by the EDs within licensed hospitals resulted from treating uninsured psychiatric patients and under-reimbursement from commercial insurers (Table 13). According to the JLARC staff survey, 30 percent of psychiatric patients seen in the ED were uninsured, which accounted for 36 percent of total unreimbursed costs experienced by emergency departments. Another 28 percent of psychiatric patients seen in the ED had commercial insurance. Under-reimbursement from commercial insurers accounted for 35 percent of total unreimbursed costs.

Table 13: Treating Uninsured Psychiatric Patients Led to Largest Amount of Unreimbursed Costs for Emergency Departments

Payer Type	Percent of Psychiatric Patients	Percent of Unreimbursed Costs
Uninsured	30%	36%
Commercial	28	35
Medicare	20	8
Medicaid FFS	4	4
Medicaid HMO	6	4
Medicaid plus DSH	6	2
Other[a]	6	11
TOTAL	**100%**	**100%**

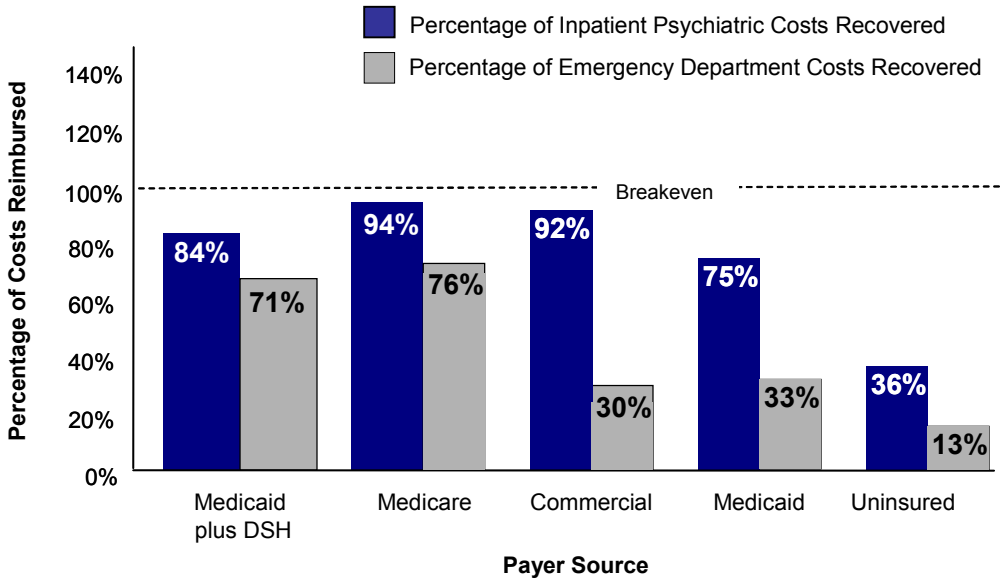
Note: FFS, fee for service; HMO, health maintenance organization; DSH, disproportionate share hospital.

[a] Includes payer sources with less than 10 percent of psychiatric patients: Community services board per diem, CHAMPUS/Military, Medicaid HMO, temporary detention order, worker's compensation, and other (as specified by the hospital).

Source: Analysis of emergency departments' financial data (2005).

Figure 16 shows the CRR by primary payer source for both the inpatient costs reported above and for ED costs. It indicates that the CRR for uninsured patients seen in the ED was only 13 percent of the cost, and the CRR for patients with commercial insurance was 30 percent.

Figure 16: Emergency Departments Were Only Reimbursed for 13 Percent of the Costs of Uninsured Psychiatric Patients



Source: Analysis of psychiatric facilities and emergency departments' financial data (2005).

CHANGES IN THE PROVISION OF HEALTH CARE MAY RESULT IN FURTHER BED REDUCTIONS

Changes in the provision of health care appear to have affected the financial reimbursements received by licensed hospitals over time, and may affect their ability or willingness to provide psychiatric services in the future. Given the State's interest in assuring an adequate supply of psychiatric beds, it should examine its potential role. This role could involve increasing financial support for uninsured psychiatric patients, or by changing the way in which Medicaid rates are set, as discussed in the next chapter.

General Hospitals Responded to Earlier Financial Incentives by Increasing the Supply of Inpatient Psychiatric Beds

Most of the unreimbursed costs reported on the JLARC staff survey were from general hospitals, but over time both general and freestanding hospitals have expressed concerns about the sufficiency of reimbursements.

In 1950, at an annual meeting of the American Psychiatric Association, the medical director of one freestanding hospital stated that

> the time when you could run a private [freestanding] hospital as a hospital and make money has gone, I am afraid forever. . . . Operating expenses have so increased that it is almost impossible to collect the cost from our patients.

General hospitals reported financial concerns as well. According to a 1959 article in the *American Journal of Psychiatry*, "Problems Establishing and Maintaining Psychiatric Units in General Hospitals," there were two main hardships facing inpatient psychiatric care: a lack of insurance coverage for mental health, and problems obtaining malpractice insurance. Those concerns are reported to still be present today. However, a salient difference between 1959 and today is that licensed hospitals are now serving a large proportion of all public mental health clients, as a result of deinstitutionalization. This increased role in the public mental health system may indicate a need for greater State attention to the financial situation facing psychiatric facilities.

More recently, general hospitals viewed their acute care psychiatric units as lucrative sources of revenue and welcomed public sector patients. As described in the journal *New Directions for Mental Health Services*:

> the growth in psychiatric admissions helped insulate hospitals from declining admissions in general medicine and sur-

> gery and from lower occupancy rates. Medicare and third-party insurance were lucrative sources of reimbursement. . .

In response to these financial incentives the number of general hospital psychiatric beds increased in the 1980s. However, growing expenditures led to the introduction of managed care companies, and as these companies consolidated and began to manage more insurance policies they developed significant purchasing power. This in turn led to reductions in hospital per diem rates and in the number of covered days of care. Additionally, Medicare changed its reimbursement system, leading to reductions in reimbursement rates. Subsequently, in the late 1990s general hospitals began to question whether inpatient psychiatric services were part of their core mission. According to a 2007 article in the *American Journal of Psychiatry*, financial consultants often recommend that a hospital reduce its costs by closing the inpatient psychiatric unit.

To recover losses from managed care, psychiatric units have begun to serve even more public sector patients, causing their payer mix to swing toward much greater Medicaid reimbursement. This trend is projected to continue, and the National Association of Psychiatric Health Systems (NAPHS) projects that the percentage of psychiatric unit revenues accounted for by Medicaid will increase to 70 percent by 2017. (These are national figures; the percentage for Virginia is not known.) According to NAPHS, these changing forces mean that "inpatient units are caught between what they perceive as patients' needs and changes in financing that affect unit survival."

The marketplace has been changing as well, and physicians have cut their traditional ties with hospitals in order to provide more profitable outpatient services. Unlike surgeons, who need the hospital's operating room, psychiatrists typically do not need hospital facilities. Hospitals thus face not only a financial disincentive but a competitive disadvantage if they retain inpatient psychiatric services when the market rewards outpatient services.

Licensed Hospitals May Choose to Convert Inpatient Psychiatric Beds to Other Uses or Stop Staffing Beds to Reduce Losses

If licensed hospitals feel they are not recovering a sufficient percentage of costs then they may respond by reducing the number of inpatient psychiatric beds. The decision to close psychiatric beds, as it has been described to JLARC staff, depends upon whether the losses resulting from remaining in operation exceed the losses resulting from closing a bed. If a hospital closes beds, it may still incur overhead costs. The extent of overhead costs incurred depends upon whether the hospital decides to convert the bed to another use (such as surgical) or stop staffing the bed altogether.

VDH staff note that a hospital can convert a psychiatric bed to a surgical bed without State approval, but that it cannot convert a surgical bed to a psychiatric bed unless it goes through the COPN process. This results from VDH regulations and effectively means (according to VDH staff) that a hospital can use psychiatric beds as a "bank" from which withdrawals can be made whenever another type of bed would be more profitable. The decision to stop staffing a bed may also be a way to reduce costs without eliminating the bed altogether because it would allow the hospital to indicate that the bed is not available, which could lower overall losses. It should be noted, however, that some or all of the unstaffed psychiatric beds may result from an actual lack of qualified staff and not from a decision to stop using the bed.

Because State hospitals and licensed hospitals are interdependent, a reduction in the use of one type of hospital must be offset by an increase in services provided by another. Alternatively, other community-based services may decrease the need for either type of hospital, but these services have never been widely available across the State and CSBs report long waiting lists for the services they provide. In order to ensure an adequate supply of psychiatric beds, the State may need to assess whether licensed hospitals are recovering the costs of providing inpatient psychiatric services to a sufficient degree. Part of this assessment would need to take into consideration what amount of charity care services should be required of hospitals, and this should be balanced with a commitment to providing sufficient funding for indigent care programs, including SLH and the IHCTF.

Chapter 5

Changes to the Medicaid Rate-Setting Process for Psychiatric Services May Be Warranted

In Summary

The Medicaid rates for inpatient psychiatric and psychiatric services are set by the Department of Medical Assistance Services (DMAS), and the temporary detention order (TDO) rate is set at the inpatient Medicaid rate. However, a policy of lowering the calculated rate by a specified percentage is identified by hospitals as a reason for unreimbursed Medicaid costs, and creation of a tiered rate structure may better reflect the costs incurred by individual patients. The rate-setting process for inpatient psychiatric services generally appears to be reasonable. However, DMAS has set the TDO reimbursement rate without adopting statutorily-required regulations. The rates for psychiatrists have decreased by 16 to 24 percent since 2000 when accounting for inflation, and are lower than the rates paid by other payer sources, including Medicare. Using an inflation adjustment or regional differential in rates may help address the shortage of psychiatrists who are willing to treat Medicaid recipients.

The previous chapter indicated that for most licensed hospitals, Medicaid fee for service (FFS) rates cover 75 percent of the costs licensed hospitals incur when treating psychiatric patients. Licensed hospital staff have expressed several concerns about Medicaid rates, and inadequate rates may lead to additional bed closures at a time when a growing and aging population increases the demand for beds. Psychiatrists have also stated that Medicaid rates have remained flat or declined. These concerns were noted in the study mandate, which directed JLARC to "evaluate the Medicaid rate-setting process for psychiatric services, services provided under temporary detention orders, and services provided by psychiatrists." The rate-setting processes discussed in this chapter pertain only to Medicaid fee-for-service rates. The rates paid by Medicaid health maintenance organization (HMO) carriers to providers are set by the HMOs themselves.

MEDICAID REIMBURSES HOSPITALS AND PSYCHIATRISTS FOR PSYCHIATRIC SERVICES

Although the eligibility requirements for Virginia's Medicaid program are among the strictest in the nation, Medicaid is an important source of revenue for licensed hospitals in the Commonwealth. The JLARC staff survey of psychiatric facilities indicated that Medicaid was the primary payer for 16 percent of psychiatric patients in 2005, and accounted for 20 percent of overall hospital revenues from psychiatric services.

Presently, there are four types of major medical services that are administered by DMAS under the general category of inpatient care: inpatient acute care services, rehabilitation hospital services, long-stay inpatient hospital care, and inpatient psychiatric hospital services. This chapter discusses the inpatient psychiatric services.

The rates for Medicaid services are established by DMAS within guidelines created by the federal Centers for Medicare and Medicaid Services (CMS). The rate-setting process used by DMAS has been adopted by the Board of Medical Assistance Services as regulations in the *Virginia Administrative Code* (VAC). Medicaid rates for inpatient care were last evaluated by JLARC in 2000, when reimbursements for inpatient hospital services were reviewed. That study questioned one aspect of DMAS's rate-setting process, which is addressed below.

MEDICAID RATE-SETTING PROCESS FOR HOSPITAL-BASED PSYCHIATRIC SERVICES IS REASONABLE, BUT A MORE REFINED PROCESS MAY BE BENEFICIAL

The current Medicaid rate-setting process appears to be reasonably designed to reimburse licensed hospitals for the cost of services they provide. The rates are recalculated (or "rebased") within a reasonable timeframe, and are based upon reasonably current costs. If hospital costs have increased since the last rebasing period because the cost of mental or medical health care has increased, then the newly rebased rates reflect this increase. As part of the rebasing process, adjustments are made for inflation and for regional variation in labor costs. Both operating and capital costs are included in the rates.

A more contentious issue concerns the use of a "rate adjustment factor" (RAF) which serves to artificially decrease the calculated rates. The use of this factor was questioned by JLARC staff in 2000 but since then its use has become more established, and it is no longer set by DMAS through a formula. Instead, the RAF is determined by the General Assembly, and the 2007 Appropriation Act included an adjustment to the RAF which increased the payments received for providing inpatient psychiatric services.

Many of the Medicaid concerns noted by licensed hospital staff involved the eligibility standards for Medicaid. This issue is outside the scope of the study, but it is a part of a larger policy question about responsibility for the uninsured.

Certain Psychiatric Services Are Reimbursed by Medicaid

Licensed hospitals provide a variety of psychiatric services which are reimbursed by Medicaid. These services are typically provided by licensed staff in the acute care units of general hospitals and in freestanding psychiatric hospitals. The acute care services provided by hospitals fall into several general categories, including room and board, medical services, psychiatric and psychological services, discharge planning, family assistance and education, occupational therapy, and social work services.

DMAS does not automatically pay for the services provided to a Medicaid recipient. The department requires that services be provided in the least restrictive treatment environment, and that inpatient hospitalization should only be used when no other option is available. In order to receive reimbursement, hospitals must obtain prior authorization for admission from DMAS, and because of federal Medicaid requirements, the hospitals must demonstrate to DMAS that the services they provided were medically necessary (42 CFR 441.154; 42 CFR 456.50-101; and 42 CFR 456.150-181).

DMAS uses "severity of illness" criteria to establish medical necessity, which include the presence of ongoing hallucinations, assaultive behavior, or attempts at suicide. Moreover, not all psychiatric illnesses justify inpatient hospitalization, including eating disorders or Alzheimer's disease, unless the severity of illness criteria are also met. Lastly, DMAS will not pay for certain services and will discontinue payment unless the individual can be shown to need "active treatment" to address one of the severity of illness criteria. All payments, however, cease after 21 days. These criteria are set forth in the agency's psychiatric services provider manual.

The rate-setting process used by DMAS differs for each type of psychiatric facility, as do the criteria that must be met in order to qualify for Medicaid reimbursement. A more important distinction, however, is that the rate-setting process for psychiatric services differs from that of most medical services as a result of historical changes made to the Medicaid program.

Previous Changes to the Medicaid Rate-Setting Process Have Shaped the Way Today's Rates Are Calculated

Since Medicaid was adopted in Virginia, the State has used three different reimbursement systems for inpatient hospital services. The first system reimbursed hospitals after services were provided (retrospectively) for 100 percent of allowable costs. In order to contain Medicaid expenditures, the State switched to a prospective payment system in 1983. Under this system, payments were made based on rates which were set before services were provided. The

"per diem" rates used under this system were intended to reimburse hospitals for the costs they incurred on a daily basis.

Licensed hospitals expressed dissatisfaction with the State's payment rates, and the Virginia Hospital and Healthcare Association (VHHA) sued Virginia in 1986 (*VHHA v. Baliles*, 830 F.2d 1308). In this suit, VHHA alleged that Virginia's Medicaid plan violated the federal Medicaid Act because

> the reimbursement rates for health care providers were not reasonable and adequate to meet the economically and efficiently incurred costs of providing care to Medicaid patients in hospitals, and did not assure access to inpatient care.

In a 1990 decision, the U.S. Supreme Court decided that the Medicaid Act created a right, which was enforceable by hospitals, to have the State adopt reasonable and adequate rates (*VHHA vs. Wilder*, 496 US 498). The suit was settled in 1991, and an additional agreement was reached in 1996 between DMAS and VHHA.

As a result of the 1996 agreement, DMAS began to implement a new prospective payment system that used per case rates rather than per diem rates. (The term "case" refers to a patient who is admitted to an inpatient bed.) The effect of the switch to per case rates is that a set payment is established for each case based on the expected costs of treatment. These payments use a system known as diagnosis-related groups (DRG), which classifies hospital cases according to the patient's diagnosis, age, sex, and the presence of any medical complications or co-occurring (secondary) medical conditions. DRG categories group patients with similar clinical problems who are expected to require similar amounts of hospital resources. For example, a patient who has a hip replacement would be in DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity).

Under a per case rate, hospitals are paid different amounts for each DRG rather than receiving a flat daily rate for each person. The change to a per case rate was made for all but six services, including psychiatric services, for which the per diem basis was retained. A per diem rate was retained for these services due to the difficulty of accurately setting a per case rate.

Current Medicaid Per Diem Rate-Setting Process in Virginia

All hospitals are required to maintain records of the costs they incur providing medical services, and these "cost report" records are submitted to DMAS each year as part of a "cost settlement" process. (These records are in addition to the claims forms submitted by the hospitals during the year to seek reimbursement for ser-

vices rendered.) To set rates, every three years DMAS conducts a "rebasing" process, primarily using annual cost report data.

Rate-Setting Process for General Hospitals. The process for establishing a per diem rate for psychiatric services begins by determining the average daily cost of treating a Medicaid patient, and ends with a specific rate for each general hospital. This process applies to "Type Two" hospitals, which are all general hospitals except the State-owned teaching hospitals. Exhibit 1 has a detailed description of this process, which has four primary steps:

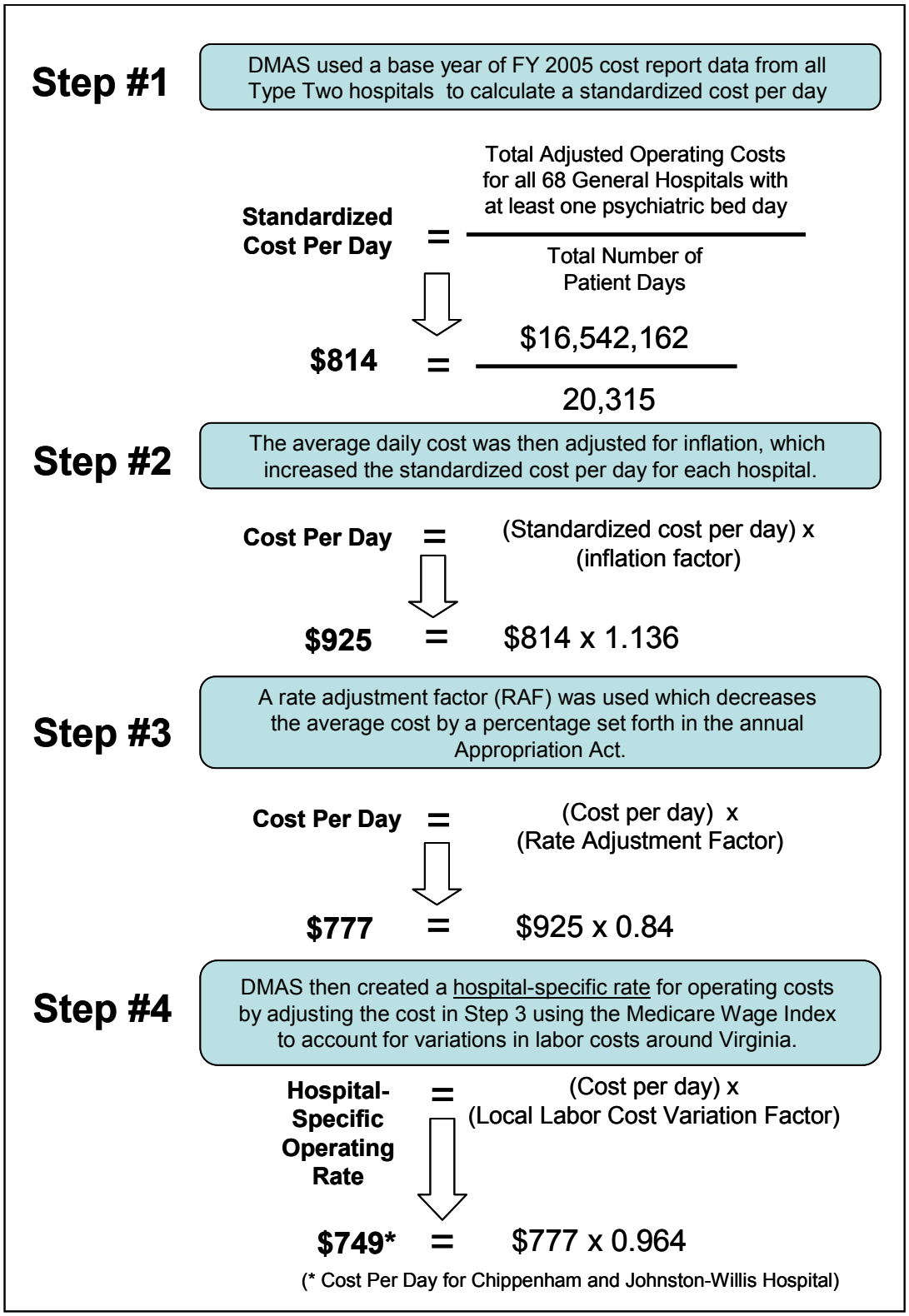
- A standardized cost per day is calculated by taking the total adjusted operating costs for all Type Two hospitals that have at least one psychiatric bed day and dividing it by the total number of patient days.
- This average daily cost is then adjusted for inflation.
- The inflation-adjusted cost is then adjusted downward using a "rate adjustment factor" which is based on a percentage reduction set forth in the Appropriation Act.
- A hospital-specific rate for operating costs is developed by adjusting the cost found in the previous step to account for variations in labor costs around Virginia.

The "rebased" rate is used for three years. For the latter two years, the rebased rate is adjusted for inflation and for any legislative changes, such as changes made to the RAF. Three years later the rates are rebased again. These final rate calculated for FY 2008 will be used in FYs 2009 and 2010. For the latter two years, the FY 2008 rate will be adjusted for inflation using the Hospital Price Index, and for any legislative changes made to the rate adjustment factor. Then, in FY 2011, the rates will be rebased again.

Rate-Setting Process for Capital Costs. DMAS pays general hospitals for their capital costs every time a claim is made for reimbursement. The amount of the payment is determined by the "capital percentage," an add-on amount which increases the per diem rate by a hospital-specific percentage. The amount of the capital percentage is listed on the DMAS website, along with the hospital-specific operating rates. These interim payments for capital costs are then "settled" during the annual cost settlement process, where any under- or over-payments are resolved.

The rate (which is the capital percentage) for capital costs is determined following the cost settlement process. The rate is calculated by dividing the total amount of a hospital's reimbursement for capital costs by the hospital's total operating reimbursement. The calculated amount then becomes the capital percentage for future payments.

Exhibit 1: Medicaid Rate-Setting Process for Per Diem Inpatient Psychiatric Services in Fiscal Year 2008



Source: JLARC staff.

This process was modified by the General Assembly in 2003, and capital payments to Type Two hospitals were reduced from 100 percent to 80 percent of allowable costs (2003 Appropriation Act, Item 325 OOO). As noted by DMAS in their regulatory review process, this reduction resulted in a savings of $2.6 million annually to the Commonwealth, but a loss of the same amount to the hospital community. However, no objections were received during the period allotted for public comment.

As part of the regulatory review process, the Department of Planning and Budget (DPB) evaluated the economic impact of the rate reductions. DPB noted that hospitals could choose to stop serving Medicaid recipients, raise the rates they charge to private payers, or scale back services. A hospital's decision to scale back or eliminate Medicaid-funded services depends on the hospital's profit margin, and their ability to raise the rates receives from commercial insurers. If a hospital cannot offset its revenue losses from other sources, DPB concluded, it could choose to stop participating in the Medicaid program.

Rate-Setting Process for Other Hospitals. The rate-setting process for the two State-owned teaching hospitals (also known as Type One hospitals) and the freestanding hospitals differs slightly from the process described above. For the State-owned teaching hospitals, the primary difference is that a different rate adjustment factor is used, as described in 12 VAC 30-70-341.

One difference between freestanding hospitals and other hospitals is that the capital costs for freestanding hospitals are included in the per diem rate. Additionally, since 2004 DMAS has excluded the freestanding hospitals from rebasing in order to prevent reductions in their rates. As a result, DMAS now calculates the rates for freestanding hospitals by adding an inflation adjustment to the rate existing in 2004. Prior to 2004, the rates for freestanding hospitals were calculated by determining a hospital-specific operating rate and then determining a standard capital cost per day. The capital cost was calculated by using base year data, subtracting 20 percent, and adjusting it for inflation to create a re-based standard capital cost per day. This cost was multiplied by a Medicare geographic adjustment factor to create a hospital-specific capital cost per day. Finally, the hospital-specific *total* rate per day was the sum of the operating and capital costs.

Hospitals Have Several Concerns Regarding Current Medicaid Rates

Staff of both general and freestanding hospitals have several concerns about Medicaid funding that are broader than the rate-setting process per se. These concerns reflect a combination of is-

sues involving the rate-setting process, federal policies regarding a hospital's eligibility to receive Medicaid payments, and the restrictiveness of the State's eligibility criteria for Medicaid. In combination, their concerns reflect a belief that Medicaid payments overall are not fair and appropriate. These are the same concerns that motivated VHHA's 1986 lawsuit against the State. In response to the language of the study mandate, the remainder of this section focuses on concerns identified with respect to the rate-setting process.

Three-Year Interval Between Rebasing Appears to be a Reasonable Way of Setting Rates. Prior to FY 2001, DMAS rebased rates every two years. Hospital staff assert that that an annual rebasing process would more accurately reflect their costs. However, many commercial insurers use a three-year cycle for renegotiating rates, and VHHA agreed with the change to a three-year rebasing policy. Therefore, the use of a three-year rebasing cycle, with updates for inflation in intervening years, appears to be reasonable.

Per Diem Rate Does Include a Payment for Capital Costs. Staff members at some licensed hospitals believed that Medicaid rates do not reimburse them for capital costs. Based upon information provided by DMAS, these concerns appear to reflect a misunderstanding of how per diem payments are made. As described above, DMAS does in fact pay psychiatric facilities for capital costs, but the process is different for general and freestanding hospitals.

Because the acute psychiatric unit at a general hospital is part of the larger hospital, DMAS calculates the payment for capital costs separately from the per diem psychiatric rate, and makes an "add-on" payment. General hospitals are informed of the amount of their hospital-specific add-on payment and their hospital-specific per diem rate in an annual letter provided by DMAS. If a hospital has a psychiatric unit, it may not receive these capital payments but the hospital has received a payment for capital costs that accounts for the psychiatric unit.

Use of Rate Adjustment Factor to Reduce Payments Is Still Contentious. As part of its review in 2000, JLARC staff assessed the adequacy of Medicaid rates for inpatient hospital care by addressing whether the use of a rate adjustment factor was justified. The use of rate adjustment factor is one of several changes made by DMAS in 1996 as part of its move to a prospective payment system. The 2000 JLARC report noted that the agreement between DMAS and VHHA anticipated that the factor would be used temporarily, to reduce the cost of shifting to the new payment system.

At the time, VHHA asserted that the adjustment factor had two negative consequences. First, it limited the ability of hospitals to

offset the losses they incurred from managed care, the uninsured, and declining Medicare reimbursements. Second, it failed to recognize trends in hospital costs: that hospitals had reduced the average length of stay of patients (thereby lowering costs), and had kept the overall growth in costs below inflation. DMAS responded that an adjustment factor was consistent with the 1996 agreement with VHHA, was pursuant to regulations, and also met the need to control costs by ensuring that hospitals operated efficiently. The JLARC report concluded that its continued use was "not supported by trends in hospital costs."

DMAS is still required to use the RAF, and the Appropriation Act adopted by the 2007 General Assembly provided an additional $4.9 million in order to change the adjustment factor for psychiatric services from 78 percent to 84 percent (Item 302, JJJ1).

Under Current Regulations, the Rates for Freestanding Psychiatric Hospitals Will Not Decrease. In 2007, DMAS was also directed in the Appropriation Act to amend its Medicaid regulations to *permanently* exclude the freestanding hospitals from the rebasing process (Item 302, JJJ2). Had the rates for these hospitals been rebased—using newer data that showed lower costs—then their per diem rates would have decreased. As noted in the Conference Report, the additional funding provided to exclude these four freestanding psychiatric hospitals from rebasing amounts to a rate increase, which "is designed to stem the loss of inpatient psychiatric beds and improve access to psychiatric services in local hospitals as opposed to state facilities."

However, it does not seem reasonable to permanently exclude a group of hospitals from any future decreases or increases in Medicaid rates. Although this action was designed to assure an adequate bed supply, it is not clear if this blanket action was necessary given the information contained in the financial filings prepared by the owners of two freestanding hospitals. Psychiatric Solutions Incorporated, in its 10-K filing for 2006 with the U.S. Securities and Exchange Commission, stated that the behavioral health industry has experienced "favorable industry fundamentals over the last several years." This was attributed in part to "significant improvement in reimbursement rates," with an observation that since the corporation receives Medicaid payments from more than 40 states, "we do not believe that we are significantly affected by changes in reimbursement policies in any one state."

Recommendation (4). The General Assembly may wish to direct the Board of Medical Assistance Services to amend the State Plan of Medical Assistance Services governing Medicaid reimbursements for

freestanding psychiatric hospitals licensed as hospitals to include the rates in the hospital rebasing process.

Use of a Weighted Per Diem Rate May Address Some of the Concerns Expressed by Hospitals

A common thread that runs through many of the concerns expressed by staff of licensed hospitals is that Medicaid's per diem psychiatric rates do not reflect the unique costs incurred in treating individual patients. Because the per diem payment provides a fixed reimbursement, and does not vary with the diagnosis, hospitals assert that this rate does not provide sufficient reimbursement for patients with non-psychiatric medical costs. This is reported to be exacerbated by the aging of the population, and the associated increase in medical costs.

In light of the challenges that an aging population may create for providers, it appears reasonable to ensure that Medicaid rates reflect the higher costs that are typically associated with increased age. Presently, the higher costs associated with treating secondary medical conditions are accounted for, but in an indirect way. Every three years, when rebasing occurs, if hospitals incur higher costs, they are reflected in the rate-setting process through the calculation of the standardized cost per day.

Weighted Per Diem Rate May Better Reflect Variation in Costs Among Patients. One solution that may allow Medicaid rates to better reflect the costs incurred in providing psychiatric services would be the adoption of some of the features Medicare now uses in its inpatient psychiatric rate. In 1999, the federal Balanced Budget Refinement Act required Medicare to develop a prospective payment system for inpatient psychiatric services. In November 2004, CMS published final rules in the Federal Register for this system. The final rules provide for a per diem prospective system. This is the same approach used by DMAS for psychiatric rates.

However, one difference between the Medicare system and the one used by DMAS is the use of weights to adjust the daily per diem reimbursement received for a given patient. One of these weights is based upon the number of days a patient has been hospitalized, and varies from a weight of 1.12 for the second day (a 12 percent increase in Medicare's per diem rate) to a weight of 0.92 for day 21. Medicare also adjusts the per diem rate based upon a patient's age, their diagnosis, and any secondary non-psychiatric medical conditions. The use of these weights is illustrated by two contrasting examples:

- Patient one is under 45 years of age, has a primary diagnosis of psychosis, and has no secondary conditions. This patient

receives a weight of 1.00 for each of these characteristics, and thus the hospital's per diem rate is not adjusted.

- Patient two is 80 years of age (weight of 1.17), has a primary diagnosis of personality disorder (weight of 1.02), and also has a cardiac condition (weight of 1.11). This person's per diem rate is adjusted upward to reflect the combination of these exacerbating characteristics.

Outlier Payments May Help Offset Cost of Extremely Costly Patients. Another solution that may be available is to adopt the "outlier" feature of the DRG-based per case rate that DMAS uses for most inpatient services. Because the DRG system reimburses licensed hospitals a set rate for a given illness, hospitals have a financial incentive to avoid patients with a very complicated illness (and seek out patients with a less costly illness). This is because a hospital will receive the same reimbursement for all cases of a given illness (for example, a hip replacement), although a hospital's cost for treating a given case within any DRG will vary among patients. Payers such as Medicare and Medicaid expect that hospitals will "offset losses on some cases (in which costs exceed the payment rate) with gains on others (in which costs are below payments)."

It is recognized, however, that some cases are too costly for cross-subsidization to provide adequate reimbursement. To address this, DMAS (like Medicare) makes additional payments called outlier payments. In the DRG system, DMAS defines outlier cases as situations where a hospital's losses on a case exceed a defined threshold. If psychiatric patients have extremely costly illnesses, then outlier payments may better structure the incentive system by covering some of this loss, and thereby removing some of the financial disincentive which currently may dissuade some hospitals from serving these costly patients.

The use of outlier payments or weights may promote the kind of reimbursement system that both hospital and CSB staff appear to desire, which is a tiered rate structure that provides higher or lower rates, depending on the services provided to the patient.

Recommendation (5). The General Assembly may wish to direct the Department of Medical Assistance Services to study and report back to the House Appropriations and Senate Finance Committees prior to the 2009 General Assembly Session on the advisability of adopting weighted per diem rates and outlier payments for inpatient acute care psychiatric services.

LICENSED HOSPITALS RAISED CONCERNS REGARDING PAYMENTS FROM INVOLUNTARY MENTAL COMMITMENT FUND

Licensed hospital staff expressed some concerns regarding the sufficiency of the rates paid from the Involuntary Mental Commitment Fund (IMCF) for services rendered during the temporary detention order (TDO) process. They state that the payment rates are too low and do not cover all of their costs. Concern has also been expressed that capital costs are not covered. Lastly, hospital staff are concerned that DMAS has inappropriately deemed some services provided during the TDO process as inappropriate for reimbursement.

Payments During the TDO Period Are Made From a State Fund Administered by DMAS

A licensed hospital may be reimbursed for the costs of medical and psychiatric care during the TDO process from the IMCF, a portion of which is administered by the DMAS. (A portion of the fund, pertaining to reimbursements for court costs, is administered by the Supreme Court of Virginia.) For the 2007-2008 biennium, the IMCF consists of approximately $21 million in State general funds (Item 300 of the 2007 Appropriation Act).

The IMCF is intended to act as a payment source of last resort for individuals detained under a TDO who are uninsured or not fully covered for the costs incurred. According to § 37.2-809 of the *Code of Virginia*, "the costs incurred . . . by the facility in providing services during the period of temporary detention shall be paid and recovered pursuant to § 37.2-804." The latter section, insofar as it pertains to licensed hospitals, states that "all expenses incurred... shall be paid by the Commonwealth."

The fund, which was created in the 1970s, was intended to facilitate deinstitutionalization by ensuring that licensed hospitals would not have to pay for unreimbursed costs incurred during a TDO. Licensed hospitals assert that not all of the costs they reasonably incur are reimbursed, although the purpose of the IMCF is to reimburse these costs. Licensed hospital staff assert that if they are to provide care for persons held under a TDO, a role they did not play prior to deinstitutionalization, then the State should not require them to incur unreimbursed costs.

Originally, the fund was administered by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and was transferred to the Supreme Court of Virginia in 1980. In response to a JLARC recommendation, responsibility for paying medical and hospital costs out of the IMCF was transferred to DMAS in 1995.

The payment rate hospitals receive from the IMCF are required by § 37.2-809 to be set by the Board of Medical Assistance Services:

> The maximum costs reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of Medical Assistance Services based on reasonable criteria. The State Board of Medical Assistance Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary detention.

Once DMAS assumed responsibility for the IMCF the Board followed the practice of the Supreme Court and set the TDO rate at the Medicaid rate for inpatient psychiatric services. In evaluating claims, DMAS uses the same procedures as it does for all Medicaid claims. Therefore, there are no substantive differences between the rate for psychiatric services and the rate for TDOs.

Licensed Hospitals Express Concern That Costs Incurred During Emergency Custody Are Not Reimbursed

Licensed hospitals express concerns that costs incurred during the emergency custody order (ECO) period are not consistently paid through the IMCF. As noted in Chapter 1, care provided by a hospital during the TDO period is reimbursable under § 37.2-809. However, the statute is silent regarding ECOs. This situation was clarified through the Appropriation Act in 2006:

> Payments may be made from the Involuntary Mental Commitment Fund to licensed health care providers for medical screening and assessment services provided to persons with mental illness while in emergency custody (2006 Acts of Assembly, Chapter 3, Item 300 B).

In response to this language, DMAS has reimbursed hospitals and emergency department physicians for assessment and evaluation services during the ECO. However, the General Assembly may wish to consider permanently clarifying this by amending the *Code of Virginia*.

Recommendation (6). The General Assembly may wish to amend § 37.2-809 (E) of the *Code of Virginia* to state, "The costs incurred as a result of the hearings and by the facility in providing services during the period of *emergency custody and* temporary detention shall be paid and recovered pursuant to § 37.2-804." This amendment would clarify that licensed hospitals may be paid for services rendered during an emergency custody order.

Concerns Pertain to DMAS Policies Regarding Reimbursement Rates and Criteria for Payment

Licensed hospital staff stated that the rates they receive for services during the TDO process do not reimburse them for all of the costs they incur. Hospital staff are also concerned about the reimbursement policies adopted by DMAS, which do not reimburse hospitals for all of the services they render during the TDO process. DMAS staff believe that the TDO rate methodology used is reasonable.

Rate for Services Rendered During the TDO Process Does Not Cover All Costs Incurred by Licensed Hospitals. Because the TDO rate is the same as the Medicaid rate for inpatient psychiatric services, the same concerns expressed by licensed hospital staff regarding the insufficiency of that rate apply to the TDO rate. When a detained individual is treated in an inpatient bed, the hospital receives the Medicaid inpatient psychiatric services per diem rate, regardless of the number and expense of the services provided by a hospital.

As a result, the current TDO rate only reimburses hospitals for 84 percent of the average cost, statewide, of treating a person during the TDO process. Moreover, because DMAS adjusts this rate for statewide variation in labor costs, some hospitals may not receive the same rate as other hospitals. DMAS staff assert that the rate is reasonable because the department uses the criteria used to establish the inpatient psychiatric services per diem rate.

Some Hospital Claims May Be Deemed Not Medically Necessary. Licensed hospital staff indicate that some medical care they provide as part of a medical screening is not reimbursed by DMAS, and that the rates for these services are insufficient. When a detained individual is treated in an emergency room bed, DMAS reimburses the hospital for the individual services at its emergency rate.

The primary concern expressed by licensed hospital staff is that DMAS will not reimburse hospitals for all of the services they provide during a TDO. This appears to result from the fact that DMAS will only pay for services that it deems are medically necessary. As stated in Appendix B of the department's Hospital Provider Manual:

> Medical screening provided through the emergency rooms are not covered unless there is documented evidence that there may be an underlying medical condition affecting the physical or mental health of the person.

According to DMAS staff, the agency will reimburse for "emergency medical evaluations or treatment" if emergency room staff

reasonably believe and can document that the patient has an apparent injury such as a fracture or laceration. Additionally, DMAS staff state that the department will reimburse hospitals if they reasonably believe that a patient has an underlying medical condition that needs to be evaluated (such as diabetes, drug interaction or reaction, heart issues) to determine if it may be associated with the apparently psychotic behavior. This kind of activity has been described as a "medical screening" in a guidance document published in March 2007 by DMHMRSAS, VHHA, the Virginia Association of Community Services Boards, and the Virginia College of Emergency Physicians.

However, the manual as presently drafted states that DMAS will not reimburse for costs incurred as part of a medical screening. DMAS staff state they the department will in fact reimburse for services provided as part of a medical screening (if the medical necessity is documented and reasonable), and that the restriction on reimbursement for a "medical screening" is intended to restrict services provided as part of the "medical clearance" process. A medical clearance may be required in situations in which a licensed hospital is trying to transfer a person to another hospital. If DMAS decides that these tests are not medically necessary in order to *treat* the patient, then they will not be paid even if they are required to *transfer* the patient.

These situations could arise because all hospitals can choose which patients to accept by transfer. Many hospitals reportedly will not indicate whether a bed is available until the patient is medically cleared and the hospital is thoroughly informed of a patient's medical condition. This situation also occurs with State hospitals. According to DMHMRSAS, State hospitals have limited medical capacity and they may require a clearance to determine if the hospital can handle that individual's medical care. DMAS staff also state that the agency will not pay for medical tests in instances in which the inpatient side of a hospital requires that all persons brought to the hospital under a TDO first be screened in the emergency room, if such screening is not determined to be medically necessary.

Payments May Be Limited Because of Medicaid Procedures. A further reason some services may not be reimbursed is because DMAS evaluates reimbursement claims for medical screening by using the Medicaid reimbursement criteria described in its *Hospital Provider Manual*. Therefore, if Medicaid does not reimburse for certain procedures, then DMAS will not authorize a payment from the IMCF for those procedures. DMAS staff state that the Department adopted this rule when the Fund was transferred to DMAS in order to conform TDO claims processing with Medicaid claims processing.

Recommendation (7). The Department of Medical Assistance Services should revise the language in Appendix B of its *Hospital Provider Manual*, which pertains to temporary detention orders, to clarify whether the department will reimburse providers from the Involuntary Mental Commitment Fund for services provided as part of a medical screening, and to provide a definition of a medical screening. In developing this definition, the Department of Medical Assistance Services should consult with the Department of Mental Health, Mental Retardation and Substance Abuse Services.

DMAS Should Adopt the Statutorily-Required Regulations Concerning the TDO Rate

When the IMCF was transferred to DMAS in 1995, the statutory language included a requirement that the "State Board of Medical Assistance Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary detention" (§ 37.2-809). DMAS has not adopted a specific regulation for TDO rates.

Given the concerns expressed by licensed hospital staff regarding the sufficiency of the rate and the criteria used to determine payment eligibility, the Board of Medical Assistance Services should set the rate and establish reimbursement criteria through regulation. Using the regulatory process would provide the opportunity for interested stakeholders and the general public to give input and would help to legitimize the IMCF reimbursement process. Moreover, adopting the regulations would be responsive to the legislative directive.

Recommendation (8). The Board of Medical Assistance Services should adopt regulations to establish a reasonable rate per day for payments from the Involuntary Mental Commitment Fund for services rendered during temporary detention orders, as required by § 37.2-809 of the *Code of Virginia*, and use the regulatory process to establish reasonable reimbursement criteria.

MEDICAID RATES FOR PROFESSIONAL PSYCHIATRIC SERVICES ARE LOW COMPARED TO OTHER BENCHMARKS

Licensed hospitals and other providers face a shortage of psychiatrists, especially those willing to work "on call," and as a result, fewer psychiatric beds are available. This has been attributed to the fact that Medicaid reimbursements have not kept pace with inflation because DMAS does not adjust these reimbursements for inflation.

Shortage of Psychiatrists In Hospitals Results From Low Reimbursements and Other Concerns

Psychiatrists are one of the direct care providers who render services to patients in licensed hospitals. Services are also provided on an outpatient basis by psychiatrists who have chosen to work outside of a hospital setting. It has been reported to JLARC staff that many psychiatrists, particularly younger doctors, are choosing to work in outpatient settings in order to avoid some of the shortcomings of hospital-based employment. These shortcomings include the need to be "on call" and the inability to decide which patients to treat. By working in an outpatient setting, and by not being on call, a psychiatrist can have a predictable working schedule and reportedly reduce his or her risk of a malpractice lawsuit.

Moreover, by working in an outpatient setting the number of Medicaid and uninsured patients a physician will see can be decided by choice rather than by who is admitted to the hospital. According to psychiatrists interviewed by JLARC staff, having to treat a substantial number of Medicaid recipients and uninsured patients can jeopardize the financial viability of a psychiatry practice.

Medicaid Rates for Professional Psychiatric Services Have Generally Remained Flat Over the Last Six Years

A possible explanation for the shortage of psychiatrists who do not treat Medicaid recipients is the fact that Medicaid rates are lower than the rates paid by other payer sources, including Medicare.

The procedures performed by physicians, including psychiatrists, have been assigned codes by the American Medical Association known as Current Procedural Terminology (CPT) codes. For example, code 90801 is assigned to a psychological evaluation, which includes taking a patient's medical history, evaluating their mental status, and communication with family members. A specific rate is created for each code by Medicaid and other insurers. In FY 2006, DMAS calculated individual rates for 40 different psychiatric CPT codes.

Table 14 provides information on the five procedures most frequently performed by psychiatric services providers, based upon the number of Medicaid claims received by DMAS in FY 2006. As indicated in the table, these nominal Medicaid rates (unadjusted for inflation) have generally remained flat or decreased between FYs 2000 and 2006.

Table 14: Medicaid Rates for Common Psychiatric Services Have Generally Remained Flat Over the Past Six Years

CPT Code	Description of Procedure	Total Payments in 2006	Number of Claims in 2006	2006 Rate	2000 Rate
90862	Medication management	$1,474,826	43,228	$35	$36
90801	Diagnostic Interview	669,630	6,686	103	99
90817	Psychotherapy in an inpatient setting for 20 to 30 minutes, with medical evaluation and management	172,989	3,565	48	51
90816	Psychotherapy in an inpatient setting for 20 to 30 minutes	123,951	3,107	44	46
90853	Group Psychotherapy	46,692	2,305	22	24

Source: Analysis of Medicaid fee for service claims data provided by the Department of Medical Assistance Services.

Medicare Rates for Psychiatric Services Are Higher Than Medicaid Rates

Medicare uses two sets of rates for Virginia: one for Northern Virginia and one for the rest of the State. When setting rates for physician services, Medicare defines Northern Virginia to be the Counties of Arlington and Fairfax and the Cities of Alexandria, Fairfax, and Falls Church.

Using the five Medicaid rates described in Table 14, JLARC staff compared the rates set by Medicare for Virginia and Northern Virginia to those set by DMAS for the years 2000 to 2006. As seen in Table 15, the Medicare rates in 2006 consistently exceed the Medicaid rates in that year. For the period 2000 to 2006, the weighted average DMAS rate was typically 73 percent of the weighted average Medicare rate for Virginia, and 65 percent of the weighted average Medicare rate for Northern Virginia. (The number of Medicaid claims in 2006 was used as the weight.)

Table 15: Medicare Rates for Psychiatric Services Are Higher Than Medicaid Rates

CPT Code	Description of Procedure	2006 Medicare Rate[a]	2006 Medicaid Rate	DMAS Rate as Percentage of Medicare Rate
90862	Medication management	$49	$35	71%
90801	Diagnostic Interview	145	103	71
90817	Psychotherapy, in an inpatient setting, for 20 to 30 minutes, with medical evaluation and management	70	48	69
90816	Psychotherapy, in an inpatient setting, for 20 to 30 minutes	64	44	69
90853	Group Psychotherapy	31	22	71

[a] Medicare rates are the Virginia rates (excluding Northern Virginia). To calculate the Medicare rates, JLARC staff used the average of the Facility and Non-Facility rates, with no modifier. DMAS does not calculate Facility and Non-Facility rates.

Source: Analysis of Medicaid fee for service claims data provided by the Department of Medical Assistance Services.

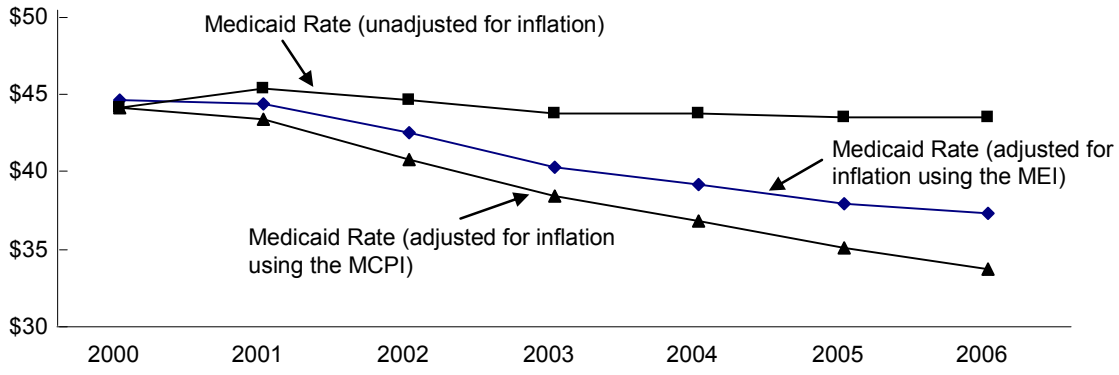
The rates for psychiatric services paid by the State employee mental health care provider are higher than Medicaid rates. Although these rates have not changed over the past several years, they have exceeded Medicaid's rates for psychiatric services. According to the provider, its rates for psychiatric services performed by psychiatrists are 33 percent higher on average than Medicaid rates paid by DMAS in FY 2006.

In 2007, the General Assembly directed DMAS to increase physician rates, and most physicians (including psychiatrists and emergency department physicians) received a five percent rate increase effective July 1, 2007 (2007 Acts of Assembly, Chapter 847, Item 302 KK). As a result of this increase, DMAS staff state that the agency now pays psychiatrists about 80 percent of what Medicare would pay for the same claims.

Medicaid Rates Have Not Kept Pace With Inflation

Overall, inflation-adjusted Medicaid rates for psychiatric services declined between 2000 and 2006. Figure 17 shows the weighted average inflation-adjusted Medicaid rates for the five procedures listed in Table 14. Two types of inflation adjustment are shown. The first, using the annual medical care component of the Consumer Price Index (MCPI), indicates that rates declined by about 24 percent. The second inflation adjustment, using the Medicare Economic Index (MEI), indicates rates decreased by about 16 percent. According to DMAS staff, the department does not adjust any physician payments for inflation, including payments for physician psychiatric services, because DMAS has not been given that authority by the General Assembly.

Figure 17: Medicaid Rates Have Not Kept Pace With Inflation



Note: MCPI, Medical care component of the Consumer Price Index for All Urban Consumers; MEI, Medicare Economic Index. Rates are the weighted average of the five procedures most frequently performed by psychiatrists based upon Medicaid claims data.

Source: Analysis of Medicaid fee for service claims data provided by the Department of Medical Assistance Services.

Recommendation (9). The General Assembly may wish to direct the Department of Medical Assistance Services to amend the State Plan of Medical Assistance Services to include inflation adjustments for the rates for professional psychiatric services.

MODIFICATION TO EXISTING RATE-SETTING PROCESS MAY BE NEEDED TO IMPLEMENT INFLATION ADJUSTMENTS

If the General Assembly wished to adjust the psychiatric services rates for inflation, it could do so through one of three ways. First, the rates for all medical procedures could be adjusted for inflation. This approach would be the most costly. Second, it may be possible to make a one-time inflation adjustment, by targeting the specific procedures used for psychiatric services. However, unless this was done annually, these rates would decline for reasons discussed below. Lastly, a modification to the existing rate-setting process for professional services could be created. This step was taken in 2005 to implement targeted rate increases for certain services.

The study mandate directs JLARC to "evaluate the Medicaid rate-setting process for . . . services provided by psychiatrists." Presently, no specific rate-setting process for psychiatrists exists. Instead, DMAS adjusts the rates for the procedures performed by psychiatrists as part of the overall rate-setting process for physicians and other professionals. As discussed below, the only way to target psychiatrists for a permanent rate increase or inflation adjustment is to modify the existing rate-setting process. This modification would affect the rate for the procedures within the group of *psychiatric services*, not the rates received by *psychiatrists*, because many other types of providers, including psychologists, mental health counselors, nurses, and social workers, also provide psychiatric services.

DMAS Rate-Setting Process Is Based in Part on Medicare Rates

As discussed above, DMAS calculates an individual rate for 40 different procedures within the group of psychiatric services. DMAS adjusts these rates by conducting an annual rate-setting process, which is based in part upon the Medicare "fee schedule." Medicare develops the rates (or "fees") for procedures covered by Medicare by using a system known as the Resource Based Relative Value Scale (RBRVS). The physician fee schedule derived from the RBRVS is intended to reflect the "relative value" of each procedure, and is based on the resources consumed in performing the procedure. The RBRVS has three major components that are designed to quantify the resources involved in providing healthcare services:

- professional work, which measures the time and intensity of effort expended in providing the service;
- practice expense, which measures the costs involved, such as salaries and overhead expenses; and
- malpractice expense, which separately measures the cost of professional liability insurance.

The Medicare RBRVS system is adjusted annually. As part of these annual updates, the "value" of a given procedure will change relative to all other procedures, depending upon the relative amount of resources it uses. To illustrate the effect this may have upon rates for psychiatric services, if the resources expended by a psychiatrist in counseling a patient are relatively less than those expended by a surgeon who uses robotic equipment to operate on a patient, then the rate calculated for psychiatric counseling will be relatively less than the rate for robotic surgery. If robotic surgery uses an increasing amount of resources over time, relative to those used in performing psychiatric counseling, then the rate for robotic surgery will increase over time relative to the rate for psychiatric counseling. As a result, in a given year the rate calculated for a given procedure may increase, stay the same, or decrease—depending upon the amount of resources it uses compared to other medical procedures.

Annual Updates Must Be Budget Neutral

DMAS uses Medicare's annual updates, but the agency's regulations have required that the updates be budget neutral. As a result of this overall "budget ceiling," the total expenditure cannot change from year-to-year solely because of changes in the Medicare updates. This has the effect of meaning that an increase in one rate must be offset by a decrease in another rate. Returning to the previous example, if the rate for surgery increased then the rate for counseling would decrease. (However, if the number of procedures performed increases, the amount of the expenditure will increase.) DMAS complies with budget neutrality in part by not adopting the inflation adjustments implemented in Medicare's annual updates.

To Preserve a Rate Increase, the Rate-Setting Process Must Be Modified

This rate-setting process was modified in 2005, after the Appropriation Act (Item 326) gave one-time Medicaid fee increases to four physician services (and the associated procedures) in FY 2006:

- obstetrical and gynecological services (36.5 percent increase, inclusive of the 34 percent increase resulting from emergency regulations implemented in FY 2005);
- preventive and primary care services (5 percent);
- pediatric services (5 percent); and
- emergency services delivered by physicians in hospital emergency rooms (3 percent).

In order to ensure that these rate increases were not offset in later years by changes in Medicare's annual updates, and to ensure budget neutrality, the agency has created a separate budget ceiling for each of the four services. In effect, the agency created silos for these four services within the overall professional services rate-setting process. If this was not done, these one-time rate increases could be eroded by increases to other rates resulting from the Medicare annual updates.

For example, the average rate for all procedures within the group of pediatric services increased by five percent in FY 2006. Without the silo, in subsequent years these pediatric rates could decrease if the rates for other procedures (such as surgery) increased. This results from the effect of the annual Medicare updates. However, because DMAS created a silo for pediatric services, the rates for pediatric procedures will not be affected by changes in the rates for non-pediatric procedures. This preserves the increase directed by the Appropriation Act. Instead, the individual rates for each pediatric procedure will now change within the silo, and an increase in the rate for one pediatric procedure will be offset by a decrease in the rate for another pediatric procedure. Overall, however, the average rate across all pediatric services will still reflect the five percent rate increase.

Although the use of a silo protects the rates for a given service from decreasing as another rate increases, it also keeps them from increasing at the expense of decreases elsewhere. In 2007, as a result of adopting the annual Medicare update, the relative value of many psychiatric procedures increased. This affected the extent to which the rate for each psychiatric procedure benefited from the five percent increase adopted by the 2007 Appropriation Act. Because the relative value of these procedures increased, compared to non-psychiatric procedures, the rates for the five procedures listed in Table 14 generally increased by more than five percent:

- 90862, medication management (11.3 percent increase);
- 90801, diagnostic interview (8.8 percent increase);

- 90817, psychotherapy with medical evaluation (4.8 percent increase);
- 90816, psychotherapy (5.5 percent increase); and
- 90853, group psychotherapy (7.9 percent increase).

Because an across-the-board inflation adjustment for all procedures would be the most costly approach, it may be preferable to create a silo for psychiatric services. This would likely be done by following the same steps used by DMAS to implement the rate increases directed by the 2005 Appropriation Act.

Chapter 6

Current Role of State Hospitals Needs to Be Clarified

In Summary

The use of State hospitals as a means of treating persons with mental illness has decreased sharply since 1970. This process, known as deinstitutionalization, has shifted the locus of care away from the State to community-based services. Presently, many persons with mental illness receive services as residents of assisted living facilities, students in special education programs, residents of juvenile detention centers, and inmates in local and regional jails. Many persons with mental illness are also patients in licensed hospitals, and the staff of these hospitals have raised concerns regarding the present role of State hospitals. The Department of Mental Health, Mental Retardation and Substance Abuse Services indicates that some persons are not appropriate for admission to State hospitals, but required regulations to establish State hospital admission criteria have not been adopted. In addition, State hospitals are increasingly serving persons who were admitted by the criminal justice system, and this decreases the number of State hospital beds that are available to patients in licensed hospitals and other community-based providers.

Since Virginia's first State hospital for the mentally ill was proposed in 1766, these institutions have been responsible for serving most of Virginia's mentally ill citizens. The number of State hospital beds has decreased since 1970, and many of the persons who would have been admitted to State hospitals in previous years are now served by licensed hospitals. Moreover, as the number of State hospital beds has decreased, there has been an increase in the proportion of State hospital patients who are in the custody of the criminal justice system. According to licensed hospital staff, these two changes have hindered their ability to transfer to State hospitals patients who need the level of care that a State hospital can provide. This change is seen by licensed hospital staff as a shift of responsibility from the public sector to the private sector.

RELATIONSHIP BETWEEN STATE HOSPITALS AND LICENSED HOSPITALS CHANGED DURING DEINSTITUTIONALIZATION

Since deinstitutionalization began in 1970, State hospitals have ceased being the primary provider of care to persons with mental illness. Moreover, State hospitals have stopped serving some types of persons who were served in previous years, such as persons with dementia or secondary medical conditions. These changes suggest that the role of State hospitals vis-à-vis licensed hospital needs to be clarified.

Role of State Hospitals Has Changed Over Time in Relation to Licensed Hospitals and Community Services Boards

For 200 years, State hospitals provided most of the mental health services needed by Virginians, who were admitted to the State hospitals largely through the civil commitment process. Although the community services boards (CSB) were created in order to increase the role of local governments in mental health care, the responsibility for inpatient care has never been statutorily assigned to them. This would appear to leave this responsibility with the State. However, the number of State hospital beds has decreased, and the State has stopped serving certain types of patients. As a result, there appears to be a need to clarify the role of State hospitals.

First Public Mental Hospital in America Was Located in Virginia. In Virginia, Eastern State Hospital opened near Williamsburg in 1773 as the first public facility in the United States constructed solely for the care and treatment of the mentally ill. The hospital was built in response to Governor Fauquier's call in 1766 for the colony to "care for people who are deprived of their senses and wandering about the country." This was followed by Western State Hospital in 1828, which was built in the geographic center of the State (Staunton). Two other hospitals were built shortly thereafter. One of these hospitals, located in Weston, was built in 1859 and later given to West Virginia. Central State Hospital was then built in 1865. Other hospitals were built in the decades that followed, and are located in the City of Danville and in the Counties of Fairfax, Roanoke, Smyth, and Prince Edward.

Institutionalization Resulted in Part From Use of Civil Commitment Process to Transfer Persons From Local Poorhouses. For decades, many local governments had committed individuals to the State hospitals who may have been able to be served in the community. Care for the indigent, many of whom were mentally ill, was part of the local government responsibility for the public welfare. This responsibility had its deepest roots in the Elizabethan Poor Act of 1601, and was reiterated in 1785 when the General Assembly enacted a law which removed responsibility for the poor from the parish church and placed it directly with the local governments. To oversee this responsibility, local governments employed a constitutional officer known as the Superintendent of the Poor. These officers were in charge of the poorhouse, or almshouse.

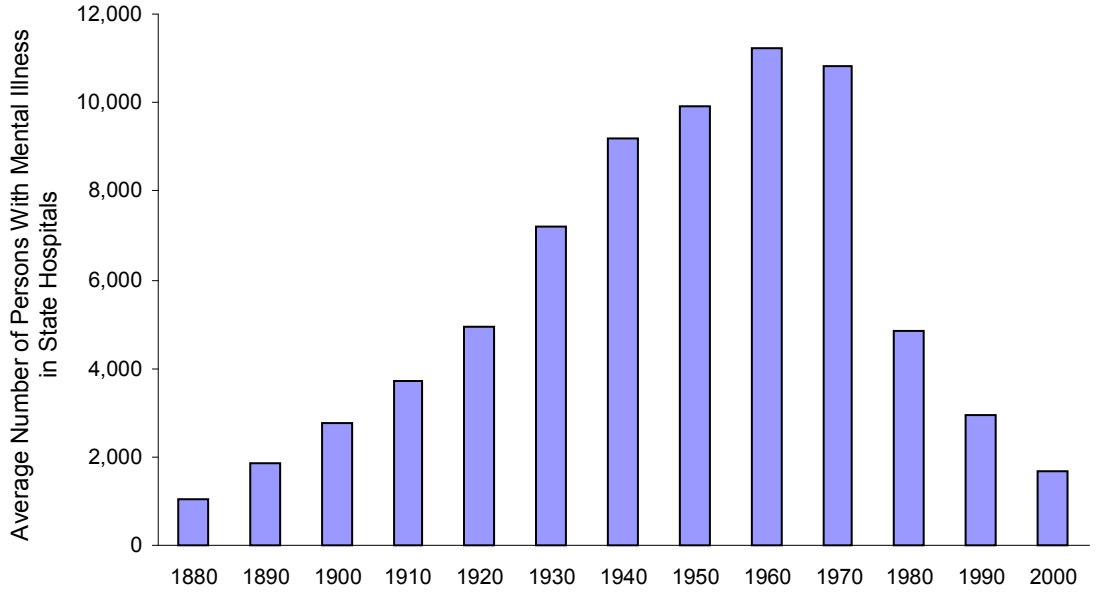
As described in two reports issued by the State Department of Public Welfare, in 1926 and in 1948, the almshouse "was the only place available for the county's insane, feebleminded, epileptic, tubercular, blind, and delinquent indigents." Some local governments used the civil commitment process to transfer these persons to

State hospitals rather than care for them in almshouses. These transfers resulted from the fact that local governments did not have a financial obligation to pay for State hospital care, as a result of legislation passed in 1906 which stated

> That no citizen of the State of Virginia, who shall be committed to an insane asylum of the State, his estate or personal representative, shall be charged with any of the expenses attendant therewith, or for his maintenance therein (1906 Acts of Assembly, Chapter 115).

As a result, a process began which could be described as institutionalization, as illustrated in Figure 18. In the 1940s, the State began to try to reverse this trend, beginning with the establishment of mental hygiene clinics by the Department of Mental Hygiene and Hospitals (the precursor of today's Department of Mental Health, Mental Retardation and Substance Abuse Services, or DMHMRSAS). These clinics were first built in the late 1940s, and were intended to increase the availability of community services to persons discharged from State hospitals. The clinics were funded with a combination of State and local funds, but were State organizations. (Appendix J contains the data used to create Figure 18.)

Figure 18: Institutionalization Began in About 1920 and Deinstitutionalization Began in 1970



Source: Analysis of data from the Department of Mental Health, Mental Retardation and Substance Abuse Services, and archival data from the State Department of Public Welfare.

CSBs Were Intended to Increase Local Responsibility for Mental Health Care. As the 1960s approached, the State hospitals had extensive capital needs and had become custodial institutions that provided inadequate care. In response to the federal Community Mental Health Centers Act, in 1968 the State allowed local governments to apply to the Department of Mental Hygiene and Hospitals for matching grants to develop community mental health and mental retardation services. To apply for these grants, the local government had to first create a community mental health services board (CSB).

These boards were part of an effort to increase local provision of mental health services. As noted in 1965 by the Virginia Mental Health Study Commission (Cary Commission), which recommended the creation of local boards,

> There is a necessity for a realistic approach to the problem of financing and particularly a realization on the part of local governments that a shift to community based programs will inevitably result in increased costs to local governments. Organizing to develop improved and more adequate community services is a local responsibility.

The creation of local boards supplemented the services provided by the State-run mental hygiene clinics and "provide[d] for more services and broaden[ed] the degree of local operations and control over such services."

The enabling legislation allowed the local boards to provide eight services, including inpatient and outpatient services (1968 Acts of Assembly, Chapter 477). These services were closely linked to the requirements of the federal Community Mental Health Centers Act because federal funds could only be obtained if specific services, including inpatient and outpatient services, were provided. As noted by the State Hospital Board in 1969, the new legislation provided a vehicle for the department (DMHMRSAS) to participate in

> *local expenditures* for construction of facilities to be utilized in community mental health and mental health programs. Although not limited by the Act to the development of Community Mental Health Centers, it is certainly the Department's primary intention to work in the direction of these Centers which would provide comprehensive services at the local level [emphasis in original].

Creation of Community Services Boards Did Not Transfer Responsibility for Inpatient Care to Local Governments. The *Code of Virginia* presently assigns local governments the responsibility to

provide four specific mental health services, as discussed in Chapter 1. However, the current statute also states that

> The core of services *may* include a comprehensive system of *inpatient*, outpatient, day support, residential, prevention, early intervention, and other appropriate mental health, mental retardation, and substance abuse services (§ 37.2-500) [emphasis added].

These "core" services, as indicated by the permissive language in the statute, do not have to be provided. Presently, if a local government wishes to provide these services it may do so through local funds.

When the State originally gave local governments the permission to form CSBs, the statutory language envisioned that these core services would be provided, although this was not required. The first CSBs partnered with local licensed hospitals to provide the inpatient component, including Fairfax Hospital, the University of Virginia, Bon Secours Maryview, and Riverside Hospital.

However, the permissive language in the statute did not mandate that local governments provide inpatient services. This effort was taken up in 1980 by the Commission on Mental Health and Mental Retardation (Bagley Commission), but the permissive language was never changed. As a result, local governments and their CSBs do not have any statutory responsibility to provide inpatient services. Moreover, during the civil commitment process if a CSB does not identify the facility to which a person should be committed, State law holds that the person shall be admitted "to a facility designated by the Commissioner" (§ 37.2-817). Therefore, it would appear that responsibility for inpatient services continues to rest with the State.

Role of Licensed Hospitals Has Changed Since Deinstitutionalization. Licensed hospitals in Virginia were slower to develop than State hospitals, and prior to deinstitutionalization they played a very limited role. The first freestanding psychiatric hospitals provided care to paying patients, and early statutes allowed individuals to be committed to freestanding hospitals if family members paid for their care. As of 1965, there were only four freestanding hospitals. The Cary Commission observed that these hospitals were supported by patient fees and were therefore "utilized primarily by the upper income groups." Because of this, the Cary Commission recommended that the under-utilized capacity in the general hospitals be used to relieve "the problem of the handling of committed persons prior to their transfer to the appropriate State hospital."

However, the role of licensed hospitals was not to become long-term care providers, but to divert people from State hospitals. For this to succeed, State hospitals had to provide those services that community-based providers were not providing. This relationship was outlined in the 1961 Congressional report *Action for Mental Health*, which noted that

> care for patients with major mental illness should be given if possible, or for as long as possible, in a psychiatric unit of a general hospital and then, on a longer-term basis, in a specialized...State hospital.

This approach was supported by the Cary Commission, and included in the plan the State submitted to receive federal funding for community mental health centers. To qualify for these funds, the General Assembly embraced the Cary Commission's recommendation that local boards be created to operate the federally-funded services. Licensed hospitals now appear to play the role envisioned when CSBs were created. At that time, almost all involuntary commitments were to State hospitals. In 2005, most (85 percent) of the involuntary commitments were to licensed hospitals.

In 1965, almost all involuntary commitments were to State hospitals. In 2005, most (85 percent) involuntary commitments were to licensed hospitals.

Capacity at State Hospitals Has Been Reduced to Provide More Appropriate Patient Care and Reduce Spending

The number of State hospital beds has been reduced as part of an effort to provide less restrictive and less costly care when possible. The majority of the bed reductions has occurred since 1970, when DMHMRSAS adopted the policy of deinstitutionalization.

Although an exact count of State hospital beds is not available over this time period, the effect of deinstitutionalization can be seen by looking at the number of patients (the "census"). The average daily census at State hospitals in 2006 (1,452 patients) has been reduced by 87 percent from its high in 1962 (11,532). These data, which represent mental health patients only, indicate that the average biennial reduction has been 7.7 percent.

Certain Persons Are Now Considered to Be Inappropriate for State Hospital Admission

In recent years, DMHMRSAS has adopted procedures that CSBs must follow during pre-admission screening for State hospital admission. These procedures indicate that certain persons are not appropriate for State hospital admission. As a result, it is not clear which agency or level of government is responsible for ensuring needed care is provided for these persons.

Eligibility for Admission to a State Hospital Depends on Meeting Specific Criteria. As required by statute, DMHMRSAS and the CSBs sign annual performance contracts. A required part of the performance contract is a delineation of the responsibilities of DMHMRSAS and the CSBs (§ 37.2-508). The performance contract for FY 2008 delineates which individuals are appropriate for admission or transfer to the State hospitals, and who is not appropriate.

According to the Continuity of Care Procedures outlined in the performance contract, a person is appropriate for admission (or transfer) if one of these three conditions are met:

- meets the statutory civil commitment criteria, which include an imminent danger of harm to self or others, or a substantial inability to care for self;
- has a condition that requires intensive monitoring because of a newly prescribed drug that has a high rate of complications or adverse reactions; or
- has a condition that requires intensive monitoring and intervention because of toxic effects resulting from therapeutic psychotropic medication, with the result that community-based care is inappropriate.

In addition to meeting one of these conditions, an adult can only be admitted if there is no less restrictive alternative to State hospital admission. An alternative would usually be the availability of a bed in a licensed hospital or another community-based facility. (The criteria for children and adolescents are similar.)

Because the availability of these alternatives can change on a daily basis, the same person could be deemed appropriate for admission one day, but deemed inappropriate on another day (because a bed in a licensed hospital or other community facility exists). Moreover, because the availability of community services varies around the State, an adult could be more likely to be admitted in one region than in another. DMHMRSAS staff state that admission to a State hospital is more likely to occur in Southwest Virginia, because of the lack of licensed hospital beds.

Presence of Other Conditions Indicates That a Person Is Not Appropriate for State Hospital Admission. In the annual performance contract, the Continuity of Care procedures indicate that there are specific persons for whom admission to the State hospitals is "not appropriate." This includes individuals who have

- primary diagnosis of dementia, unless they also have significant behavioral problems, as determined by qualified State hospital staff;

- primary diagnosis of substance use disorder;
- unstable medical conditions that require detoxification or other extensive medical services; or
- behaviors due to neurological disorders, including head injury.

According to the Continuity of Care procedures, one exception to this list is that individuals with a mental illness who are also diagnosed with a substance use disorder may be admitted to a State hospital. Otherwise, no exceptions are indicated.

Licensed hospital staff state that these are the groups of patients whom they feel are not appropriate for extended care in one of their acute care psychiatric beds. However, licensed hospital staff report that it is very difficult to transfer these individuals to State hospitals due to the guidelines in the performance contracts.

State Hospitals Used to Serve Certain Persons Now Deemed Not Appropriate for Admission. When deinstitutionalization began in 1970, the patient population in State hospitals included many of the people who are now deemed inappropriate for admission. For example, one of the most notable results of deinstitutionalization is the reduction in the number of geriatric patients, as well as the shift away from treating persons with a substance use disorder or individuals with major medical needs.

An early component of deinstitutionalization consisted of transferring geriatric patients to nursing homes and homes for the aged (assisted living facilities). This was made possible by two events in 1965: the enactment of Medicare and Medicaid, and a regulatory change made by the Virginia Department of Health. This regulatory change for the first time allowed nursing homes to accept persons with a psychiatric diagnosis, if they were certified to not pose a danger to themselves or others.

The transfer of geriatric patients to community-based facilities was one of the first "census reduction" efforts, where the number of patients (as counted on the patient census) was reduced through a targeted effort to place them in community-based settings. This was followed by a program called geriatric screening. This program began in 1971, and it resembled today's regular pre-admission screening because it was designed to determine if the individual actually needed psychiatric hospitalization or could instead be served in a nursing home or home for the aged.

In addition to patients with dementia, State hospitals used to serve many more persons with substance abuse disorders. At the present time, about four percent of State hospital patients have a primary diagnosis of substance abuse. In contrast, the Director of

Eastern State Hospital reported in 1965 that "one-fifth of our patients are committed as alcoholics and drug addicts," adding that "often they are worse off than those who are mentally ill." Other State hospitals also served these persons. Both Central State Hospital and Southwestern State Hospital established alcoholic units in 1968.

In addition, the State hospitals provided many more medical services than today. In its annual report for 1969, Central State Hospital reported that its staff performed 211 surgeries, which were supported by the hospital's laboratory, x-ray, and dental facilities. The hospital noted that a "high percentage" of its geriatric admissions had "major medical and surgical conditions" that required hospitalization in the hospital's medical-surgical building. Similar statistics were reported by Eastern State Hospital.

Lastly, there was a clear awareness that the State hospitals were serving many other persons who did not meet the definition of being mentally ill. According to the Director of Eastern State Hospital,

> These patients are not hospitalized for treatment but for custody due to social offenses against the community. Included are the mild or moderate mental defectives, those who won't work, the sexual deviants, the juvenile delinquents, the psychopaths, the hypochondriacs, the rejects of socially prominent families, those with permanent brain injuries, the uneducated, the unskilled, and others.

Many of the individuals noted by the director now receive services in other settings, and from other local and State agencies. For example, one of the changes that occurred at about the same time as deinstitutionalization was the creation of special education classes in elementary and secondary schools, which served many younger persons previously defined as mentally defective or retarded. This began after the 1972 Session of the General Assembly required the State Board of Education to provide special education classes in all schools. In addition, the Juvenile Correction Centers now care for many mentally ill youths. In 2005, 41 percent of juveniles (387 persons) had a diagnosed mental health disorder at the time of admission.

Persons with mental illness are also served in assisted living facilities (ALF). The needs of the mentally ill residents of ALFs have been discussed in several JLARC reports, including the 2006 report on the *Impact of Assisted Living Facility Regulations*. As noted in that report, although no data are available to describe all 33,000 ALF residents, data are available on the 19 percent of the ALF population whose care is paid for through the State auxiliary

grant program. These data show that in 2005, 65 percent of auxiliary grant recipients had a diagnosed mental disability. In addition, eight percent of State hospitals discharges in fiscal year 2006 were to an ALF.

However, as discussed in Chapter 3, licensed hospital staff report that it is very difficult to discharge these groups of persons to nursing homes or ALFs. Moreover, as discussed in the 2007 JLARC review of *Access to State-Funded Brain Injury Services in Virginia*, there is virtually no system of care for individuals with behavioral problems resulting from a head injury who cannot afford private care. As a result, such individuals may be placed in a nursing home or incarcerated in a local jail or State prison, where the person is unlikely to receive needed services.

DMHMRSAS Has Stated That Persons Not Appropriate for State Hospital Admission Should Be Served by Other Providers. When an individual whose condition is not appropriate for State hospital admission seeks publicly-funded services, CSB staff will not recommend them for State hospital admission and will instead look for another community-based provider. It appears that DMHMRSAS first identified some of these individuals as not appropriate for admission in the 1990s. For example, in 1999 DMHMRSAS and the Department of Rehabilitative Services proposed that individuals with a head-injury diagnosis who were not mentally ill be barred from State hospital admission. Table 16 provides a list of alternative programs and providers that DMHMRSAS staff believe can serve those persons now determined not to be appropriate for admission to State hospitals.

Table 16: Locations Identified by DMHMRSAS as Suitable for Persons Not Appropriate for State Hospital Admission

Characteristics of Persons Identified as Not Appropriate for State Hospital Admission	Alternative Service Provider Identified by DMHMRSAS
Primary diagnosis of dementia	Nursing home, specialized assisted living facility, or other community residential program
Primary diagnosis of substance use disorder	Community outpatient or residential substance abuse treatment program
Unstable medical conditions	Local licensed hospital or a local substance abuse detoxification program
Behaviors due to neurological disorders	Nursing home, local licensed hospital, community residential program, Department of Rehabilitative Services program, other local rehabilitation services provider, or other community provider

Source: Letter provided by staff of the Department of Mental Health, Mental Retardation and Substance Abuse Services on August 27, 2007.

Licensed Hospitals Cannot Be Legally Required to Accept Involuntarily Committed Patients

Although DMHMRSAS has identified licensed hospitals as one of the community-based providers to which persons not appropriate for State hospital admission could be placed, licensed hospitals serve individuals at their discretion, not the State's. This has implications for the State hospitals in another sense as well, because licensed hospitals do not have to accept anyone detained under a temporary detention order (TDO) or involuntary commitment order. This is because the courts do not have the legal authority to order a private provider to deliver treatment against the private provider's will. Therefore, a court does not have the authority to order a licensed hospital to admit a patient under a civil commitment order if the hospital objects. This conclusion has been maintained in two recent opinions issued by the Attorney General of Virginia, both of which state that

> although the community services board staff must designate the facility in which the person will be confined, the court may not require the hospital to admit the person over its objection; rather, admission to the hospital is accomplished in accordance with hospital policies and procedures (1997 Va. Atty. Gen. Op. 141 and 2001 Va. Atty. Gen. Op. 146).

As this opinion makes plain, licensed hospitals cannot be required to provide mental health care, and only do so by choice.

In addition to the use of licensed hospital beds during TDOs and involuntary commitments, these beds are vital to the success of current initiatives designed to reduce the use of State hospitals. According to DMHMRSAS,

> It is vitally important that funding for the purchase of local inpatient psychiatric treatment services delivered through contracts with private providers be maintained and even increased as Virginia moves to transform its public mental health, mental retardation, and substance abuse services system to serve individuals with serious mental illnesses most appropriately and effectively.

Clarification, therefore, of the role of State hospitals may serve to ensure that licensed hospitals remain willing to serve patients who were served by State hospitals prior to deinstitutionalization.

State Board Should Adopt Statutorily Required Admission Criteria Through Regulation

Although the role of State hospitals has shifted over time, both as a result of institutionalization and deinstitutionalization, DMHMRSAS contends that the role of State hospitals vis-à-vis other providers does not need to be clarified. DMHMRSAS states that the role and mission of State hospitals is to provide care and treatment for persons with mental illness who are admitted through the involuntary civil admission process, the forensic admission process, or who seek voluntary admission. DMHMRSAS adds that they do not think the role and mission of State hospitals should be further defined in statute because current statutory provisions are sufficient; that policies adopted by the State Mental Health, Mental Retardation and Substance Abuse Services Board (State Board) address their role and mission; the role and mission has changed and continues to evolve over time; and the role and mission needs to be flexible for each State hospital in response to the overall availability of services in their service region.

However, the department is aware of the limitations of relying upon the commitment process and State Board policies to define the role of State hospitals. As described by the Commissioner of DMHMRSAS in 1979, in response to the JLARC study on *Deinstitutionalization and Community Services*,

> I can assure you that there was a time in Virginia when a commitment to a State hospital could not be refused. The hospital system was expected to be the permanent haven for many different segments of our society, including the poor, the homeless, the unemployed, the deviant, the orphan, the aged, the anti-social, the underprivileged, the wanderer, the "peculiar" transient, the pennyless, and at times, the mentally ill and mentally retarded. These were acceptable criteria for admission and many local and State agencies including welfare departments, courts, police, health departments, schools, and other agencies participated actively in the process of admitting and committing individuals to State mental hospital care.

State Board policies do not have the effect of law, unlike regulations, and cannot be relied upon to fully clarify whom the State hospitals should serve.

Regulations Required by the General Assembly Have Not Been Adopted. In 1980, the General Assembly directed the State Board to "adopt regulations to institute preadmission screening" (§ 37.2-823). Regulations have never been adopted in response to this statutory directive. Instead, DMHMRSAS has established the cri-

teria for admission to State hospitals through the Continuity of Care procedures. These procedures, which were last published in 1997, are incorporated by reference into the CSB annual performance contracts. Language in those contracts states that "Boards and the Department shall comply with the *Procedures for Continuity of Care*."

The legislative requirement that regulations be adopted to institute preadmission screening were intended to require that the State Board develop, and that CSBs would use, standard admission criteria. This resulted from documented instances, noted by the 1972 Commission on Mental, Indigent and Geriatric Patients (Hirst Commission) and JLARC, where people were inappropriately hospitalized in State hospitals and people in need of State hospitalization were not being admitted. In 1980, the Bagley Commission recommended, and the General Assembly agreed, that admission criteria needed to be established through regulation so that CSBs would be properly guided in determining whether persons seeking services would best be served in a State hospital or by a community-based provider.

Criteria for Determining Who May Be Admitted to State Hospitals Have Significant Implications. State hospital admission criteria are important because they define the role of the State hospitals in relation to licensed hospitals and the mental health system as a whole. The admission criteria result in some individuals receiving State-funded treatment that they need, while other individuals must be served by licensed hospitals or other community mental health service providers. Licensed hospitals believe that changing criteria have resulted in a shift in responsibility from the State hospitals to the licensed hospitals in cases where inpatient care is necessary. Licensed hospital staff are also concerned that the lack of a clear rationale for the existing State hospital admission criteria makes it difficult to determine the role that State hospitals should play in relation to licensed hospitals in today's public mental health system.

In addition, decisions that exclude certain groups from treatment in State hospitals directly affect other parts of the State mental health and social services systems. This is because persons who are not appropriate for admission to a State hospital become the responsibility of local government agencies. The Continuity of Care procedures state that the director of each State hospital

> shall appropriately evaluate any individual who presents at the facility for admission.... Should the hospital find that the individual does not require hospitalization, the hospital shall notify the appropriate community services board... to arrange for other services. *It is the CSB's responsibility to*

put into place alternative services for the willing individual, if needed [emphasis added].

Because this contractual language is intended to bind the department, its hospitals, and the CSBs, it would appear that the persons identified as not appropriate for admission (discussed on page 100) are a local responsibility, notwithstanding the lack of clear statutory responsibility for CSB provision of inpatient services.

Local responsibility for those persons denied admission to State hospitals is further indicated by § 37.2-837 of the *Code of Virginia*, which states that the director of a State hospital may discharge "any consumer in a State hospital who is not a proper case for treatment within the purview of this chapter." The section of statute adds that any person discharged on this basis "shall, if necessary for his welfare, be received and cared for by the appropriate local department of social services."

Given this local responsibility, the practical effect of the current State hospital admission criteria is that some of those individuals denied admission to State hospitals may instead be served by local government agencies. For example, some individuals could become residents of assisted living facilities, and may be supported by the auxiliary grant, which is funded by both the State and the local governments. This impact of State hospital admission decisions upon local government agencies as well as community-based mental health providers further supports the need to develop regulations regarding pre-admission screening as directed by statute.

Clarifying the Role of State Hospitals in the Continuum of Care May Address Concerns Raised by Licensed Hospitals. Licensed hospitals are also concerned that State hospitals have become increasingly stringent in determining which types of physical health issues will result in an admission being denied, and that there is considerable variation between State hospitals as to the physical health issues they can accommodate. In addition, licensed hospitals claim that individuals with substance abuse or behavioral problems are difficult to transfer to State hospitals, and that the licensed hospitals become the only inpatient service provider for those individuals. DMHMRSAS was not able to provide the number of persons denied admission to State hospitals, or the reason for each denial.

Licensed hospital staff note that some of the individuals they are not able to serve in an acute care setting may be more appropriate for admission to a nursing home rather than a State hospital. However, there is no statutory requirement that nursing homes accept these persons, unlike the requirement that appears to place this responsibility upon DSS. As a result, the federal requirement

under the Emergency Medical Treatment and Labor Act (EMTALA) that licensed hospitals stabilize all persons in their emergency rooms results in the licensed hospitals being the only provider with any legal responsibility for ensuring all persons receive needed care. Although licensed hospitals could deny inpatient admission to a patient whom they could not appropriately treat, this would appear to be an inadequate mechanism for addressing this issue.

Given the importance of the State hospital admission criteria and the legislative directive to address the criteria through regulation, DMHMRSAS should develop regulations that establish the admission criteria for the State hospitals. Using the regulatory process will place the public on notice that the State is proposing admission criteria and will provide a structured opportunity for interested stakeholders as well as the general public to provide input. This process should provide the department with more comprehensive information so that it can make a more fully informed decision regarding what the criteria should be. Furthermore, it will serve to legitimize the admission criteria that are developed.

Recommendation (10). The State Mental Health, Mental Retardation and Substance Abuse Services Board should develop regulations to institute preadmission screening as directed by § 37.2-823 of the *Code of Virginia* and use these regulations to establish admission criteria.

INCREASE IN FORENSIC PATIENTS IN STATE HOSPITALS FURTHER REDUCES CIVIL CAPACITY

State hospitals serve two classifications of persons, based upon how they were admitted into the hospital. Civil patients are admitted through either the involuntary civil commitment process (Chapter 8 of Title 37.2) or else seek a voluntary admission (§ 37.2-805). In contrast, forensic patients have been detained through the criminal justice system, and are admitted to State hospitals for mental health evaluations or competency restorations, or subsequent to being found not guilty by reason of insanity. Forensic patients are generally admitted pursuant to Chapters 11 and 11.1 of Title 19.2 of the *Code of Virginia* and in response to judicial orders.

Virginia Has Attempted to Reduce the Number of Mentally Ill in Jails for Many Decades

Although jails have housed persons with mental illness for over 200 years, it has not been until recently that mental health services were provided. In 1841, the Governor reported to the General Assembly that

> I have visited our lunatic asylums, and was gratified to find them in good order, and under an admirable system of management. It is to be regretted, that so many of the unfortunate class for whose benefit they are designed, should be confined in jails so long as to incur great expense to the state, and to render their cure more doubtful when they are admitted to the hospitals.

In the 1920s and 1930s, State hospitals were expanded in order to accommodate the mentally ill in jails. The Legislative Commission on Jails found in 1937 that there was one mentally ill person in the jails for every six mentally ill persons in State hospitals. The State "fee system" created a disincentive for sheriffs to send people to the State hospitals. Although operation, construction, and maintenance of the jail was a local responsibility, the State reimbursed the locality by paying a daily fee for each prisoner. A 1934 report by the State Department of Public Welfare observed that "the State pays the jailers a higher per diem board allowance for mental patients held as such than for ordinary jail inmates."

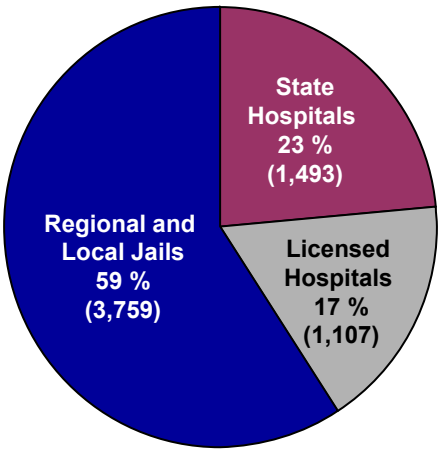
Today in Virginia, many persons with mental illness are served in jails, and some of these persons are transferred to State hospitals. DMHMRSAS staff state that these transfers could be reduced if CSBs provided additional jail-based services, but the department has had limited success in developing these services. In part because of persons transferred from jails, 31 percent of persons in State hospitals are considered "forensic" patients, meaning that they entered the mental health system through the criminal justice system.

As of 2005, there were five mentally ill persons in jails for every two people in State hospitals.

Jails Serve More Mentally Ill Than State Hospitals and Licensed Hospitals. While data on mentally ill patients in jails is limited, a September 2005 survey of the jail population by the Compensation Board provides an opportunity to examine the relative proportion of the mentally ill served by the State hospitals, licensed hospitals, and jails on a given day. As indicated in Figure 19, the results indicate that on that day the jails served 59 percent of the mentally ill utilizing beds at these three providers. State hospitals served 24 percent, and the licensed hospitals served 17 percent. Therefore, as of 2005 there were five mentally ill persons in jails for every two persons in State hospitals.

Differences are apparent in the characteristics of the individuals in each type of setting. As shown in Table 17, State hospitals are much more likely to serve persons with schizophrenia or a delusional disorder. These persons accounted for 57 percent of State hospital patients, and 22 percent of the mentally ill persons in jails and in licensed hospitals. The licensed hospitals, in contrast, appear to be much more likely to serve persons with mood disorders

Figure 19: One-Day Snapshot Shows That Jails Serve More Mentally Ill Persons Than State Hospitals or Licensed Hospitals



Source: Analysis of data from Virginia Health Information, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Compensation Board for September 13, 2005.

Table 17: More Mentally Ill Persons in Beds Are Served in Jails Than in State Hospitals or Licensed Hospitals (Sept. 13, 2005)

Primary Diagnosis	State Hospitals	Licensed Hospitals	Local and Regional Jails
Schizophrenia and Delusional Disorders	838	252	831
Mood Disorders	223	524	1,958
Anxiety Disorders	16	21	436
Substance Abuse	54	107	n/a
Dementia	192	44	n/a
Other	139	159	534
Total Number of Mentally Ill Persons	**1,493**	**1,107**	**3,759**

Notes: JLARC staff defined dementia as dementia (ICD-9 code 290) and persistent (ICD-9 code 294). Data from jails combined schizophrenia and delusional disorders.

Source: Analysis of data from Virginia Health Information, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Compensation Board.

(such as bipolar disorder or major depression) than the State hospitals. Jails, however, held more persons with mood disorders than all the persons in State hospitals, and also had the highest proportion of persons with anxiety disorders.

There are also differences between the State hospitals and licensed hospitals in other areas:

- State hospital patients were less likely to have a substance abuse diagnosis. Four percent had a primary substance abuse diagnosis, and 29 percent had a secondary diagnosis. In contrast, 13 percent of licensed hospital patients had a primary diagnosis, and 39 percent had a secondary diagnosis.

- State hospital patients were more likely to have dementia. Ten percent had dementia, versus four percent of licensed hospital patients. (Geriatric patients accounted for 26.4 percent of persons in State hospitals, versus 13.7 percent of licensed hospital patients.)

- More State hospital patients had secondary medical conditions (84 percent) than did licensed hospital patients (72 percent).

- More geriatric patients in State hospitals had secondary medical conditions.

As shown in Table 18, State hospital patients typically had a much longer length of stay.

Table 18: Adult and Geriatric Patients in State Hospitals Have Substantially Longer Length of Stay Than in Licensed Hospitals

Age Range	State Hospitals	Licensed Hospitals
	Average Length of Stay in Days (Data are for Sept. 13, 2005)	
Child/Adolescent (ages 0-17)	21	77
Adult (ages 18-64)	798	11
Geriatric (ages 65 and older)	1,750	20

Source: Analysis of data from Virginia Health Information and the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Licensed Hospitals Serve More Individuals Than State Hospitals, but State Hospitals Provide More Days of Care. Licensed hospitals served the vast majority (86 percent) of all individuals who were served in inpatient psychiatric beds in 2005. In fact, as noted by DMHMRSAS in the FY 2005 *Annual Report on CSB Contracts for Private Inpatient Psychiatric Treatment Services*, more non-geriatric individuals were served in licensed hospitals through the State-funded Local Inpatient Purchase of Services (LIPOS) bed purchase program than were admitted into the State hospitals. However, although State hospitals served fewer individuals than the licensed hospitals, State hospitals provided the majority of patient care. This can be seen by comparing the relative number of bed days (Table 19), as measured by the total number of bed days.

Definition of Bed Days

The use of bed days is a way of measuring the amount of care provided by a hospital in a given year. If a hospital had one bed, and it was used every day of the year, this would equal 365 bed days.

Table 19: Licensed Hospitals Serve More Patients Than State Hospitals, but State Hospitals Provide More Bed Days of Care

	State Hospitals FY 2005	Licensed Hospitals CY 2005
Persons Served	5,723	35,718
Average Length of Stay (Days)	55.3	7.4
Cost Per Bed Day	$544	$861
Total Number of Bed Days	535,387[a]	377,276

[a] Does not include bed days where patients' community services board was unknown, out-of-state, or unrecorded

Source: Analysis of data from Virginia Health Information and the Department of Mental Health, Mental Retardation and Substance Abuse Services and Financial Survey Data.

State hospitals serve a patient population that is older, has more secondary medical conditions, and has a length of stay that is sometimes measured in years, not weeks. The average length of stay for State hospital patients is more than seven times the average length of stay at licensed hospitals.

Jail-Based and Jail Diversion Services Can Reduce the Demand for Forensic Beds at State Hospitals. It appears that some of the mentally ill persons in jails may be there in part because a law enforcement officer charged them with a crime instead of seeking mental health services. For example, CSB and DMHMRSAS staff indicated in interviews that in some parts of the State, law enforcement officers may choose to charge a mentally ill individual with an offense such as urinating in public and take them to jail. This is consistent with national studies which indicate that police officers are almost twice as likely to arrest someone if they appear to have a mental illness.

In many localities, CSB staff will provide services in jails, but this is not required. As documented in a survey of local and regional jails conducted by the Compensation Board for the week of September 13, 2005, 29 of the 67 jails responding to the survey reported that the CSB did not provide any mental health services that week. Another 22 reported that under 10 hours of services were provided. Only the CSBs in the Counties of Henrico and Fairfax, and the City of Alexandria, provided 100 hours or more of services.

Improvements in the availability of jail-based services, or jail diversion services, may decrease the number of mentally ill persons in jails, or the number of individuals in jail who need inpatient services. This, in turn, may decrease the number of forensic patients in State hospitals—who may be occupying beds that otherwise would be available to civil patients.

Forensic Beds Account for an Increasing Proportion of State Hospital Beds

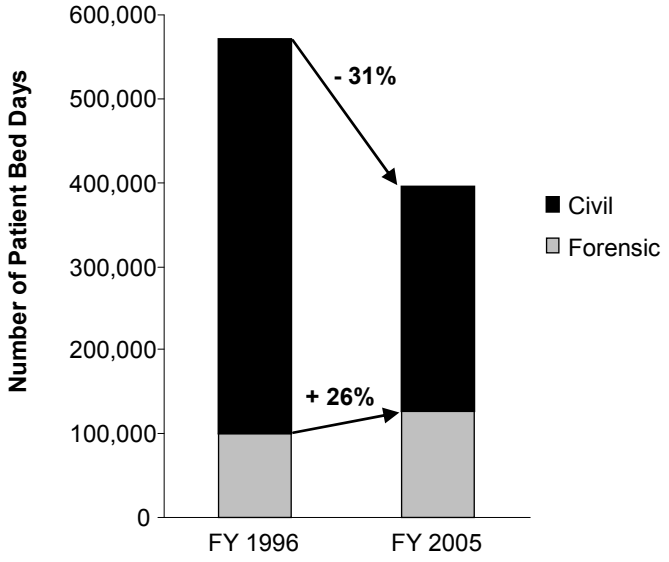
In recent years, State hospitals have reduced the number of civil beds. At the same time, the number of forensic beds has increased, which has further reduced the availability of civil beds at some State hospitals. CSBs and licensed hospitals have noted that State hospital civil beds are being reassigned as forensic beds, which makes them unavailable for civil patients. In addition, they claim that when State hospitals reach their capacity for forensic patients, these patients are placed in civil beds, rendering them unavailable to patients in licensed hospitals.

As a result of the overall bed day reduction and forensic bed day increases, civil bed usage at State hospitals has decreased by 43 percent.

As can be seen in Figure 20, from FY 1996 to FY 2005 the total annual number of bed days for all adult patients at State hospitals (civil and forensic) *decreased* by 31 percent. However, at the same time the number of bed days used by forensic patients *increased* by 26 percent. As a result of the reduction in overall bed days, but the increasing proportion of beds days used by forensic patients, the number of bed days used by civil patients decreased by 43 percent.

Although the number of bed days used by forensic patients increased by 26 percent, forensic admissions increased by only 13 percent from FY 1996 to FY 2005. This increase has not occurred

Figure 20: Forensic Patients Are Using an Increasing Proportion of State Hospital Bed Days



Source: Analysis of data from the Department of Mental Health, Mental Retardation and Substance Abuse Services.

uniformly across all patient groups, however, and adult forensic admissions decreased by 20 percent. In contrast, juvenile forensic admissions increased by 712 percent.

The increase in the number of forensic bed days does not result from a substantial increase in forensic admissions, but instead from a limited ability to discharge forensic patients. From 1996 to 2005, there were a total of 12,509 forensic admissions but only 11,330 forensic discharges (including persons who died in the hospital). Because fewer people have been discharged than admitted, it appears that the increase in bed days results in part from a limited ability to discharge forensic patients.

Forensic patients are referred through the criminal justice system, and as a result DMHMRSAS has limited ability to control or reduce the number of forensic admissions. In addition, a lack of community services for discharged forensic patients, such as services for persons found not guilty by reason of insanity (NGRI) further reduces the ability of the department to reduce the use of State hospital beds by forensic patients.

There are indications that the need for forensic beds may continue. According to DMHMRSAS, "for the past decade the Department has had to delay admission of jail inmates to State hospitals due to the limited capacity of State hospitals to provide forensic mental health services." The department adds that on any given day there are 100 jail inmates, on average, who are waiting to be admitted to Central State Hospital or Eastern State Hospital for treatment to restore their competency to stand trial. These individuals may wait up to three months to receive services.

DMHMRSAS Is Not Planning for State Hospital Bed Needs

Although forensic beds are increasing as a proportion of all State hospital beds, DMHMRSAS staff state that the department does not conduct any planning or projections regarding the number and type of State hospital beds needed. According to DMHMRSAS, "The department is not currently planning for state facility census projections and is rather planning and implementing expanded community services capacity to prevent and replace the need for state facility beds." Although the proportion of forensic patients is increasing, the department's forensic planning group does not currently forecast bed needs, and there is currently no dialogue with the Department of Corrections regarding forensic planning.

However, as DMHMRSAS continues to reduce bed capacity at State hospitals, bed projections would allow licensed hospitals an opportunity to plan for reduced State bed capacity. Additionally, these projections have potential utility in expanding public aware-

ness of DMHMRSAS efforts to reduce State hospital usage. Bed projection and planning in regards to forensic bed usage has significant value as well. As forensic patients increasingly utilize and encroach on civil beds at State hospitals, projections of forensic growth would allow planning for the consequent decrease in civil capacity. This would allow DMHMRSAS as well as licensed providers to more accurately assess how many beds will be available for civil patients.

A document that outlined efforts at deinstitutionalization as a part of planning and projecting bed usage would provide a historical record of specific initiatives and a benchmark against which to measure success. It would allow DMHMRSAS the opportunity to ensure that adequate funding is moving to community-based services in areas where State hospital service capacity has been reduced. Moreover, because the current role of State hospitals is not clarified by any means other than the civil and forensic commitment and voluntary admission procedures, additional planning would help the department better define its relationship not just to other community-based providers, but in regard to other State agencies, including the Departments of Corrections and Social Services.

Recommendation (11). The Department of Mental Health, Mental Retardation, and Substance Abuse Services should initiate formal planning tied to the State capital funding process to project the number of civil and forensic beds provided in each State hospital, and publish an annual report on bed need projections for each facility. This should be done collaboratively with agencies in the criminal justice system to adequately plan for forensic bed needs.

Chapter 7

Basis for CSB Board Regional Partnerships and Purpose of Their Programs Need To Be Clarified

In Summary

With deinstitutionalization, there has been a planned transition away from treating mentally ill individuals in State hospitals to treating them in the community. In recent years, community services boards (CSB) have begun to manage this transition through regional partnerships with State hospitals. A major part of the transition has been the purchase of psychiatric beds at licensed hospitals to "divert" individuals from State hospitals. This has occurred through the Local Inpatient Purchase of Services (LIPOS) program. Licensed hospitals express the concern that the State has shifted a significant part of its role in mental health service provision to the private sector without the requisite funding. Although funding has been used to purchase licensed hospital beds through the LIPOS program, issues with the purpose of this program and the adequacy of funding exist. In addition, there appears to be a lack of definition for these regional partnerships, as well as a lack of monitoring of regional activities by the Department of Mental Health, Mental Retardation and Substance Abuse Services.

A more recent aspect of deinstitutionalization is the creation of regional partnerships of community services boards (CSB). In order to further reduce the number of State hospital beds, these partnerships expend State funds which are used to purchase beds for eligible patients in licensed hospitals through a Local Inpatient Purchase of Services (LIPOS) program. These funds have been "reinvested" from the State hospital system into community-based services, but this has occurred at a time when the availability of licensed hospital beds is decreasing.

However, the purpose of the LIPOS program has never been clearly established, which hinders an assessment of whether the funds are being spent appropriately. There is also a lack of clarity on whether existing eligibility criteria for the receipt of LIPOS-funded services by individual patients are appropriate. Lastly, the statutory basis for the creation and assignment of duties to the regional partnerships is not clear.

REGIONAL CSB PARTNERSHIPS NOW MANAGE THE TRANSITION AWAY FROM CARE IN STATE HOSPITALS

As discussed in Chapter 6, Virginia has been transitioning away from State hospital care towards community-based care since 1970. However, the way in which licensed hospitals have been used as community-based providers has changed since 1999. This

change resulted from the use of contracts between CSBs and licensed hospitals, which have increased the involvement of licensed hospitals in the continuum of public mental health care.

The use of contracts marks a distinction from previous instances in which licensed hospital beds were purchased, because the contracts include negotiated daily (per diem) rates and give the licensed hospital specific responsibilities. At the same time, there has been a shift in the locus of decision-making from individual CSBs to regional partnerships of CSBs.

Previous Census Reduction and Diversion Projects Resulted From Economic and Legal Factors

State hospitals around Virginia have been purchasing beds in local hospitals since at least the 1980s. However, these purchases were on an ad hoc basis and were done to address temporary instances of overcrowding at the State hospitals. At the local level, CSBs had been purchasing a very limited number of beds from licensed hospitals, primarily for detoxification services. Since 1990, there have been several significant efforts to reduce State hospital beds, and "reinvest" institutional funding into the community by moving individuals from a State facility (State hospitals and State training centers) into the community.

Shift From Facility to Community-Based Services Began in Early 1990s. The most recent effort to do so began in the early to mid 1990s. This effort focused on persons who, because of newly available Medicaid-funded services in the community, could be transitioned to assisted living facilities and other community-based providers. The beds they previously occupied would then be closed, and the State would generate savings by shifting the source of funding from State-funded to Medicaid funded services. At the same time, efforts were underway to "divert" persons from ever entering State facilities by providing funds to CSBs to provide or purchase community services.

This effort was in part a response to budgetary pressures. The State experienced a recession in the early 1990s that led to the decision to expand Medicaid-funded services (to leverage federal funding) and to decrease institutional expenditures. State facilities also had a backlog of capital needs because of a deteriorating and outdated physical plant, and these expenses could be avoided if beds could be reduced.

Justice Department Investigations Led to Census Reductions. Legal pressures also played a large role. Beginning in 1990, the U.S. Department of Justice began to investigate conditions at State facilities in Virginia and in other states. These investigations were con-

ducted under the federal Civil Rights of Institutionalized Persons Act (CRIPA). Starting with Northern Virginia Training Center in 1990, and then Eastern State Hospital in 1993, and the Northern Virginia Mental Health Institute in 1995, the Governor was the subject of several investigations and subsequent lawsuits filed by the Justice Department. The federal investigations continued at Central State Hospital in 1997, and in each of these instances a plan of correction was created to settle or avoid litigation. These plans required several changes to address substandard conditions, including reductions in the number of State hospital beds.

Use of Licensed Hospital Beds Has Been Recommended for Many Years. Several Virginia studies were conducted in response to these factors, as well as the continued interest in deinstitutionalization spurred by the U.S. Supreme Court's 1999 *Olmstead* decision. As described in Chapter 1, *Olmstead* was a pathbreaking case in mental health law in which the Court held that mentally ill individuals should be treated in the least restrictive manner possible. The commissions and committees that studied the mental health system recommended, among other changes, an increase in the use of licensed hospital beds. For example, in December 1998 the Hammond Commission (chaired by Catherine Hammond, then Vice President of the Virginia Hospital and Healthcare Association), recommended funding for a pilot that would

> increase CSB admissions to private acute care hospitals for state patients, especially for Medicaid enrollees, who are in need of short term inpatient treatment. CSBs should engage in competitive bidding for these inpatient contracts.

This echoed a JLARC recommendation made in 1986 that the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) should

> provide incentives for the use of local inpatient beds, such as "buying" State hospital beds for clients. In addition, the department should provide technical assistance to CSBs in the development of programs, and in the development of contracts with local hospitals.

The result of the Hammond Commission's recommendation was the establishment of a pilot program in the service area of Central State Hospital. The 1999 Appropriation Act allocated $2.57 million for a public-private partnership pilot, and stated that the purpose of the pilot was

> to secure short-term inpatient psychiatric services through competitive contracts with community-based hospitals or other private health care providers, for purposes of serving individu-

als closer to their homes. Pursuant to individual agreements with the Department, community services boards will reduce their utilization at a selected state facility or facilities for short-term (30 days or less) acute hospitalization by a specified number of beds, and will contract by competitive bidding with community-based hospitals for short-term psychiatric inpatient services (1999 Acts of Assembly, Chapter 1072, Item 341 I).

Later that year, Central State Hospital and the CSBs in its service area began a pilot project with these funds, which involved the closure of 30 beds at the State hospital and the use of licensed hospitals to serve short-term "acute care" admissions. Although the CSBs which worked with Central State Hospital appear to have been the only recipients of the pilot project funding, CSBs in other parts of the State also were trying to reduce the use of State hospital beds by using licensed hospital beds.

Use of Licensed Hospital Beds Facilitated Census Reduction Efforts. The purchase of beds in licensed hospitals facilitated the Comprehensive Plan for the Restructuring of Virginia's Mental Health Care Programs and Facilities, which the Governor announced in January 2001. Language in the introduced budget for the 2001-2002 biennium directed the Commissioner of DMHMRSAS to work with CSBs to "develop and implement a plan to discharge eligible state hospital residents to the greatest extent possible, utilizing savings from gains in system efficiency" (2001 Introduced Budget, Item 323 B).

Reporting on the status of the settlement agreements with the Justice Department, the Commissioner of DMHMRSAS told the Senate Finance Committee in October 2001 that the use of State hospital beds had been reduced by 30 percent, on average. Because compliance with the Justice Department agreements required improved staff-to-patient ratios, there was a need to reduce the number of State hospital patients or increase staffing levels.

Because compliance with the Justice Department agreements required improved staff-to-patient ratios, there was a need to reduce the number of State hospital patients or increase staffing levels.

In his report to the Senate Finance Committee, the commissioner noted that a "delicate balance" had been struck between the demand for State hospital beds and the capacity of CSBs and licensed hospitals. The continued success of this effort was based on the availability of crisis stabilization and other emergency services, the use of assertive community treatment teams (discussed in Chapter 3), and the availability of licensed hospital beds.

Recent Study Noted That Number of Beds Was Adequate, but Mental Health System Was Strained. Given the growing importance of licensed hospital beds to the success of State hospital bed reductions, the 2002 Session of the General Assembly passed Senate Joint Resolution 94, which directed the Joint Commission on Be-

havioral Health Care, in conjunction with the Joint Commission on Health Care, to "study and recommend long term solutions to the shortage of inpatient psychiatric beds and the adequacy and access to outpatient mental health treatment." In November of 2002, the Access and Alternatives Work Group report—*Long-Term Solutions to the Shortage of Inpatient Psychiatric Beds and the Adequacy of Access to Outpatient Mental Health Treatment*—concluded that the State was experiencing a significant, systemic problem which was marked by "insufficient care capacity for Virginians in need of acute and long-term psychiatric services." The report noted that this problem "has less to do with a shortage of actual beds than with the availability and distribution of inpatient and outpatient resources."

Budgetary Pressures Appear to Have Accelerated Reinvestment Activities. This report came two months after the Governor's report to the Senate Finance, House Appropriations, and House Finance Committees on the projected shortfall of $1.5 billion for FY 2003. There was a resulting need to further reduce State expenditures, and DMHMRSAS proposed further State hospital bed reductions, with some of the savings being reinvested in community services (including purchases of licensed hospital beds) and other savings being used to meet the budget shortfall.

In December 2002, the Governor proposed regional reinvestment projects in five regions. The 2003 General Assembly endorsed the Governor's proposed "Community Reinvestment Initiative," and modified it to limit the FY 2004 projects to Western State, Eastern State, and Central State Hospitals. The legislature directed that $11.9 million in appropriations to these three State hospitals instead be given to the CSBs in their service areas "to expand community mental health, mental retardation, and substance abuse programs to serve patients in the community who are discharged or diverted from admission" (2003 Acts of Assembly, Chapter 1042, Item 329 P2). The General Assembly further stipulated that

> Local governments shall not become financially responsible for the regional reinvestment projects funded through this item. Local governments shall not be required to provide matching funds for regional reinvestment projects. The Commonwealth retains its long-standing financial responsibility for public acute inpatient psychiatric services (Item 329 P5).

Though not expressly set out in subsequent budgets, DMHMRSAS asserts that this funding has continued to flow to these three regions in subsequent fiscal years. Additionally, the General Assembly endorsed the continuation of similar projects in the other regions.

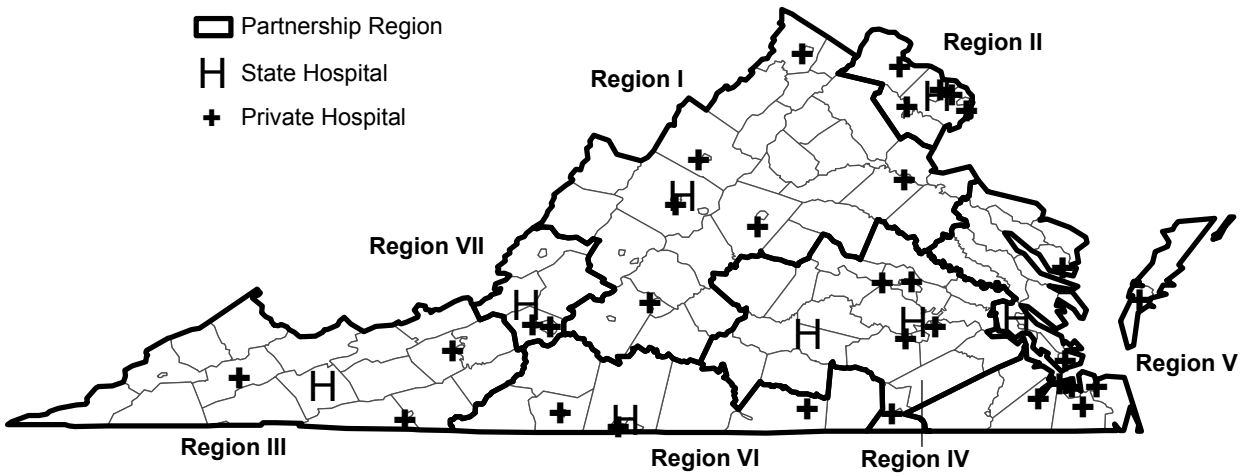
Seven Regional Partnerships Reduced State Hospital Bed Usage in Exchange for More Community Service Funding

To implement the regional reinvestment projects, DMHMRSAS divided the State into seven regions based on the service areas for the seven State hospitals (Figure 21). A regional partnership organization was created in each region to improve resource management around state facilities. Prior to the creation of these partnerships, some regional planning had occurred, but services do not appear to have been coordinated on a regional basis.

Regional Partnerships Determine How State Hospital Diversion Activities Are Implemented. The CSBs within each regional partnership have been working collectively to coordinate bed usage at State hospitals. In order to effectively manage admissions to their State hospital, CSBs in each region have entered into memoranda of understanding (MOU) with the State hospital in their assigned region. The MOUs have been used to create regional utilization committees, which consist generally of representatives from CSBs in the regional partnership, the State hospital, and sometimes licensed hospital staff.

Since Central State Hospital and the CSBs in its service area (Region IV) had developed experience as a result of the pilot project, their regional project was one of the first to begin. Starting in FY 2004, DMHMRSAS allowed the CSBs in Regions IV and V, acting as regional partnerships, to contract with licensed hospitals. The reason for this devolution was a belief that the regional partner-

Figure 21: Locations of Partnership Regions and State and Private Hospitals



Source: Analysis of data provided by the Department of Mental Health, Mental Retardation and Substance Abuse Services, and Virginia Health Information.

ships could negotiate a better per diem rate from the licensed hospitals than DMHMRSAS could obtain centrally. Starting in the summer of 2003, the project in Region IV consisted of two phases with a total reduction of 40 additional civil beds (one full civil unit) at Central State Hospital and a reinvestment of $2.8 million in general funds to be used for services provided by the CSBs.

Two other reinvestment projects, one based around Eastern State Hospital in Region V and one based around Western State Hospital in Region I, were also funded in FY 2004. In addition, a State-funded project based around the Northern Virginia Mental Health Institute (NVMHI) in Region II began in FY 2005. This project, which is called the Discharge Assistance and Diversion Program (DAD), differed somewhat because State hospital beds were not reduced. Instead, the purpose of DAD funding was to use community-based services, including purchasing beds at licensed hospitals, to keep individuals from needing a State hospital bed. This resulted from the fact that DMHMRSAS had previously identified a need for more State hospital beds at NVMHI. Projects followed in each of the other three regions. However, in these regions the CSBs in each partnership did not always receive reinvestment funding from the State hospital, because bed usage could not always be reduced.

Presently, every CSB in the State is taking part in one of the seven reinvestment regions. The CSBs in these regional partnerships are jointly responsible for managing the funding for several programs which appear largely designed to reduce the use of State hospital beds. These programs include

- Discharge Assistance Projects (DAP), which provide "aftercare" services to persons discharged from State hospitals;
- crisis stabilization programs, including System Transformation Initiative crisis stabilization programs; and
- the Local Psychiatric Inpatient Purchases of Services (LIPOS) program, and other CSB purchases of local inpatient psychiatric services.

It is difficult to determine what funding has been given to the CSBs in each regional partnership, and what programs are being done at a regional level, because DMHMRSAS does not appear to track or report on regional projects in a centralized and consistent manner.

LIPOS Program Has Been Used to Reduce Use of State Hospital Beds. One of the ways in which State hospital bed usage has been reduced is through the purchase of beds in licensed hospitals. This

funding comes from the Local Inpatient Purchase of Services (LIPOS) program, which is used to pay for licensed hospital beds purchased through contracts.

LIPOS contracts result from RFPs issued by each of the regional partnerships. Generally, a single CSB in each region acts as the fiscal agent for that partnership, and in that capacity a contract may be executed by that CSB with more than one licensed hospital.

The regional committees created as part of the MOU determine the eligibility criteria that must be satisfied in order for an individual's stay in a licensed hospital to be paid for with LIPOS funding. In practice, this occurs through a post facto review of the individuals who were prescreened by CSB staff during the civil commitment process and admitted to licensed hospital beds to determine if they were appropriate for LIPOS funding. Basically, a licensed hospital can be reimbursed through LIPOS if the patient meets the admission criteria for a State hospital but was instead "diverted" to the licensed hospital. To be eligible for LIPOS, therefore, the individual patient must meet certain criteria set by each regional committee. The committees also determine the number of days of a patient's stay in a licensed hospital that will be paid for with LIPOS funds. As is shown later in the chapter, some variation between regions does occur.

The fact that the committees determine who is eligible for LIPOS, and also authorize the number of days for which LIPOS funds will be used, is tied to the use of State hospitals. This is because the LIPOS contracts are intended to assist in reducing the use of State hospitals. However, at some point certain individuals may need to be admitted to a State hospital because the licensed hospital could not meet their needs.

LIPOS Is Now an Essential Part of Regional State Hospital Diversion in All Regions. Beginning in FY 2005, the General Assembly required the Commissioner of DMHMRSAS to submit an annual report to the legislature on LIPOS usage (2004 Acts of Assembly, Chapter 4). According to DMHMRSAS staff, this marks the first time that the department systematically tracked the purchase of inpatient beds from licensed hospitals. As of the 2005 report, 98 percent of LIPOS expenditures were being made on a regional basis (the other two percent is done through individual CSB contracts).

The budget language first adopted in 1999 remains in the budget (page 117), and the FY 2006 budget expressly added an additional $2.8 million to increase the purchase of inpatient beds from licensed hospitals. DMHMRSAS indicates that it has transferred

additional funding through the years as funding was available. The most recent available report on LIPOS expenditures indicates that around $12 million in funding was directed toward LIPOS in FY 2006.

LIPOS Allows Less Restrictive Care and Shorter Hospital Stays. LIPOS funding allows an individual to be cared for in a licensed hospital, which is a less restrictive and therefore more appropriate level of care than a State hospital bed. Since licensed hospitals focus on acute care, in contrast to the long-term care provided at State hospitals, their programs may be better designed for short inpatient stays and transfers to community services.

According to DMHMRSAS, in its FY 2006 *Annual Report on Community Services Board Contracts for Private Inpatient Psychiatric Treatment Services*, the use of LIPOS reduces State hospital expenditures because the average length of a patient's stay in a licensed hospital is one-eighth the length of stay in a State hospital. As can be seen in Table 20, the average LIPOS rate for licensed hospitals is $59 higher per day than the average daily cost of a State hospital bed. The shorter length of stay results in reduced cost despite the higher per diem cost.

Table 20: LIPOS Saves Money, Despite Higher Average Daily Rate, Because the Length of Stay in Licensed Hospitals Is Lower

	State Hospital Provided Services	LIPOS Provided Services
Length of Stay (Days)	47.2	5.4
Per Diem Cost	$557	$616
Bed Days Provided	540,224	19,678

Source: Department of Mental Health, Mental Retardation and Substance Abuse Services.

At the present time, the use of LIPOS contracts, and the relationships they establish with licensed hospitals is in different stages in different parts of the State. This results from the variation both in LIPOS funding and in the availability of licensed hospital beds. A comparison between the central region (Region IV) and the southwestern region (Region III) illustrates this point. The central region has more than three times as many licensed hospital beds per capita as the southwest region. As a result, the southwest region uses 57 percent more State bed days per capita than the central region. Conversely, CSBs in the central region receive funding to purchase three times as many LIPOS bed days per capita, in order to divert people from State hospital beds.

CONCERNS REGARDING LIPOS AFFECT WILLINGNESS OF LICENSED HOSPITALS TO CONTRACT WITH REGIONAL PARTNERSHIPS

Licensed hospital staff have three concerns about the LIPOS program. First, licensed hospital staff indicate that a lack of clarity about the appropriate use of LIPOS funding makes it difficult to determine if the funds are being spent appropriately. Second, a lack of guidelines about what eligibility criteria are appropriate make variation between regional LIPOS practices appear arbitrary. Third, LIPOS bed day rates are reported to be insufficient to cover hospital costs. These issues affect the willingness of licensed hospitals to continue to contract with the regional partnerships and participate in LIPOS.

Resolution of these concerns would appear to be in the best interest of the State because licensed hospital beds are vital to the success of current initiatives designed to reduce the use of State hospitals. According to DMHMRSAS,

> It is vitally important that funding for the purchase of local inpatient psychiatric treatment services delivered through contracts with private providers be maintained and even increased as Virginia moves to transform its public mental health, mental retardation, and substance abuse services system to serve individuals with serious mental illnesses most appropriately and effectively.

LIPOS Rates Do Not Cover All Costs

Licensed hospital staff assert that the rates paid by the regional partnerships are insufficient. According to the JLARC staff survey of licensed hospital costs and reimbursements, LIPOS rates reimbursed 81 percent of costs reported by licensed hospitals, with an average calculated reimbursement of $679. (These numbers exclude the three outlier hospitals discussed in Chapter 4.) This represents the reimbursement rate for individuals for whom LIPOS is the primary payer source for their hospital stay. In comparison to other payer sources, LIPOS rates reimburse a higher percentage of reported costs than Medicaid HMO and self-pay patients, but less than other primary payer sources.

Of note, the JLARC staff survey also indicated that CSB payments accounted for only three percent of all discharges, and two percent of all bed days. These percentages suggest that CSB payments do not have a substantial financial impact. As a result, it appears that licensed hospitals may be more concerned about the difficulty they reportedly face in obtaining funding for a patient through the LIPOS program.

Appropriate Use of LIPOS Funding Is Not Well-Defined

Other than general budget language, the proper use of LIPOS funding is not clearly defined. The goal of the program appears to be a reduction in the use of State hospital beds. If this is true, then the funding provided by the State could reasonably be used to provide any service that reduces State hospital bed use. However, DMHMRSAS has never clarified how the funds can be appropriately used. Instead, the department relies on Appropriation Act language, which states that the funds are to be used to contract with "community-based hospitals or other private health care providers" and that CSBs "will contract by competitive bidding with community-based hospitals for short-term psychiatric inpatient services."

The lack of clear and consistent policy statewide on the purpose of the LIPOS program is a concern for licensed hospitals because in the absence of a clear description of purpose, it is not possible to determine if the CSBs and regional partnerships are using LIPOS funds in an appropriate manner. For example, it is not clear if a CSB could appropriately use the funds to hire a psychiatrist at the CSB, even though this might reduce the use of the State hospital, because the purpose of the funding is not clear. Licensed hospitals expressed a desire for the mission of the program to be more clearly identified, preferably by the General Assembly, so that they can ensure that regional decisions are consistent with that mission.

Appropriateness of Regional Variation in Eligibility Requirements Is Unclear

Licensed hospital staff are concerned that there is no statewide policy on the requirements an individual must meet to be eligible for LIPOS-funded services. Because of this, licensed hospital staff assert that it is not clear if the apparent regional variation in eligibility criteria is reasonable. Although the existing variation in eligibility criteria may reflect regional variation in the availability of community services, licensed hospital staff are concerned that this may not always be the case.

Generally speaking, there appears to be a degree of consistency among the eligibility requirements in each region. All regions require an individual to meet the criteria for a temporary detention order (TDO) to be eligible. All regions also focus their LIPOS funds on the uninsured and underinsured.

There are, however, some differences in regional policies that raise questions about whether these funds are used appropriately. For example, the guidelines used by Region V state that no person who

has had insurance at any point during their hospital stay is eligible, while other regions will pay for a person whose insurance has run out. In addition, some regions will not pay for individuals who are admitted to a licensed hospital without assistance by CSB staff. In addition, one region will not allow LIPOS funds to pay for the hospital stay of anyone with a primary diagnosis of substance abuse.

DMHMRSAS Efforts to Guide Regions Have Been Inadequate

Until 2007, DMHMRSAS had not issued any guidelines or statement of purpose for how these State funds should be used. DMHMRSAS issued Regional Utilization Management guidelines in January 2007, which included a discussion of LIPOS, but the guidelines were not issued until after the regional partnerships were in effect. As described in the guidelines, they are meant to be "the first step in an iterative process through which each region ultimately will produce a set of utilization management processes." The guidelines are not proscriptive, but instead describe best practices and other considerations that the regional partnerships need to address in developing their own processes. In particular, LIPOS is only addressed in the guidelines in a section governing the disbursement of funds to the CSB that acts as the fiscal agent, and the use of these funds is not addressed.

DMHMRSAS has not collected regional LIPOS eligibility requirements, and appears to be unaware of what those requirements are and how they vary from region to region. Instead, DMHMRSAS only requires that the CSBs outline procedures for monitoring and managing regional programs in a regional memorandum of agreement which is not required to be submitted to the department. Moreover, DMHMRSAS does not collect diagnostic or demographic data on LIPOS-funded individuals, nor do the regional partnerships consistently maintain data on LIPOS-funded individuals. Because of the lack of data, and the absence of any clear guidelines on the purpose of the program or what eligibility criteria are reasonable, it is not possible to say whether or not the variation among regional partnerships is consistent with the mission of the program.

Recommendation (12). The Department of Mental Health, Mental Retardation and Substance Abuse Services should issue guidelines which outline the purpose of the Local Inpatient Purchase of Services program and clearly indicate which, if any, services other than acute psychiatric beds in licensed hospitals may be purchased with these funds.

Recommendation (13). The Department of Mental Health, Mental Retardation and Substance Abuse Services should provide guid-

ance to community services boards on eligibility requirements, and whether the procedures and eligibility definitions are consistent with the purpose of the program.

Recommendation (14). The Department of Mental Health, Mental Retardation and Substance Abuse Services should work collaboratively with the community services boards to develop a common data submission system for reporting on individuals served through the Local Inpatient Purchase of Services (LIPOS) program. This reporting system should be designed to allow the department to determine whether LIPOS programs are being operated according to the department's guidelines and whether regions are consistently applying their own guidelines.

ROLE OF THE REGIONAL PARTNERSHIPS HAS NOT BEEN APPROPRIATELY DEFINED

In addition to the concerns identified by licensed hospitals, as part of this review JLARC staff identified some problems with the way the regional partnerships were created. The creation of regional organizations reflects a distinct change in the manner in which CSBs have acted as the single point of entry into the publicly funded mental health system. In the past, CSBs were individually responsible for handling admissions and transfers to the State hospitals and working with licensed hospitals. Presently, a large portion of these responsibilities has been assigned to the regional partnerships. Despite the increasing role of these organizations in the mental health system, there is an inadequate statutory or regulatory framework to govern them.

Regional Partnerships Do Not Appear to Have Been Implemented Appropriately

In return for funding provided by DMHMRSAS, the CSBs must meet certain conditions set by the department in the statutorily-required annual performance contracts. The performance contract has several provisions that are required in statute. These include a delineation of "the responsibilities of the department and the community services board," and the specification of any "conditions that must be met for the receipt of state-controlled funds" (§ 37.2-508).

It is not clear, however, if DMHMRSAS has appropriately used its statutory authority regarding these contracts. DMHMRSAS encouraged the development of regions and currently requires participation in regional planning as a part of the performance contract. DMHMRSAS points to Appropriation Act language which endorsed the Governor's proposed "Community Reinvestment Ini-

tiative" as the basis for its authority to mandate the creation of the regional partnerships. This language states:

> It is the intent of the General Assembly that the Governor and the Department of Mental Health, Mental Retardation, and Substance Abuse Services continue working to restructure the mental health, mental retardation, and substance abuse system. Restructuring shall include collaboration with communities and other stakeholders to develop community reinvestment plans for addressing the care needs of individuals discharged or diverted from state facility care with appropriate services and supports (2003 Acts of Assembly, Chapter 1042, Item 329 P1).

Although legislative support for the creation of new regional organizations may have been implied, there is nothing in the language stating such.

Functions Assigned to Regions Do Not Appear to Have Sufficient Statutory Basis

As discussed in Chapter 1, CSBs are currently assigned the statutory responsibility of screening individuals for State hospital admission. This occurs as part of the civil commitment process. As provided for in § 37.2-805, CSBs are assigned the responsibility of coordinating voluntary admission, and the State facility must admit the person if the CSB and the State facility agree that the individual needs State hospital treatment. In addition, under the current statutory framework licensed hospitals can request that a committed patient be transferred to a State hospital through the provisions in § 37.2-840 (B), which states that

> If the guardian, conservator, or relative of a consumer in a licensed hospital refuses or is otherwise unable to provide properly for his care and treatment, the person in charge of the licensed hospital may... apply to the Commissioner for the transfer of the consumer to a state hospital.

A plain reading of the statutory language places responsibility for this decision with the Commissioner of DMHMRSAS. However, regional partnerships appear to currently be acting as gatekeepers to State hospital entry although this role is not contemplated in statute.

DMHMRSAS also asserts that because the regional partnerships are referenced in the annual performance contract these assigned responsibilities have a sufficient legal basis. In support of this, DMHMRSAS cites the following underlined language regarding CSB responsibilities from the 2007 Annual Performance Contract:

> The [Community Services] Board shall identify or develop jointly with the Department mechanisms, such as the Discharge Protocols, Extraordinary Barriers to Discharge lists, and reinvestment and restructuring projects and activities, and employ these mechanisms collaboratively with state hospitals that serve it to manage the utilization of state hospital beds.
>
> The [Community Services] Board shall implement, in collaboration with other Boards in its region and the state hospitals and training centers serving its region, the Regional Utilization Management Guidance document, adopted by the System Leadership Council on January 10, 2007 [emphasis in original].

The only other references in the contract are in sections that describe procedures involving the disbursement and reporting of funds. In an appendix, two examples are given of how a group of CSBs could form a regional partnership to manage LIPOS funded bed purchases. However, the responsibilities of these regional partnerships are not described in the contract, and the contractual language does not indicate to the local government that created the CSB that the reinvestment projects affect the CSB's role in State hospital admission.

The use of the performance contract to implement these organizations appears to undercut the legislative effort to improve accountability. In response to a legislative desire for greater accountability for the use of funds and the effectiveness of agency services, in 1998 the General Assembly made statutory modifications to the requirements of the annual performance contract. One of these statutory changes required CSBs to submit the contract to local governments for approval by "formal vote" prior to submitting it to DMHMRSAS. The CSBs and DMHMRSAS were also required to provide for a public notice and comment period on the terms of the contract. This shift of some responsibility to regional partnerships without statutory direction appears to be inconsistent with the intent of the legislative changes enacted in 1998 which sought to increase the accountability of CSBs to the local governments that created them.

During the 2006 session, the General Assembly enacted § 37.2-512, which gave CSBs the authority to form "joint agreements." This section states that

> A community services board may enter into joint agreements, pursuant to subdivision A 4 of § 37.2-504 with one or more community services boards or behavioral health au-

> thorities, to provide treatment, habilitation, or support services for consumers....

Additionally, the statute states that "no community services board shall be required to enter into a joint agreement pursuant to this section as a condition for the receipt of funds." This would appear to be in conflict with the description offered by DMHMRSAS that CSBs may only receive regional funds if they participate in regional planning activities. The statute also requires that the joint agreements be submitted to local government officials and be described in the performance contract. It is currently unclear as to what degree either of these activities are being performed.

The statute does contain permissive language that may form a sufficient statutory basis for the delegation of State hospital admission decisions from CSBs to the regional partnerships:

> No joint agreement shall relieve a community services board of any obligation or responsibility imposed upon it by law, but performance under the terms of a joint agreement may be offered in satisfaction of the obligation or responsibility of the community services board.

While this section may allow CSBs to manage State hospital entry as a part of a regional partnership, it is not explicitly stated in this statute. It is therefore unclear whether the State hospital transfer duties assigned to the commissioner in § 37.2-840, and the voluntary admission determination assigned to CSBs in § 37.2-805, can be assigned to the regional partnerships created pursuant to § 37.2-512. As a result, it appears that these regional partnerships act as gatekeepers for State hospital admission in a manner that is not clearly contemplated under current law or regulation.

Although these regional partnerships appear to have many beneficial aspects, it also appears as though their functions do not have a clear statutory basis. If the regional partnerships are to continue to perform these tasks, their role and responsibilities need to be established in the *Code of Virginia*.

Recommendation (15). The General Assembly may wish to consider amending § 37.2-512 of the *Code of Virginia* to clarify whether joint agreements between community services boards can be used to form regional partnerships. The General Assembly may wish to further clarify whether regional partnerships of community services boards may make decisions regarding State hospital admissions, and whether these admission decisions conform to the duties assigned to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services pursuant to § 37.2-840 and to the community services boards pursuant to § 37.2-805.

DMHMRSAS Is Not Adequately Planning and Monitoring Regional Admissions to State Hospitals

DMHMRSAS appears to do a sufficient job of tracking the number of admissions to and discharges from State hospitals. The department also appears to collect data regarding individuals housed in its facilities, including demographic data, number of bed days used, and the type of patient (forensic, geriatric).

However, according to DMHMRSAS staff, the department does not track denials of admission to the State hospitals. In some regions, this is tracked by the regional partnership. But this is not done in all regions nor is the same information consistently tracked or reported to DMHMRSAS. Without this information, it is impossible to ascertain the extent of demand for State hospital beds or whether persons are being appropriately admitted. As a result, DMHMRSAS lacks the tools to determine if the regional partnerships are appropriately approving and denying State hospital admissions, which is a task that is statutorily assigned to the CSBs.

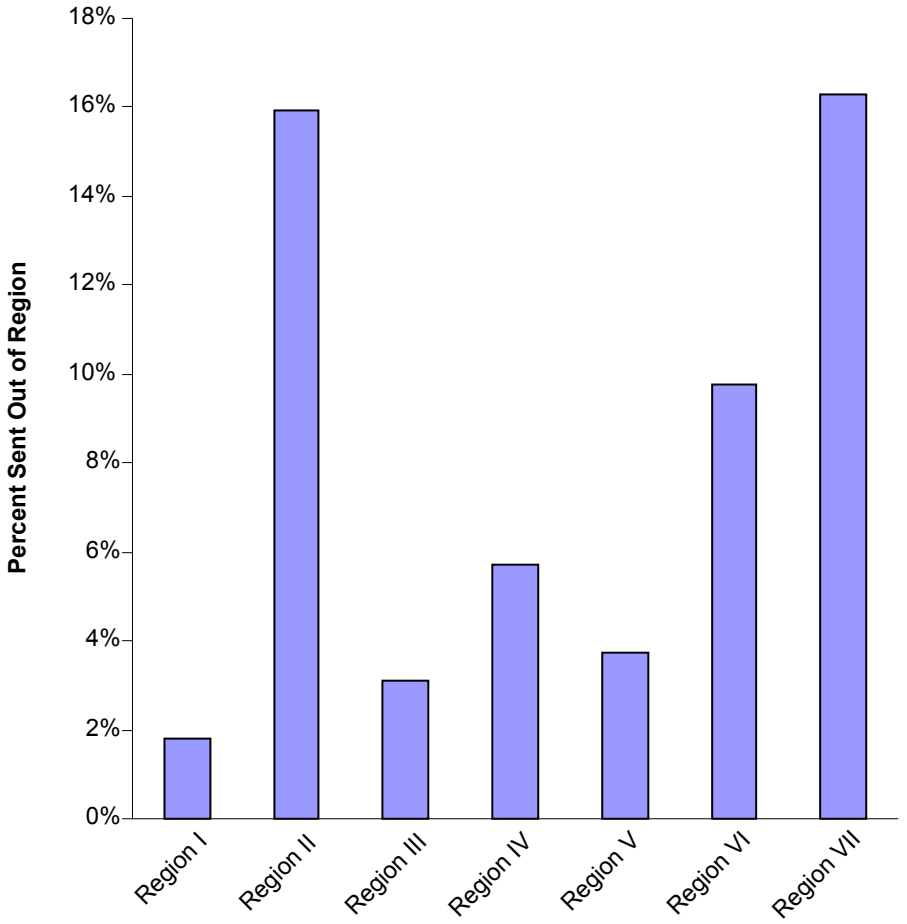
Recommendation (16). To allow for the Department of Mental Health, Mental Retardation and Substance Abuse Services to more fully monitor State hospital admissions and denials, the General Assembly may wish to modify § 37.2-703 of the *Code of Virginia* as follows: (b) An efficient system of keeping records concerning the consumers admitted to or residing in each state facility, *and of all requests for admission which were denied and the reasons for their denial.*

DMHMRSAS Should Monitor Interregional Bed Usage

Since regions are at different stages of development, some regions are more effectively diverting individuals from State hospitals for a variety of reasons. If reductions in State hospital utilization in one region leads to open beds at that facility, those beds could then be taken by individuals from other regions which have not reduced bed utilization. This creates the potential for regional cost-shifting and potential difficulty in inter-regional planning as the regional partnerships move forward in future years.

Currently, 6.7 percent of State hospital bed days for civil adult patients are being utilized by CSBs from outside of State hospitals' regional service areas. This varies by region, as can be seen in Figure 22. In addition, because geriatric patients, children, and forensic patients have regional service areas that differ from the regional boundaries, these groups present an opportunity for regional cost-shifting, and may hinder inter-regional planning. (For example, although Region II works most directly with the

Figure 22: Regional Placement of Civil Adults in State Hospitals Out of Region Varies



Source: Analysis of data from the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Northern Virginia Mental Health Institute, CSBs in that region regularly send consumers to Western State Hospital in Region I, and send all of their geriatric consumers to Eastern State Hospital in Region V.) Moreover, there is no regional planning for the groups of patients that regularly use facilities outside of their home region. If no structure exists to govern out-of-region placements, partnership-style planning will not take place for these patient groups.

DMHMRSAS does submit monthly and annual reports to the General Assembly on CSB usage of State hospital bed days. However, the reports are currently based on the Virginia Department of Health's health planning regions, which have no relevance to the regional partnership boundaries. If the regional partnerships are

now the primary structure for State hospital bed planning, then bed usage needs to be tracked on the basis of these regions.

Recommendation (17). The Department of Mental Health, Mental Retardation and Substance Abuse Services should seek to encourage interregional planning with regard to State hospital bed usage. In order to determine whether interregional cost-shifting is or will be a significant issue, the department should annually monitor the extent to which individuals are placed in State hospitals outside of their home region.

List of Recommendations:

Availability and Cost of Licensed Psychiatric Services in Virginia

1. The Virginia Department of Health should begin using geographic information system (GIS) software to determine the extent to which 95 percent of the population lives within one hour of the medical service under consideration as part of the department's analysis of the need for medical services in reviewing requests for Certificates of Public Need.

2. The General Assembly may wish to provide additional funding for crisis stabilization centers, mobile crisis treatment teams, and assertive community treatment teams.

3. The General Assembly may wish to direct the Department of Medical Assistance Services to study and report back to the House Appropriations and Senate Finance Committees prior to the 2009 General Assembly Session on the advisability of adopting regional adjustments in the rates for physician services in order to attract psychiatrists to medically underserved areas.

4. The General Assembly may wish to direct the Board of Medical Assistance Services to amend the State Plan of Medical Assistance Services governing Medicaid reimbursements for freestanding psychiatric hospitals licensed as hospitals to include the rates in the hospital rebasing process.

5. The General Assembly may wish to direct the Department of Medical Assistance Services to study and report back to the House Appropriations and Senate Finance Committees prior to the 2009 General Assembly Session on the advisability of adopting weighted per diem rates and outlier payments for inpatient acute care psychiatric services.

6. The General Assembly may wish to amend § 37.2-809 (E) of the *Code of Virginia* to state, "The costs incurred as a result of the hearings and by the facility in providing services during the period of *emergency custody and* temporary detention shall be paid and recovered pursuant to § 37.2-804." This amendment would clarify that licensed hospitals may be paid for services rendered during an emergency custody order.

7. The Department of Medical Assistance Services should revise the language in Appendix B of its *Hospital Provider Manual*, which pertains to temporary detention orders, to clarify whether the department will reimburse providers from the In-

voluntary Mental Commitment Fund for services provided as part of a medical screening, and to provide a definition of a medical screening. In developing this definition, the Department of Medical Assistance Services should consult with the Department of Mental Health, Mental Retardation and Substance Abuse Services.

8. The Board of Medical Assistance Services should adopt regulations to establish a reasonable rate per day for payments from the Involuntary Mental Commitment Fund for services rendered during temporary detention orders, as required by § 37.2-809 of the *Code of Virginia*, and use the regulatory process to establish reasonable reimbursement criteria.

9. The General Assembly may wish to direct the Department of Medical Assistance Services to amend the State Plan of Medical Assistance Services to include inflation adjustments for the rates for professional psychiatric services.

10. The State Mental Health, Mental Retardation and Substance Abuse Services Board should develop regulations to institute preadmission screening as directed by § 37.2-823 of the *Code of Virginia* and use these regulations to establish admission criteria.

11. The Department of Mental Health, Mental Retardation, and Substance Abuse Services should initiate formal planning tied to the State capital funding process to project the number of civil and forensic beds provided in each State hospital, and publish an annual report on bed need projections for each facility. This should be done collaboratively with agencies in the criminal justice system to adequately plan for forensic bed needs.

12. The Department of Mental Health, Mental Retardation and Substance Abuse Services should issue guidelines which outline the purpose of the Local Inpatient Purchase of Services program and clearly indicate which, if any, services other than acute psychiatric beds in licensed hospitals may be purchased with these funds.

13. The Department of Mental Health, Mental Retardation and Substance Abuse Services should provide guidance to community services boards on eligibility requirements, and whether the procedures and eligibility definitions are consistent with the purpose of the program.

14. The Department of Mental Health, Mental Retardation and Substance Abuse Services should work collaboratively with the community services boards to develop a common data submission system for reporting on individuals served through the Local Inpatient Purchase of Services (LIPOS) program. This re-

porting system should be designed to allow the department to determine whether LIPOS programs are being operated according to the department's guidelines and whether regions are consistently applying their own guidelines.

15. The General Assembly may wish to consider amending § 37.2-512 of the Code of Virginia to clarify whether joint agreements between community services boards can be used to form regional partnerships. The General Assembly may wish to further clarify whether regional partnerships of community services boards may make decisions regarding State hospital admissions, and whether these admission decisions conform to the duties assigned to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services pursuant to § 37.2-840 and to the community services boards pursuant to § 37.2-805.

16. To allow for the Department of Mental Health, Mental Retardation and Substance Abuse Services to more fully monitor State hospital admissions and denials, the General Assembly may wish to modify § 37.2-703 of the *Code of Virginia* as follows: (b) An efficient system of keeping records concerning the consumers admitted to or residing in each state facility, *and of all requests for admission which were denied and the reasons for their denial.*

17. The Department of Mental Health, Mental Retardation and Substance Abuse Services should seek to encourage interregional planning with regard to State hospital bed usage. In order to determine whether interregional cost-shifting is or will be a significant issue, the department should annually monitor the extent to which individuals are placed in State hospitals outside of their home region.

Appendix A Study Mandate

Senate Joint Resolution No. 185
2006 SESSION

Directing the Joint Legislative Audit and Review Commission to study the use and financing of licensed inpatient psychiatric facilities in the Commonwealth. Report.

Agreed to by the Senate, February 14, 2006
Agreed to by the House of Delegates, March 6, 2006

WHEREAS, pursuant to Title 37.2 of the Code of Virginia, the Department of Mental Health, Mental Retardation and Substance Abuse Services is established as the state authority for mental health, mental retardation, and substance abuse services; and

WHEREAS, as part of its mission to improve Virginia's system of care for individuals and their families whose lives are affected by mental illness, mental retardation, and substance abuse, the Department has developed an Integrated Strategic Plan (ISP), *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System*, that provides a framework for transforming Virginia's publicly funded mental health, mental retardation, and substance abuse services system; and

WHEREAS, the ISP identifies certain factors critical to successful implementation, including that "publicly funded services and supports that meet growing mental health, mental retardation, and substance abuse services needs are available and accessible across Virginia" and that "funding incentives and practices support and sustain quality care focused on individuals receiving services and supports, promote innovation and assure efficiency and cost-effectiveness"; and

WHEREAS, the ISP identifies as one of its priorities to "align administrative, funding and organizational processes to make it easier for individuals and families to obtain the services and supports they need"; and

WHEREAS, child and adolescent mental health services are a vital component of the mental health, mental retardation and substance abuse services system; and

WHEREAS, Medicaid payments, Community Services Board (CSB) contracts, and payments for individuals treated in hospitals under temporary detention orders account for a considerable amount of the total activity in licensed psychiatric hospitals, and publicly available data indicates that these three state funding streams currently cover, at most, about 70% of the cost of services provided; and

WHEREAS, licensed inpatient psychiatric facilities are further affected by constraints imposed by other third-party payors as well as the rising number of uninsured patients they treat; and

WHEREAS, the *Annual Report on Community Services Boards Contracts for Private Inpatient Psychiatric Treatment Services July 1, 2004-June 30, 2005*, prepared by the Department of

Mental Health, Mental Retardation and Substance Abuse Services, found that in FY2005 more individuals were served through CSB contracts with licensed inpatient psychiatric facilities than in state hospitals; and

WHEREAS, the *Annual Report* also concluded that "It is vitally important that funding for the purchase of local inpatient psychiatric treatment services delivered through contracts with private providers be maintained and even increased as Virginia moves to transform its public mental health, mental retardation, and substance abuse services system"; and

WHEREAS, financial pressures on licensed acute care psychiatric hospitals have led to the closure of approximately 600 beds in Virginia between 1991 and 2005; and

WHEREAS, the existence of an adequate number of licensed psychiatric beds, including child and adolescent beds, is a key factor in the long-term success of Virginia's initiative to transform its mental health, mental retardation, and substance abuse services system; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be directed to study the use and financing of licensed inpatient psychiatric facilities in the Commonwealth.

In conducting its study, the Commission shall (i) examine utilization trends, including sources of payment; (ii) evaluate the Medicaid rate-setting process for psychiatric services, services provided under temporary detention orders, and services provided by psychiatrists; (iii) evaluate the manner in which Community Services Boards contract with licensed psychiatric facilities; (iv) examine the adequacy of and funding for licensed psychiatric beds, including child and adolescent mental health services; and (v) determine any steps that can be taken to maintain appropriate and necessary licensed psychiatric services in Virginia.

Technical assistance shall be provided to the Commission by the Secretary of Health and Human Resources, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Virginia Association of Community Services Boards, and the Virginia Hospital & Healthcare Association. All agencies of the Commonwealth shall provide assistance to the Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its meetings for the first year by November 30, 2006, and for the second year by November 30, 2007, and the chairman shall submit to the Division of Legislative Automated Systems an executive summary of its findings and recommendations no later than the first day of the next Regular Session of the General Assembly for each year. Each executive summary shall state whether the Commission intends to submit to the General Assembly and the Governor a report of its findings and recommendations for publication as a House or Senate document. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website.

Appendix B

Research Activities and Methods

Key research activities for this study included

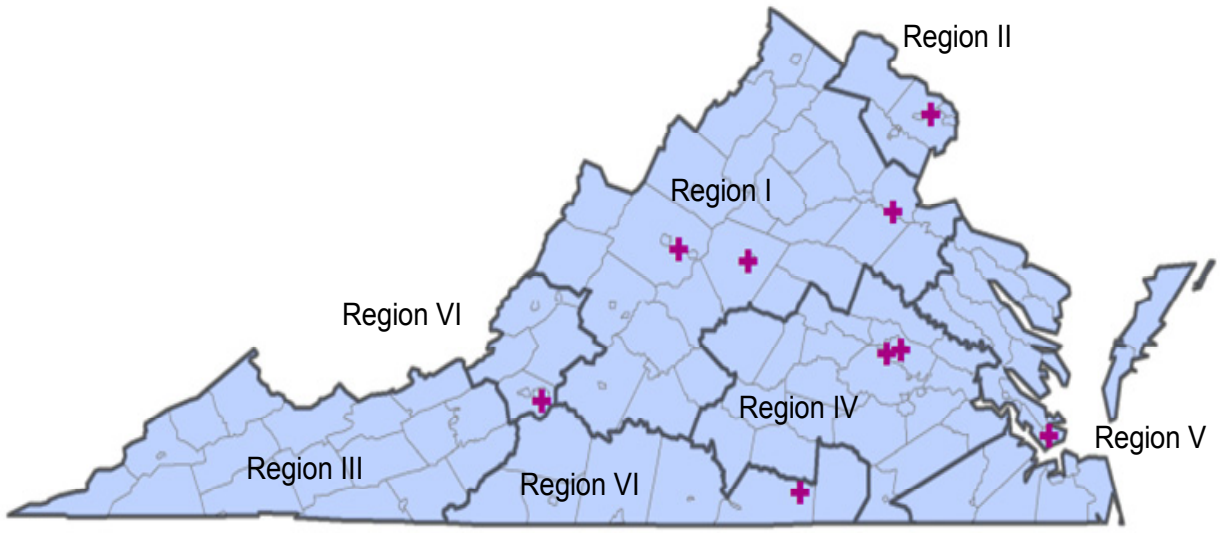
- site visits to licensed psychiatric hospitals and local community services boards;
- survey and analysis of licensed psychiatric hospitals' financial and demographic data;
- quantitative analyses of Virginia Health Information (VHI) data;
- analysis of VHI bed utilization data;
- review of contracts between licensed psychiatric hospitals and community services boards;
- review of Medicaid rate-setting process for psychiatric services;
- structured interviews; and
- review of mental health literature, regulations, and policies.

SITE VISITS TO LICENSED HOSPITALS AND LOCAL COMMUNITY SERVICES BOARDS

JLARC staff visited nine licensed psychiatric hospitals to identify their most pressing financial issues, specific causes of financial challenges, and potential solutions that may alleviate existing challenges. These interviews provided some additional qualitative validation for the results of the financial analysis described in more detail below.

In addition, JLARC staff also visited 12 local community services boards (CSBs) to obtain additional insight regarding the availability of outpatient psychiatric services in their community, as well as the role of CSBs in providing emergency services for persons with mental health needs. Specific topics discussed during these site visits are listed in Table 1 below.

Figure 1: Location of Licensed Hospitals Visited by JLARC Staff and the Regional Partnerships in Which They Are Located



Source: JLARC staff.

Table 1: Topics Discussed During JLARC Staff Site Visits to Licensed Psychiatric Hospitals and Local Community Services Boards

	Licensed Hospitals	Community Services Boards
Financial expectations and constraints related to providing psychiatric services	√	
Types of psychiatric services more likely not to be reimbursed	√	
Difficulty finding beds for persons who come into the emergency department	√	
Role of inpatient psychiatric facilities, CSBs, and State facilities regarding the types of services they should provide	√	√
Contract agreements between licensed hospitals and CSBs	√	√
Types of psychiatric patients hospitals have trouble discharging due to a lack of community-based services	√	
Availability of and access to outpatient services in the community to minimize the need for inpatient hospitalizations and provide a step-down level of service after discharge from a hospital	√	√
Adequate number of inpatient psychiatric and State facility beds in the area	√	√
Adequate access to State facilities for all patients whom need to be transferred	√	
Concerns about the TDO process as it affects the availability of acute care beds	√	
Shortage of psychiatrists	√	
Concerns regarding licensed hospitals refusing to admit certain types of persons with mental health needs		√
Role of CSB in providing psychiatric services for persons in emergency rooms and after discharge from a hospital	√	√
Barriers to providing the type and level of emergency services to persons with mental health needs		√
Use of LIPOS funding		√

SURVEY OF PSYCHIATRIC FACILITIES' AND EMERGENCY DEPARTMENTS' COST AND REIMBURSEMENT DATA

JLARC staff surveyed 35 hospitals with licensed inpatient psychiatric beds for discharge-level financial and demographic data. JLARC staff also surveyed the emergency departments (ED) within these licensed hospitals for similar financial data associated with all psychiatric patients seen in the ED regardless of whether they were admitted to the hospital. This data was requested to allow JLARC staff to portray a more complete financial picture of licensed hospitals that provide both inpatient and outpatient psychiatric services. However, during the exposure process of this report, the Department of Medical Assistance Services (DMAS) expressed concern regarding the validity of the ED cost and reimbursement data and recommended excluding this data from the report. DMAS staff explained that EDs would not be reimbursed for the costs of patients who are subsequently admitted to the hospital's psychiatric unit. Instead, the psychiatric facility would receive reimbursement for these costs. The Virginia Hospital and Healthcare Association (VHHA) conferred with major hospital organizations and submitted a letter to JLARC staff indicating that the emergency department cost and reimbursement data are reliable and reflect an accurate picture of the financial losses incurred. Therefore, JLARC staff decided to include the analysis results of the ED financial data in this report.

In addition to these recommendations from DMAS, JLARC staff primarily relied on input from a technical advisory panel (TAP) comprised of psychiatric administrators in developing the surveys that each hospital was responsible for completing. VHHA organized the TAP, which consisted of 14 psychiatric facility administrators who provided JLARC staff with input on data availability, consistency, and methodology. In particular, JLARC staff addressed four main objectives with the panel: (1) examined the feasibility of providing patient-level cost and revenue data; (2) determined an appropriate timeframe to capture potential variation in hospitals' funding across all payers; (3) identified all sources of costs and revenue for psychiatric services; and (4) developed methodology for quantifying each cost and revenue data element consistently across hospitals.

Table 2 includes a listing of the panel members. Twelve of the 14 panel members represented general hospitals with a psychiatric unit. The remaining hospitals represented two of the five freestanding psychiatric hospitals in Virginia.

Using the input obtained from the TAP, JLARC staff requested cost and reimbursement data of licensed hospitals (described below) for all psychiatric discharges assigned to a licensed psychiat-

ric bed and discharged during calendar year 2005. JLARC staff also requested patient-specific data for each psychiatric discharge, such as demographic information, length of stay, and primary and secondary payer sources.

Table 2: Technical Advisory Panel Provided JLARC With Input on Surveys of Psychiatric Facilities and Emergency Departments

Psychiatric Facility	Location	Type of Facility
Augusta Medical Center	Staunton	General Hospital
Bon Secours	Richmond	General Hospital
Carilion Behavioral Health	Roanoke	General Hospital
Centra Health	Lynchburg	General Hospital
Chesapeake General Hospital	Chesapeake	General Hospital
Community Memorial Health Center	South Hill	General Hospital
HCA -- Tucker Pavilion (CJW)	Richmond	General Hospital
Inova Fairfax Hospital	Falls Church / Fairfax	General Hospital
Memorial Hospital	Martinsville	General Hospital
Riverside Behavioral Health Center	Newport News	Freestanding
Sentara Norfolk General Hospital	Norfolk	General Hospital
Snowden	Fredericksburg	Freestanding
University of Virginia Medical Center	Charlottesville	General Hospital
Virginia Commonwealth University	Richmond	General Hospital

Table 3 includes a list of the 35 licensed hospitals that were surveyed. Twenty-six of the 35 hospitals responded to the JLARC staff financial survey. Table 4 includes summary information on the percentage of psychiatric bed days and discharges that these hospitals represent.

Direct and Indirect Costs

JLARC staff requested both direct and indirect costs (Table 5) associated with each patient assigned to a licensed psychiatric bed. In order to standardize the types of costs reported by hospitals, the JLARC staff surveys included detailed instructions on the methodology and assumptions used for each data element. Examples of direct costs requested are those incurred through providing a specific type of service, such as the cost of supplies used in diagnosis and treatment, labs performed during a patient's stay, or of providing psychiatric treatment. Typical hospital costs also include indirect items incurred to operate through the entire hospital, such as rent, utilities, or salaries of administrators. Although these indirect costs are not as closely tied in to patient care, these expenditures are incurred by psychiatric units. Therefore, JLARC staff allocated these indirect costs reported by licensed hospitals using a ratio of each psychiatric patient's length of stay (or total bed days) as a

Table 3: JLARC Staff Surveyed 35 Hospitals With Licensed Inpatient Psychiatric Beds

Hospital Name	Number of Psychiatric Discharges (FY 2006)	Type of Hospital	Tax Status
Chippenham Johnston-Willis Hospital	4,013	General	Proprietary
Virginia Beach Psychiatric Center	3,727	Freestanding	Proprietary
Bon Secours Maryview Medical Center	2,661	General	Not-for-profit
Riverside Behavioral Health Center	2,440	Free-Standing	Not-for-profit
Lewis-Gale Medical Center	2,178	General	Proprietary
VCU Health System	2,166	Teaching	Not-for-profit
Virginia Baptist Hospital	1,972	General	Not-for-profit
Poplar Springs Hospital	1,925	Freestanding	Proprietary
Carilion Roanoke Memorial Hospital	1,745	General	Not-for-profit
Inova Fairfax Hospital	1,645	General	Not-for-profit
Bon Secours St. Mary's Hospital	1,641	General	Not-for-profit
Bon Secours Richmond Community Hospital	1,629	General	Not-for-profit
University of Virginia Medical Center	1,512	Teaching	Not-for-profit
Dominion Hospital	1,497	Freestanding	Proprietary
Southside Regional Medical Center	1,380	General	Proprietary
Snowden At Fredericksburg	1,370	Freestanding	Proprietary
Carilion New River Valley Medical Center	1,305	General	Not-for-profit
Prince William Hospital	1,294	General	Not-for-profit
Inova Mount Vernon Hospital	1,109	General	Not-for-profit
Winchester Medical Center	1,056	General	Not-for-profit
Sentara Norfolk General Hospital	1,048	General	Not-for-profit
Augusta Medical Center	1,047	General	Not-for-profit
Virginia Hospital Center	983	General	Not-for-profit
John Randolph Hospital	917	General	Proprietary
Rockingham Memorial Hospital	887	General	Not-for-profit
Danville Regional Medical Center	832	General	Not-for-profit
Inova Loudoun Hospital Center	778	General	Not-for-profit
Memorial Hospital (Martinsville)	716	General	Proprietary
Community Memorial Healthcenter	711	General	Not-for-profit
Russell County Medical Center	587	General	Proprietary
Chesapeake General Hospital	563	General	Not-for-profit
Twin County Regional Hospital	328	General	Not-for-profit
Obici Hospital	281	General	Not-for-profit
Rappahannock General Hospital	217	General	Not-for-profit
Shore Memorial Hospital	216	General	Not-for-profit
TOTAL	**48,376**		

Source: Analysis of Virginia Hospital and Healthcare Association and Virginia Health Information data.

Table 4: Seventy-Four Percent of Hospitals With Licensed Inpatient Psychiatric Beds in Virginia Responded to JLARC Staff's Financial Survey

	Hospitals Surveyed by JLARC Staff			Hospitals That Responded to JLARC Staff Financial Survey		
Type of Hospital	Number of Hospitals	Total Number of Bed Days (CY 2005)	Total Number of Psychiatric Discharges (CY2005)	Number of Hospitals	Percent of Bed Days	Percent of Psychiatric Discharges
Teaching	2	31,387	3,784	2	100%	100%
Freestanding	5	123,161	10,889	3	45	61
General	28	209,406	33,459	21	78	79
TOTAL	**35**	**363,954**	**48,132**	**26**	**69**	**76**

Source: Analysis of Virginia Hospital and Healthcare Association and Virginia Health Information data.

percentage of the total number of psychiatric beds days across all patients in 2005.

Table 5: Costs Reported By Psychiatric Hospitals

Direct Costs	Indirect Costs
Psychiatric Unit	Salary overhead
Pharmacy	Rent
Lab	Utilities
Therapy	Depreciation expense
Diagnostic equipment	Purchase services
Procedures	Administration
Supplies	Supplies overhead
Other	Transportation costs
	Other

Source: Analysis of psychiatric facility financial survey data (2005).

Direct and Indirect Revenue

In order to determine how much total revenue licensed hospitals received for the care they provided to psychiatric patients, JLARC staff also requested both direct reimbursements and indirect revenue (Table 6). Direct reimbursements refer to those payments received from the patients' primary and secondary (if applicable) payer sources. For example, a psychiatric patient may have commercial insurance, which would be their primary payer source. However, if this patient submits an additional payment to the hospital that was not covered by their insurance (as indicated on patient's bill sent by the hospital), this payment would be categorized as a secondary payer source of "self-pay."

Table 6: Revenue Reported By Psychiatric Hospitals

Direct Revenue	Indirect Revenue
Reimbursements	Lump-Sum Hospital-Wide Payments
HMO/PPO/Commercial	Medicaid DSH payments
Medicare	Medicare DSH payments
Medicaid	Indigent Health Care Fund
Worker's Comp	All Other
State Local Hosp. Program	
Self-Pay	
TDOs	
CSB per diem payment	
CSB funding for pre-purchased beds	
All Other	

Source: Analysis of psychiatric facility financial survey data (2005).

In addition to these direct reimbursements, hospitals may qualify for additional funding based on their total number of Medicaid inpatient bed days or amount of charity care provided. As described in Chapter 4, the programs currently in place to mitigate the amount of otherwise uncompensated care provided by hospitals are (Exhibit 1): (1) Disproportionate Share Hospital (DSH) program, (2) State and Local Hospitalization (SLH) program, and (3) the Indigent Health Care Trust Fund (IHCTF). Hospitals are awarded funding from these programs to help offset some of the costs resulting from Medicaid losses and uninsured indigent patients.

Exhibit 1: Description of Public Funding Available to Partially Offset the Cost of Uncompensated Care

Disproportionate Share Hospital (DSH) payments

- The Medicaid and Medicare DSH programs make lump-sum payments to eligible hospitals based on Medicaid and Medicare utilization and estimated operating expenditures.
- Medicaid funds the largest portion of DSH payments, although Medicare has a similar but much smaller program.
- DSH payments are made hospitals to help compensate for their Medicaid losses.
- The magnitude of DSH payments is determined by the proportion of services provided to Medicaid patients

State and Local Hospitalization (SLH) program

- Hospitals may also receive funding through the SLH program when indigent patients qualify for the program.
- SLH is a venture between State and local governments that provides health care coverage to indigent patients who are not eligible for Medicaid.
- Because the program is capped, hospitals are not reimbursed for all eligible claims
- The State's Medicaid agency, the Department of Medical Assistance Services (DMAS), administers the Fund. DMAS staff have indicated that the funds are usually exhausted by mid-year.

Indigent Health Care Trust Fund (IHCTF)

- Hospitals that provide a certain amount of charity care (the amount in excess of the median level of charity care provided by all hospitals in the State) receive a lump-sum payment through the IHCTF to partially cover the cost of providing this care.
- Those hospitals that provide charity care below the median must contribute to the fund.
- The amount of funds available under the program is capped, and typically falls short of fully funding the amount of indigent care provided by hospitals every year.

Source: JLARC report: The *Use and Financing of Trauma Centers in Virginia*, 2004.

For purposes of the JLARC staff survey, State and Local Hospitalization was reported as a direct reimbursement source because these payments were tied to individual psychiatric patients. However, DSH and IHCTF were lump-sum payments made to hospitals, which were then allocated to individual psychiatric patients based on the number of bed days for each patient. If a hospital re-

ceived IHCTF payments, JLARC staff allocated this revenue to uninsured psychiatric patients, whereas DSH payments were allocated to help offset losses from both Medicaid and uninsured patients. (Table 7 includes a list of hospitals surveyed by JLARC staff and whether they received DSH funding.)

Table 7: Hospital-Wide DSH Medicaid Payments Made to Licensed Hospitals in 2005

	DSH Amount
Augusta Medical Center	
Bon Secours Maryview Medical Center	
Bon Secours Richmond Community Hospital	$348,318
Bon Secours St. Mary's Hospital	
Carilion Roanoke Memorial Hospital	$1,022,481
Chesapeake General Hospital	
Chippenham Hospital	
Community Memorial Healthcenter	
Danville Regional Medical Center	
Dominion Hospital	
Inova Fairfax Hospital	
Inova Loudoun Hospital Center	
Inova Mount Vernon Hospital	
John Randolph Hospital	$192,904
Lewis-Gale Medical Center	
Memorial Hospital of Martinsville & Henry County	
Obici Hospital	
Poplar Springs Hospital	
Prince William Hospital	
Rappahannock General Hospital	
Riverside Behavioral Health Center	
Rockingham Memorial Hospital	
Russell County Medical Center	$189,484
Sentara Norfolk General Hospital	$3,832,229
Shore Memorial Hospital	
Snowden At Fredericksburg	
Southside Regional Medical Center	
Twin County Regional Hospital	
University of Virginia Medical Center	$5,971,408
VCU Health System	$11,719,882
Virginia Baptist Hospital	
Virginia Beach Psychiatric Center	
Virginia Hospital Center	
Winchester Medical Center	
TOTAL	**$23,276,706**

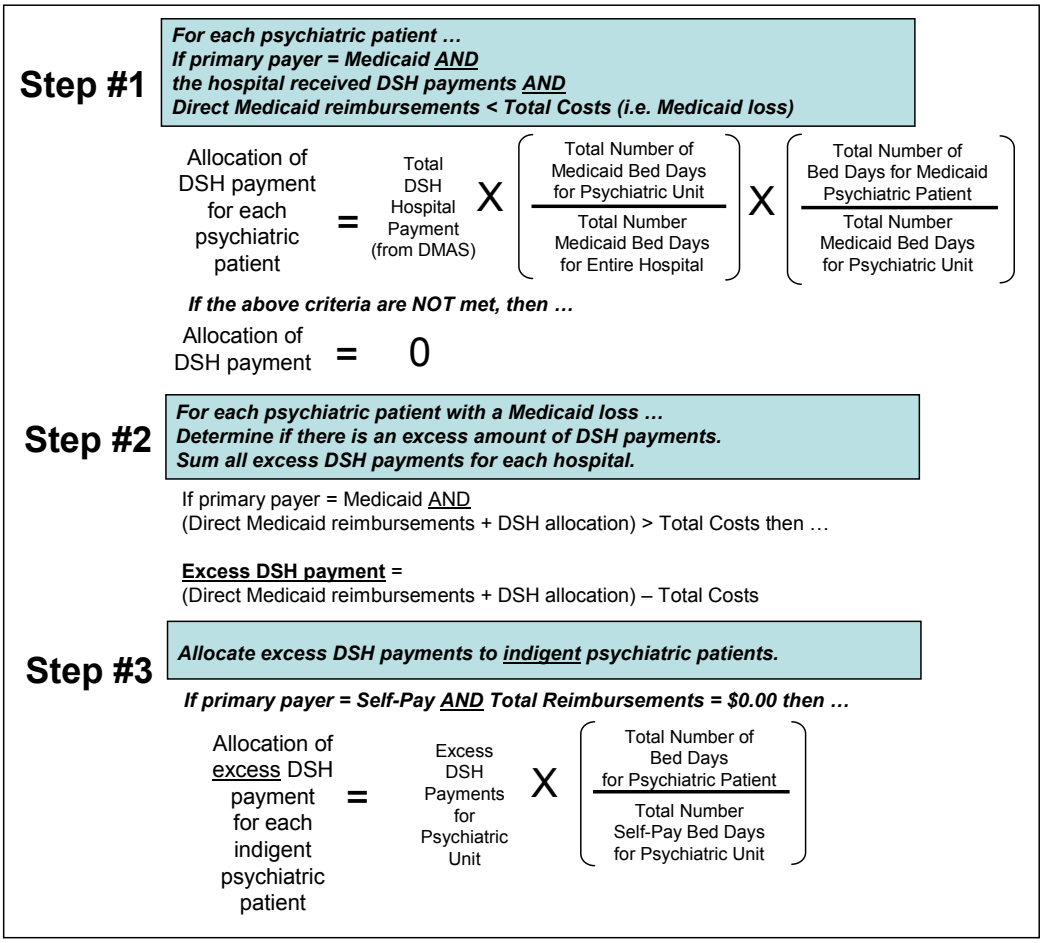
Source: Department of Medical Assistance Services and licensed hospitals.

Allocation of DSH Payments to Offset Medicaid Losses and Uncompensated Care Provided to Uninsured. As mentioned above, a hospital may receive DSH payments based on its hospital-wide Medicaid utilization and estimated operating expenses. Although these payments are not specifically designed to offset the costs of treating only psychiatric patients, hospitals have the option to utilize a

portion of these funds to reduce the amount of unreimbursed costs of their psychiatric unit.

JLARC staff requested total DSH hospital payments from the Department of Medical Assistance Services (DMAS) for all 35 hospitals surveyed. If a hospital received DSH, JLARC staff allocated a portion of this hospital-wide payment to the psychiatric unit based on the number of psychiatric Medicaid bed days. This methodology was used because hospitals qualify for DSH based on the total number of Medicaid inpatient bed days, which includes those of psychiatric Medicaid patients. JLARC staff then allocated the psychiatric portion of DSH to all psychiatric Medicaid patients whose direct Medicaid reimbursements did not cover the total cost for that patient. Figure 2 provides an illustration of JLARC staff's methodology for allocation DSH payments.

Figure 2: JLARC Staff Methodology for Allocating DSH Medicaid Payments



Note: JLARC staff used the same methodology to allocate Medicare DSH payments.

Source: JLARC staff.

JLARC staff also requested total Graduate Medical Education (GME) hospital payments from DMAS for all 35 hospitals to be included in the financial analysis. GME payments are another source of indirect revenue that helps offset unreimbursed costs incurred by a hospital that trains medical residents. However, because no licensed hospital reported a separate indirect cost amount for their GME expenses, DMAS staff recommended that JLARC staff exclude GME payments from the financial analysis since the sole purpose of this funding (as explained by DMAS) is to pay for the salaries of medical residents in the hospital. Therefore, GME payments were not included in the financial analysis presented in this report.

JLARC staff obtained advice from DMAS staff and members of the Technical Advisory Panel (TAP) regarding the allocation methodology prior to allocating the DSH payments to psychiatric patients. DMAS staff recommended that DSH payments be allocated first to psychiatric patients with a Medicaid loss, or where direct Medicaid reimbursements do not cover total costs. Subsequently, according to DMAS, if a hospital's DSH payments cover the total costs of their Medicaid patients, the hospital may use any excess payments to offset the otherwise uncompensated care provided to indigent psychiatric patients. Therefore, as illustrated in Figure 2, for each Medicaid psychiatric patient that received an allocation of DSH payments, JLARC staff determined whether there was any excess revenue from these payments, or where total revenue exceeded total costs. JLARC staff then allocated this excess revenue to self-pay psychiatric patients with no ability to pay, or where total reimbursements equaled zero. The TAP concurred with this methodology for allocating the DSH payments.

Overall, these additional DSH payments did not cover the total costs of caring for indigent psychiatric patients in 2005. Of the $11 million of indirect revenue that JLARC staff allocated among psychiatric facilities, 18 percent was allocated to uninsured indigent psychiatric patients. However, even though psychiatric facilities treat uninsured indigent patients, they may not receive a portion of this additional funding to offset their costs of providing care to uninsured indigent psychiatric patients.

FINANCIAL ANALYSIS OF LICENSED HOSPITALS' COST AND REIMBURSEMENT DATA

JLARC staff did not audit the cost and revenue data received from psychiatric hospitals and emergency departments for accuracy. Once JLARC staff properly allocated the indirect costs and revenue amounts received from licensed hospitals and DMAS (de-

scribed above), the financial data obtained through the JLARC staff survey were used to conduct five primary types of analysis:

(1) Assessing the adequacy of reimbursements rates (overall and by major payer type);

(2) Examining the extent to which uncompensated care was provided to uninsured psychiatric patients;

(3) Analyzing the variation of unreimbursed costs by type of psychiatric facility;

(4) Determining how much of the overall net loss resulted from psychiatric patients with an extended length of stay beyond 14 days; and

(5) Gauging whether reimbursements cover the total costs of treating psychiatric patients with secondary medical conditions.

First, JLARC staff assessed the adequacy of reimbursement rates by comparing the total costs to total reimbursements. If reimbursement rates did not cover costs, they were defined as inadequate. This analysis was performed overall across all licensed hospitals, as well as by each major payer type.

Second, to examine the extent to which uncompensated care was provided to uninsured psychiatric patients, JLARC staff compared hospitals' reimbursements received from uninsured patients with an ability to pay (also known as self-pay patients) to the total costs of these patients. In addition, JLARC staff also determined the proportion of uninsured patients without an ability to pay (also known as indigent patients), as well as the proportion of the net loss that resulted from providing care to these patients.

Moreover, JLARC staff also analyzed the extent of unreimbursed costs by type of psychiatric facility. Because three hospitals accounted for 59 percent of the total unreimbursed cost (as explained in Chapter 4), it was important for JLARC staff to break down the financial data by the type of hospital.

Finally, JLARC staff evaluated how much of the unreimbursed costs resulted from psychiatric patients with an extended length of stay beyond 14 days, as well as those with secondary medical conditions. These analyses involved comparing the total costs and reimbursements for these patients to determine whether hospitals were fully reimbursed for the costs of these patients.

TREND ANALYSIS OF VHI DATA

In order to examine trends in the use of inpatient psychiatric beds, JLARC staff analyzed patient data from Virginia Health Information (VHI) for calendar years 2001 through 2005. For each calendar year, VHI data includes information on patients that were discharged during the calendar year. A discharge occurs when a patient is released from the hospital that initially admitted him or her, either to their home or to another facility. For each discharge, VHI data includes information such as date of birth, gender, race, patient's zip code, date of admission, date of discharge, payer source, source of admission, secondary conditions (up to eight), hospital, and hospital charges.

Because the focus of the mandate was on inpatient psychiatric facilities, JLARC staff used the primary diagnosis codes to separate out the discharges with a primary psychiatric diagnosis. The codes for mental disorders are between 290 and 319 according to the Diagnostic and Statistical Manual of Mental Diseases, which is the standard guide for the classification of mental disorders. Within the code range 290-319, there are sub-ranges for specific psychiatric diagnoses such as dementia, drug-induced mental disorders, and schizophrenic disorders.

Generally, JLARC staff analyzed VHI records on a discharge basis. However, the data were also analyzed on a patient level. In both analyses, records that did not include a Social Security Number were excluded from the analysis.

In order to determine the number of readmissions for each psychiatric patient, JLARC staff calculated differences between patients' discharge and admission dates and then determined whether a readmission had occurred within 90 days. For each calendar year, JLARC staff only used admission dates within 90 days of a patient's discharge date. This also included admissions dates up to 90 days into the next calendar year. Discharges within 90 days of the patient's first discharge in a given calendar year were not counted. In other words, only admission dates going forward were included in this analysis, not those within 90 days from a prior year.

ANALYSIS OF BED UTILIZATION DATA

In addition to discharge-level information, VHI collects bed utilization data for various hospital services lines, such as psychiatric services, as well as data on the number of licensed and staffed hospital beds. JLARC staff used VHI data bed utilization for years 1998 to 2005 to analyze the use of psychiatric beds and other types of hospital beds over time.

REVIEW OF CSB CONTRACTS

As part of the review of CSB contracts with private providers, JLARC staff requested a series of documents from each of the seven regional partnerships. In particular, JLARC staff requested all contracts from FY 2006 and FY 2007, regional protocols on LIPOS eligibility, regional protocols on State hospital admissions, and regional protocols on discharge planning. JLARC staff also asked each of the seven regions about the types of records they maintain on State hospital admissions and denials, as well as records kept on LIPOS requests and individuals who received LIPOS funding. JLARC staff reviewed these documents to evaluate variation in regional practices and programs.

REVIEW OF MEDICAID RATE SETTING PROCESS FOR PSYCHIATRIC SERVICES

As part of the evaluation of the Medicaid rate-setting process, JLARC staff reviewed literature on the Medicare psychiatric payment system and psychiatric rates used by other states to determine if features of those systems could be adopted in Virginia. Particular attention was paid to the literature on how the Medicare reimbursement process functions and the rationale for adopting its features. In addition, structured interviews were conducted with representatives of various groups to gain their insight and opinions as to whether the existing Medicaid rate-setting process and resulting rates are fair and sufficient to address the financial concerns of licensed hospitals.

Further, JLARC staff evaluated data from the Department of Medical Assistance Services (DMAS) on the number and type of physicians who receive Medicaid reimbursements for psychiatric services to determine if there has been a change over time in the number of persons and the average reimbursement received. Moreover, JLARC staff used geographic information system (GIS) analysis to determine if certain regions of Virginia appeared to be lacking a physician who accepts Medicaid patients. Finally, literature on psychiatrist shortages was also reviewed to see what extent increases in reimbursement rates are thought to alleviate staffing shortages.

STRUCTURED INTERVIEWS

JLARC staff conducted several interviews with staff of the following entities to gain additional insight regarding the adequacy of inpatient psychiatric and State facility beds throughout the State, the availability of community services for persons with mental health needs, as well as the role of inpatient psychiatric hospitals, CSBs, and State facilities in providing psychiatric services:

- Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS),
- Virginia Hospital and Healthcare Associate (VHHA),
- Department of Medical Assistance Services (DMAS),
- Virginia Association of Community Services Boards (VACSB),
- Joint Commission on Health Care (JCHC),
- Senate Finance Committee staff,
- House Appropriations Committee staff, and
- Virginia Department of Health's Certificate of Public Need (COPN) staff.

REVIEW OF MENTAL HEALTH LITERATURE, REGULATIONS, AND POLICIES

JLARC staff reviewed numerous documents and studies to supplement and validate findings, as well as to identify other states' practices that could be transferred to Virginia. First, numerous prior studies of Virginia's mental health system were reviewed to gain a better understanding of the history of the adequacy of inpatient psychiatric and State facility beds throughout the State, as well as the availability of community services for persons with mental health needs. In addition, results from studies in other states were consulted. Finally, JLARC staff reviewed federal and State statues and policies related to the mental health system.

Appendix C

Additional Analysis of Patient-Level Trends

In response to the study mandate's directive that JLARC examine trends in the use of psychiatric beds, this appendix provides additional demographic analysis on psychiatric patients using Virginia Health Information (VHI) data.

NUMBER OF PSYCHIATRIC PATIENTS HAS BEEN DECREASING

In 2005, psychiatric patients accounted for under 10 percent of all hospital patients. As indicated in Table 1, between calendar year 2001 and 2005 there were 819,668 total discharges, on average, from licensed hospitals each year. These figures include all persons who were discharged from a Virginia hospital, regardless of their primary medical diagnosis. Of this amount, JLARC staff analyzed discharges for which complete patient data (including the Social Security Number) were available. As shown in Table 1, there were on average 655,804 "complete" discharges annually.

Table 1: Psychiatric Patients (Discharges) Have Been Decreasing

	Psychiatric Discharges (Duplicated)	Psychiatric Percentage of Complete Discharges (Duplicated)	Complete Discharges (Duplicated)	Total Discharges (Duplicated)
2001	52,811	8.4%	630,485	793,325
2002	52,042	8.1	642,496	800,131
2003	50,631	7.7	653,787	817,146
2004	49,749	7.5	660,331	825,499
2005	50,819	7.3	691,922	862,241

Source: Analysis of Virginia Health Information data.

Table 1 also indicates that the annual number of discharges with a primary psychiatric diagnosis is 51,208, on average. The presence of a psychiatric diagnosis is indicated by the use of certain codes, known as International Classification of Disease (ICD) codes, which are developed by the World Health Organization. For this analysis, JLARC staff examined all discharges where the primary diagnosis code fell into a range that indicates the presence of a psychiatric disorder, such as schizophrenia or a bipolar disorder. As shown in Table 1, psychiatric discharges represent a declining percentage of complete discharges.

USE OF BEDS BY GENDER AND AGE

With regard to the use of beds by age, there were few changes from 2001 to 2005. Generally about 50 percent of the discharges were male and 50 percent female. As shown in Table 2, the percentage of geriatric, adult, and child/adolescent discharges was similar across years.

Table 2: Median Age and Age-Based Percentage of Psychiatric Discharges Has Been Constant

	Children/Adolescents		Adults		Geriatric	
	Median Age	Percentage of Psychiatric Discharges	Median Age	Percentage of Psychiatric Discharges	Median Age	Percentage of Psychiatric Discharges
2001	14	12.0%	39	75.4%	76	12.5%
2002	14	12.3	39	75.5	76	12.2
2003	14	12.0	40	75.7	76	12.3
2004	14	11.7	40	75.1	76	10.6
2005	15	11.4	40	78.0	76	10.6

Note: Data excludes discharges with a length of stay greater than 100 days.

Source: Analysis of Virginia Health Information data.

TRENDS IN USE OF BEDS BY RACE APPEAR TO RESULT FROM VARIATION IN DIAGNOSIS BY RACE

Among unduplicated patients for 2005, approximately 70 percent were white, 25 percent were black, and 5 percent fell into other categories. The percentage of white patients was similar to the percentage of whites in Virginia's general population for 2005 (69 percent). However, the overall percentage of black patients was 32 percent higher than their percentage in Virginia's population for 2005 (19 percent). As shown in Table 3, there is considerable variation among racial groups by diagnosis.

Peer-reviewed studies in several journals have noted that the rate of some diagnoses, such as schizophrenia, is higher among

Table 3: Variation by Race Is Present in Some Diagnoses

Disorder	White	Black	Other
Other Nonorganic Psychoses	52.3%	37.7%	10.0%
Schizophrenia	48.2	46.9	4.9
Adjustment Disorder	66.7	25.2	8.1
Depressive	67.4	28.2	4.4
Substance Use	77.9	18.0	4.1
Mood Disorder	74.7	20.3	4.8

Source: Analysis of 2005 Virginia Health Information data.

blacks. This trend has been observed internationally, and the reason for this disproportionate rate of diagnosis is not known.

PSYCHIATRIC PATIENTS ARE LESS LIKELY TO HAVE A HIGH NUMBER OF SECONDARY MEDICAL CONDITIONS

Many hospital patients, including psychiatric patients, will have a secondary diagnosis in addition to their primary diagnosis. Some of the secondary diagnoses are for substance abuse or mental retardation, as noted above. The other secondary diagnoses are for medical conditions. When a psychiatric patient also has a medical condition, such as diabetes or high blood pressure, these secondary medical diagnoses can be treated in a psychiatric bed but they increase the cost of care.

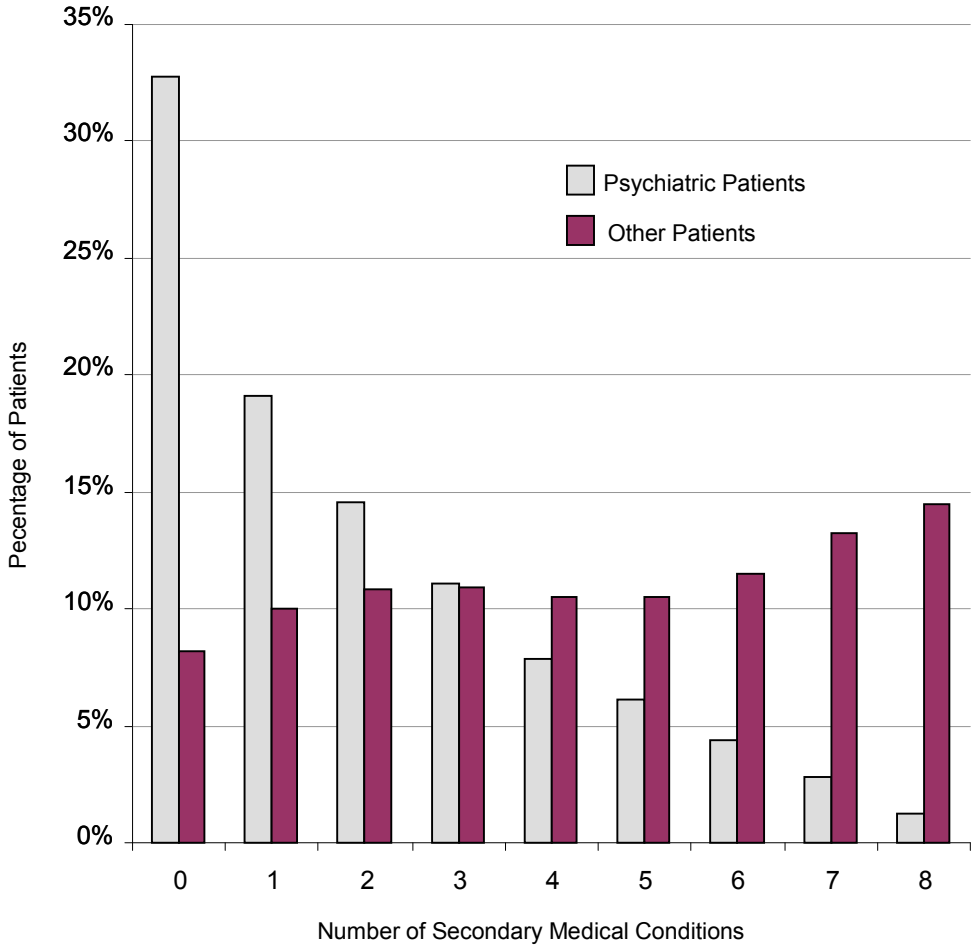
In 2005, 67 percent of psychiatric patients had one or more secondary medical conditions. In contrast, 92 percent of all other hospital patients had one or more conditions. Moreover, a psychiatric patient is more likely to have fewer conditions than other patients. As Figure 1 demonstrates, psychiatric patients are more likely to have one or two conditions (34 percent of all psychiatric patients), while other hospitals patients are more likely to have seven or eight conditions (28 percent of all other patients).

Although the comparative number of secondary medical conditions was similar from 2001 to 2005, there was an increase in the percentage of psychiatric patients *with* secondary conditions, from 62 to 67 percent. There was a similar increase among all other patients, from 89 to 92 percent.

CHARACTERISTICS OF PATIENTS WITH AN EXTENDED LENGTH OF STAY

Some patients have an extended LOS (more than 14 days), and this reportedly poses two problems for licensed hospitals. First, by remaining in their facility for more than two weeks, these patients are no longer benefiting from an acute level of care. Hospital staff report that their programming, consistent with the acute care model of medical care, is focused on short-term stabilization to enable a person to return to their community. Second, many payer sources, both public and private, will stop or reduce payments at some point between seven to 14 days. Therefore, hospitals are no longer being reimbursed for the services they provide.

Figure 1: Psychiatric Patients Are Less Likely to Have a High Number of Secondary Medical Conditions (2005)



Source: Analysis of Virginia Health Information data.

In 2005, only 4,118 patients (8.1 percent) involved an extended LOS. However, there are some wide differences in the characteristics of patients as LOS varies. Comparing patients with an LOS of seven days or less, to those with an extended LOS, the VHI data indicate that

- The average age increases from 39 to 47.
- The percentage of patients with a primary payer source of Medicare increases from 20 to 50 percent, and self-pay decreases from ten to one percent.
- The presence of dementia increases from 0.8 to 3.9 percent, and the presence of schizophrenia doubles (from 13.5 to 31.9 percent).

- The presence of substance abuse decreases. As a primary diagnosis, it decreases from 18.1 to 3.6 percent. As a secondary diagnosis, it decreases from 50 to 25 percent.

USE OF THE EMERGENCY DEPARTMENT BY PSYCHIATRIC PATIENTS

A frequently noted concern among staff of licensed hospitals is the increase in the number of psychiatric patients who are admitted to the hospital through the emergency department (ED). Using the VHI data, JLARC staff examined four ways of measuring the impact that psychiatric patients have on a hospital's ED. These measures compare the effect that psychiatric patients have upon the ED compared to other types of patients. They also compare the extent to which psychiatric patients are then admitted to an inpatient bed from the ED, and how that compares to the other ways that a person can be admitted to an inpatient bed.

However, hospital administrators noted that the admission source will be labeled as the ED only when a patient comes through the admitting hospital's own ED. As a result, hospital data fail to capture the high number of psychiatric patients that typically enter inpatient care through another hospital's ED and are then transferred to a hospital that has a psychiatric bed. Hospital staff estimated that 85 percent or more of psychiatric admissions are through an ED, if the first hospital's ED is included.

Psychiatric Visits Were the Fastest Growing Type of ED Visit from 1999 to 2005

The first way of assessing the impact that psychiatric patient have is to examine the amount of all visits to the ED that are psychiatric in nature. From 1999 until 2005, the total amount of visits to the emergency room increased by 28 percent. VHI data break out these visits into seven categories, based on the medical reason for the ED visit. Over this seven year period, the fastest growing category was "behavioral," a category which is used to capture ED visits that result from psychiatric or substance abuse needs. The number of behavioral visits in 2005 was 54.7 percent higher than in 1999.

However, during that time period behavioral visits accounted for only 2.8 percent of all ED visits, on average. Moreover, the percentage of behavioral visits in 2004 and 2005 was at its lowest rate since 1999. It appears that most of the increase in ED visits resulted from the third fastest-growing category, medical visits, which increased by 52.7 percent over that time period. Although the percentage increases are similar, the actual number of medical

visits is far higher. In 2005, there were 28,802 more behavioral visits than in 1999. In contrast, there were 667,383 more medical visits.

About One in Five Psychiatric Visits to the ED Results in an Inpatient Admission

Another way to look at the effect of behavioral visits on a hospital is to see what percentage of persons seen in the ED are subsequently admitted to an inpatient bed in the hospital. In 2005, 16 percent of all ED visits resulted in a hospital admission. This was relatively unchanged from the 1999 rate of 15 percent. Looking at this by category, 22.3 percent of behavioral visits resulted in a hospital admission in 2005, compared to 21.6 percent in 1999. In contrast, 16 percent of medical visits were admitted, in both 1999 and 2005. Although psychiatric patients are relatively more likely to be admitted than medical patients, there has been very little change in this rate.

However, there are substantial differences in this rate between the five Health Planning Regions used by the Virginia Department of Health (VDH). In the Northern and Eastern Regions, only 11 percent of psychiatric visits to the ED were then admitted. In the Southwest Region, the rate was slightly below the statewide average, at 21 percent. In Central Virginia, however, the rate is 46 percent. This means that almost half of all psychiatric patients coming to the ED are then admitted to an inpatient bed. This is an increase from the 30 percent rate for Central Virginia hospitals in 1999.

Psychiatric Visits Account for Only Four Percent of Inpatient Admissions From the ED

Although psychiatric patients are relatively more likely to be admitted from the ED than medical patients, because psychiatric patients account for only 2.8 percent of ED visits, they also account for very few hospital admissions from the ED. Medical admissions account for 67 percent of all hospital admissions from the ED, on average. In contrast, behavioral visits account for only 4.4 percent, on average. The exception to this is Central Virginia, where 8.4 percent of behavioral visits are admitted.

Most Psychiatric Patients in an Inpatient Bed Come Through the ED

The fourth way of looking at the impact of psychiatric patients is to examine the other ways that a person can be admitted to an inpatient bed, to see if psychiatric patients are different from other pa-

tients. In addition to an admission through the ED, patients can be admitted from several other sources, including a physician's office or a clinic, via a transfer from another hospital or a nursing home, or because of a law enforcement referral. Admission through the ED is the most frequent admission source for psychiatric patients, and accounts for 43 percent of admissions. This is an increase over the percentage in 2001 (37). However, this is very similar to all other patients, for which the ED is the source of admission 49 percent of the time (Table 4).

Table 4: Differences in Admission Source for Psychiatric and All Other Patients (2005)

Admission Source	Psychiatric Patients (Duplicated)	All Other Patients (Duplicated)
Emergency Room	43.1%	49.2%
Physician Referral	34.1	42.7
Court/Law Enforcement	9.2	< 1
Transfer	6.2	3.9
Other	7.4	4.1

Source: Analysis of Virginia Health Information data.

However, these admission data may not tell the whole story. Hospital administrators noted that because the admit source will be labeled as the emergency department only when a patient comes through the admitting hospital's own emergency department, VHI data fail to capture the high number of psychiatric patients that typically enter an inpatient bed through an emergency department. Staff at some hospitals estimated that 85 percent or more of psychiatric admissions are through an emergency department.

In fact, there has been a substantial increase in the number of patients transferred from the ED in one hospital to another hospital, although the type of patient transferred in not tracked. Looking at this by Health Planning Region, the number of transfers in Central Virginia increased from 1,418 in 1999 to 4,047 in 2005. This increase has remained in place, and may result from the closure in 2001 of two licensed hospitals in Richmond. The closure of beds at Central State Hospital starting in 1999 may also have had an effect. The number of transfers has also increased dramatically in Southwest Virginia, rising from 4,655 in 1999 to 11,755 in 2005. In percentage terms, these transfers rose by 185 and 153 percent, respectively. Transfers rose by about half that amount in Northwest and Eastern Virginia, rising by 90 and 73 percent, respectively. In contrast, transfers rose by only four percent in Northern Virginia.

CHARACTERISTICS OF PERSONS WITH MULTIPLE READMISSIONS IN 2005

The previous section presented information on the use of psychiatric beds by examining patients. This section also looks at patient level information, but uses a unique identifier to examine individuals instead of patients for 2005.

Schizophrenia and Substance Use Are More Prevalent

Psychiatric patients with multiple readmissions within 90 days exhibit differences from other psychiatric patients based on diagnosis:

- A greater proportion have schizophrenia: 12 percent of psychiatric patients with no readmissions had a diagnosis of schizophrenia. In contrast, 21 percent of patients with one readmission had schizophrenia. This increased to 40 percent among patients with four or more readmissions.

- A personality disorder is frequently present, according to hospital staff. However, hospital data do not contain any information on this kind of diagnosis.

- The prevalence of a secondary substance abuse diagnosis increases: 43 percent of psychiatric patients with no readmissions had a secondary diagnosis of substance abuse. This increased to 57 percent among patients with four or more readmissions.

Use of the Emergency Department Increases With the Number of Readmissions

In 2005, 43.2 percent of psychiatric patients with zero readmissions were admitted via that hospital's emergency department. In contrast, among patients with four or more readmissions the use of the ED as an admission source increased to 49 percent.

Patients With Four Or More Readmissions Are Less Likely to Be Self-Pay

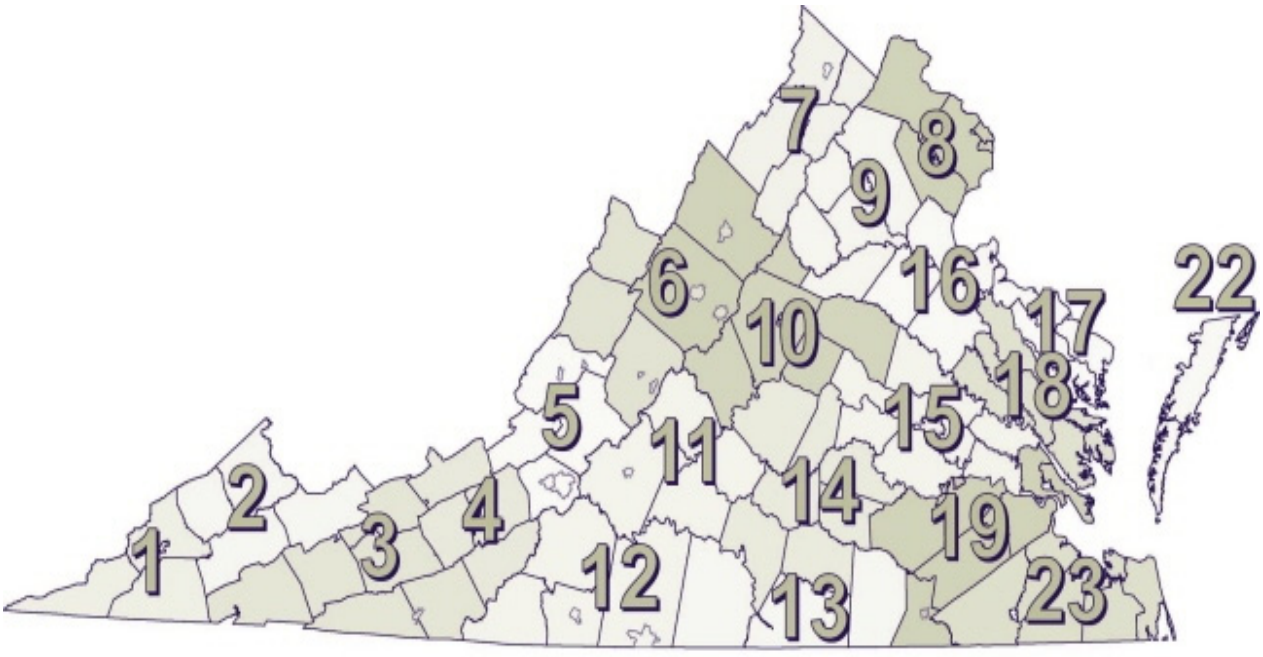
Compared to other psychiatric patients, those with four or more readmissions are more likely to have a payer source of Medicare (23 versus 33 percent), Medicaid (14 versus 24 percent), or charity (1.4 versus 2.1 percent).

Appendix D

Count of Hospital Beds by Planning District

As discussed in Chapter 2, the number of psychiatric beds has decreased since 1990. The tables in this appendix provide more detailed information on the number of beds by planning district (Figure 1).

Figure 1: Location of Planning Districts in Virginia



Source: Virginia Association of Planning District Commissions.

Table 1: Count of Licensed Beds Reported by General Hospitals

Planning District	1980 All Beds	1980 Psychiatric Beds	1985 All Beds	1985 Psychiatric Beds	1990 All Beds	1990 Psychiatric Beds	2000 All Beds	2000 Psychiatric Beds	2005 All Beds	2005 Psychiatric Beds
1	416		469	35	469	35	358	35	358	
2	418		457		578	45	506	20	481	20
3	1,067	35	1,061	40	1,007	60	522	14	526	14
4	539		539		539		368		456	36
5	1,558	99	1,845	214	1,832	214	1,673	199	1,536	196
6	899	25	899	25	899	48	597	38	546	48
7	783	30	778	30	690	60	647	60	590	26
8	2,828	110	2,771	128	2,775	162	2,423	192	2,887	178
9	227		217		217	18	156	12	156	
10	854	40	803	40	800	40	778	40	790	40
11	761	24	761	24	764	39	588	39	568	39
12	868	26	909	30	909	30	618	37	589	37
13	312		312		312		296	24	296	24
14	117		117		137		116		116	
15	3,847	275	3,839	275	3,820	327	3,436	311	3,143	277
16	285		340	15	340	15	318	10	429	10
17	76		76		76		76		76	10
18	171		171		171		138		134	
19	745	31	745	31	715		649	64	615	54
22	127		145		145		130	14	130	14
23	4,664	121	4,590[a]	184	4,687	188	3,665	210	3,535	201
TOTAL	21,562	816	21,844	1,071	21,947	1,332	18,058	1,319	17,957	1,224

Note: Data are for short-term (30 days or less) acute care hospitals and exclude rehabilitation hospitals, children's hospitals, long-term care hospitals, hospices, and ear, nose, and throat hospitals. All types of beds within short-term acute-care hospitals are included: medical/surgical, intensive care, obstetric, pediatric, long-term, psychiatric, and other. Data for 1994-1997 were not retained by any State agency.

[a] Southampton Memorial Hospital reported 116 long-term beds in 1980 and 131 in 1990, but zero in 1985. For all hospitals generally, data on long-term care beds may have been reported inconsistently but have been included in the total count of beds in acute care hospitals where reported. A total of 640 long-term care beds were reported in 1980, followed by 304 in 1985, and 837 in 1990. Data for 2000 and 2005 do not include any long-term care beds.

Source: Analysis of data from the Virginia Department of Health (Center for Health Statistics) and Virginia Health Information.

Table 2: Count of Licensed Beds Reported by Freestanding Hospitals

	1980	1985	1990 [a]	2000	2005
Planning District	Psychiatric Beds	Psychiatric Beds	Psychiatric Beds	Psychiatric Beds	Psychiatric Beds
1					
2					
3					
4	162	162	162	162	
5					
6					
7					
8	130	130	162	100	100
9					
10	50	60	75		
11					
12					
13					
14					
15	282	282	282	84	
16				30	30
17					
18					
19	42	100	100	120	187
22					
23	540	653	554	230	253
TOTAL	1,206	1,387	1,335	726	570

Note: Data for psychiatric hospitals that were later reported with general hospitals (Roanoke Valley Psychiatric Center, which is now reported with Lewis-Gale Hospital, and St. Mary's Norton, which was reported with Mountain View Regional Medical Center) are reported in Table 1.

[a] For 1990, data for psychiatric hospitals were reported in three categories; general psychiatric, drug treatment (DT), and other mental health/mental retardation (MH/MR), and include 942 general psychiatric, 332 DT, and 61 other MH/MR. In addition, of the 1,332 psychiatric beds reported with general hospitals (Table 1), 31 were for DT and 50 were for other MH/MR. In 1990, licensure data indicate that Virginia had an additional 1,139 DT beds outside of acute and psychiatric hospitals and 190 other MH/MR beds, mostly in group homes. (These data do not include any State or federally-operated facilities.) Data for 2000 and 2005 do not include these different categories.

Source: Analysis of data from the Virginia Department of Health (Center for Health Statistics) and Virginia Health Information.

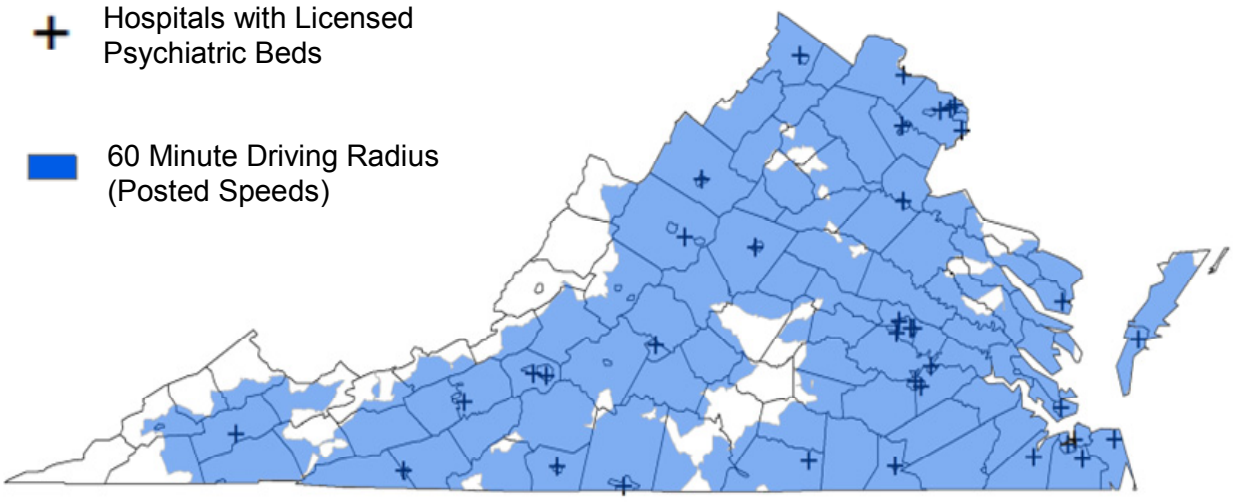
Appendix E

Proximity to Psychiatric Beds as an Indication of Adequacy

As discussed in Chapter 2, JLARC staff used geographic information systems (GIS) software to analyze the extent to which the population of each planning district is within one hour of a licensed psychiatric bed. According to the proximity threshold of the State Medical Facilities Plan used by the Virginia Department of Health, acute psychiatric services "should be available within a maximum driving time, under normal conditions, of 60 minutes one-way for 95 percent of the population" (12 VAC 5-290-30).

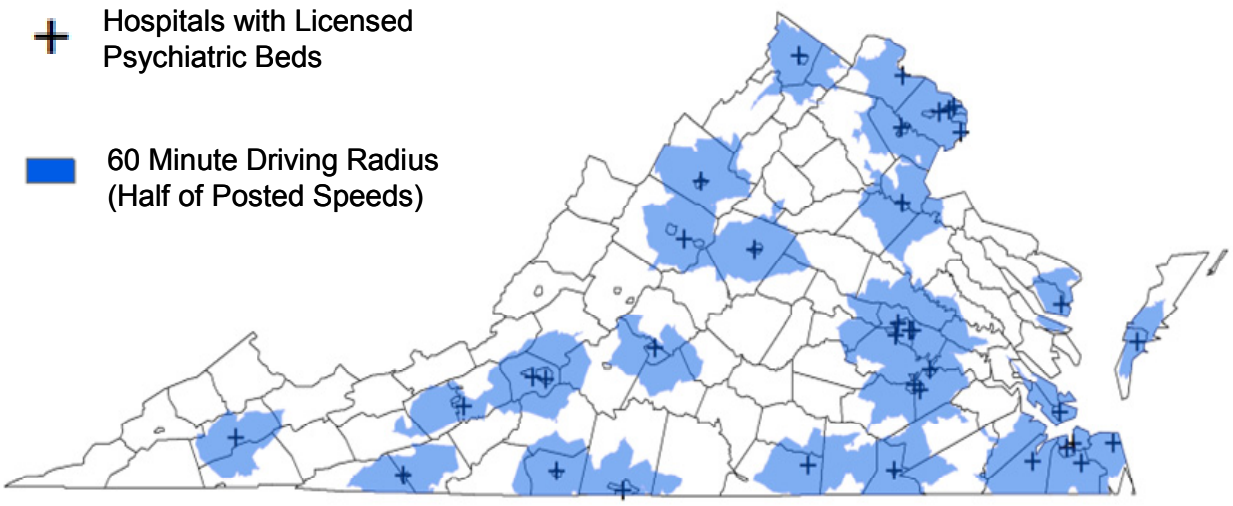
JLARC staff conducted this analysis by using a network analysis of driving distances within one hour of the 35 hospitals with licensed psychiatric beds in 2005. This analysis, which was provided by the Virginia Geographic Information Network, indicated the travel radius from each licensed hospital based upon two scenarios: a one hour travel time at posted speed limits, and at one-half of posted speed limits. To conduct the analysis, JLARC staff used the radius based upon posted speeds and then identified the U.S. Census block groups in each planning district that were outside of any hospital radius (Figure 3). The results are presented in Table 8 (page 28) of Chapter 2.

Figure 1: Travel Radius at Posted Speed Limits



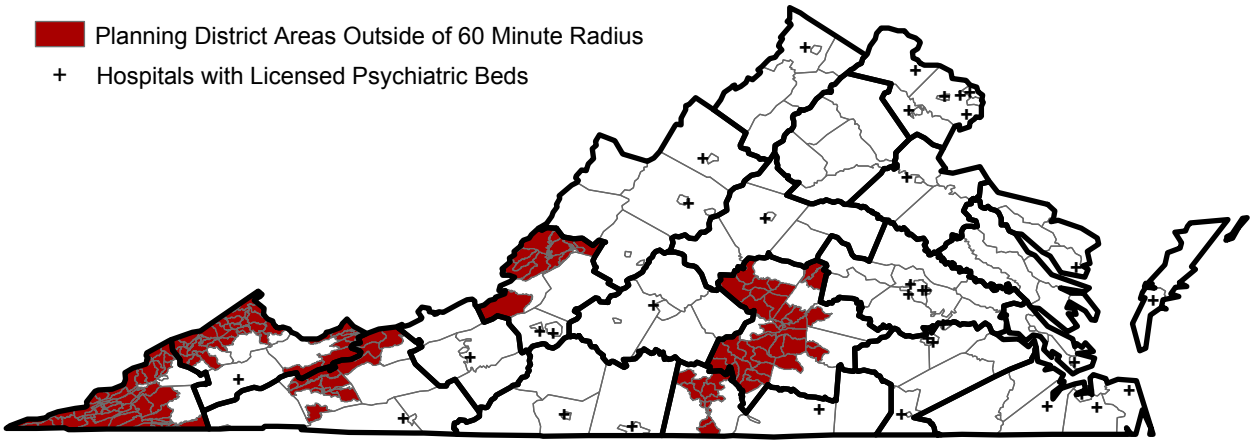
Source: JLARC staff.

Figure 2: Travel Radius at Half of Posted Speed Limits



Source: JLARC staff.

Figure 3: Census Block Groups Outside of the Posted Speed Radius of Any Licensed Hospital



Source: JLARC staff.

Appendix F

Hospital Patients Traveling More Than 50 Miles to an Inpatient Bed

	Miles from Patient's Home Zip Code to the Location of the Licensed Hospital From Which They Were Discharged						
	100+		99-75		74-50		
Hospital	Patients	Percent of Total	Patients	Percent of Total	Patients	Percent of Total	Total Patients
Poplar Springs	223	12.2%	125	6.8%	144	7.9%	1,826
Virginia Commonwealth University	91	4.3	75	3.6	123	5.9	2,092
University of Virginia	39	2.5	43	2.8	92	6.0	1,540
Lewis-Gale	43	2.0	33	1.5	79	3.7	2,136
Community Memorial	12	1.9	27	4.2	86	13.4	641
Virginia Baptist	30	1.6	13	0.7	58	3.1	1,842
Riverside Behavioral	33	1.5	43	1.9	104	4.7	2,230
Carilion New River Valley	18	1.4	45	3.5	74	5.8	1,285
Rockingham Memorial	11	1.3	7	0.8	36	4.3	828
Shore Memorial	2	1.3	1	0.6	1	0.6	156
Winchester	9	1.2	8	1.0	14	1.8	766
Augusta Medical Center	11	1.0	6	0.6	24	2.2	1,088
Virginia Beach	33	0.9	12	0.3	64	1.8	3,618
Chippenham-Johnston Willis	29	0.7	58	1.5	101	2.6	3,952
Snowden	9	0.7	19	1.5	62	5.0	1,232
Roanoke Memorial	11	0.7	8	0.5	17	1.0	1,636
Prince William	9	0.7	0	0.0	16	1.2	1,367
Memorial Hospital	4	0.6	0	0.0	0	0.0	636
John Randolph	5	0.6	5	0.6	15	1.7	861
Inova Fairfax	7	0.5	2	0.1	16	1.1	1,448
Southside Regional	6	0.5	11	0.9	30	2.4	1,263
Danville Regional	3	0.4	0	0.0	4	0.6	715
Richmond Community	6	0.4	7	0.5	44	2.9	1,532
Maryview	9	0.4	19	0.8	21	0.8	2,483
Russell County	2	0.4	5	0.9	23	4.1	565
Twin County	1	0.3	1	0.3	2	0.6	313
Inova Loudoun	2	0.3	1	0.1	4	0.6	673
Dominion Hospital	3	0.2	9	0.7	39	3.1	1,273
Sentara Norfolk	2	0.2	3	0.3	2	0.2	986
Chesapeake General	1	0.2	0	0.0	3	0.6	494
St. Mary's Hospital	2	0.1	10	0.6	28	1.8	1,580
Va Hospital Ctr	1	0.1	1	0.1	11	1.3	842
Mount Vernon	1	0.1	0	0.0	7	0.6	1,090
Obici Hospital	0	0.0	2	0.8	0	0.0	263
Rappahannock General	0	0.0	3	2.0	10	6.6	151
STATEWIDE	668	1.5	602	1.3	1,354	3.0	45,403

Source: Analysis of VHI Data

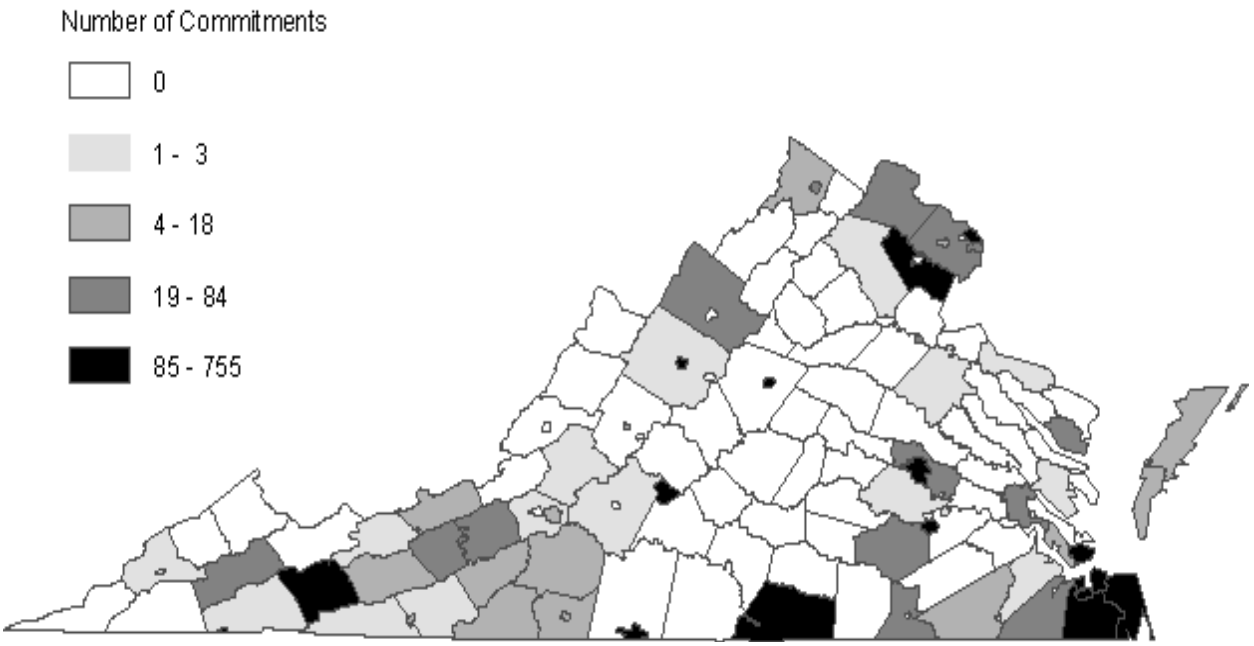
Appendix G

Count of Involuntary Commitment Orders by Locality Where Issued

Pursuant to § 37.2-819 of the *Code of Virginia*, all courts are required to submit an SP-237 form and a copy of the Involuntary Commitment Order (ICO) to the Virginia Department of State Police for all involuntary commitments. This information is entered into the Central Criminal Records Exchange and is only to determine a person's eligibility to possess, purchase, or transfer a firearm.

As discussed in Chapter 2, Certain localities have much higher concentrations of ICOs. In 2006, the City of Richmond had the highest number (755), followed by Smyth County (736), and the City of Hampton (601). The high number in Smyth County may be attributable to the location of Southwestern Virginia Mental Health Institute (SWVMHI). Figure 1 illustrates the distribution of ICOs, by quartile, for 2006 and historical data are provided in Table 1.

Figure 1: Distribution of Involuntary Commitment Orders in 2006



Source: Analysis of data provided by the Virginia Department of State Police.

Count of Involuntary Commitment Orders by Court of County Where Committed

Locality	1998	1999	2000	2001	2002	2003	2004	2005	2006
Accomack	7			4	5	10	14	7	15
Albemarle									
Alexandria	38	1	56	89	96	147	89	83	63
Alleghany		1	2	3	6	1	1		
Amelia									
Amherst	1								
Appomattox									
Arlington	92	92	132	79	76	90	112	82	124
Augusta								5	1
Bath									
Bedford City									
Bedford				17	24			1	2
Bland	4	6		1		2		1	3
Botetourt					1				1
Bristol						3		222	366
Brunswick		1							
Buchanan				1	1	2			
Buckingham							1		
Buena Vista					1				
Campbell			1	7	1				
Caroline	1								1
Carroll	11	13	14	13	10	10	5	10	3
Charles City									
Charlotte							5	1	
Charlottesville	1	1		56	333	236	201	211	205
Chesapeake	124	149	223	269	353	369	349	402	401
Chesterfield	1	1				1	1	2	2
Clarke	1								
Colonial Heights									
Covington									
Craig					1		1		
Culpeper	14				1			1	
Cumberland									
Danville	177	140	201	147	162	194	239	265	281
Dickenson				1					
Dinwiddie					26	234	195	116	78
Emporia									
Essex									
Fairfax City	1			1	1	6	1		6
Fairfax	102	76	78	92	44	74	86	83	79
Falls Church									
Fauquier	7								1
Floyd	18	15	5	5	9	14	7	10	13
Fluvanna									
Franklin City	9	7	7	7	6	10	4	5	1
Franklin	1	2		2	5	2	3		7

Locality	1998	1999	2000	2001	2002	2003	2004	2005	2006
Frederick	6	3	3	12	1	6	2	5	13
Fredericksburg				69	80	43	35	72	24
Galax	61	66	58	51	35	44	41	41	18
Giles	34	27	7	8	5	11	12	6	9
Gloucester						3		5	1
Goochland								2	
Grayson	6	1			2	7	3	5	1
Greene									
Greensville	43	20	4	15	23	4	7	6	21
Halifax									
Hampton	503	501	458	527	658	607	616	687	601
Hanover									
Harrisonburg									
Henrico	18		6		58	70	77	78	72
Henry	7	13	14	28	54	43	33	21	8
Highland									
Hopewell						1			1
Isle of Wight	22	27	17	18	7	20	12	12	3
James City	169	150	292	33	17	60	35	23	23
King and Queen									
King George									
King William						1			
Lancaster						1		3	69
Lee									
Lexington									11
Loudoun				1	1		26	42	49
Louisa									
Lunenburg									
Lynchburg	1		72	342	365	482	567	646	580
Madison	1								
Manassas									
Manassas Park									
Martinsville	3	1	4	15	12	12	22	13	7
Mathews									
Mecklenburg	94	111	100	141	120	103	90	109	100
Middlesex									
Montgomery	84	96	71	38	30	32	42	52	47
Nelson									
New Kent									
Newport News	468	360	350	259	204	195	188	30	17
Norfolk	262	384	401	465	388	364	278	258	193
Northampton	11	1	1	2	5	2	4		8
Northumberland									
Norton									1
Nottoway									
Orange	1					1	1		
Page	2			1					
Patrick				3	1	1		1	4
Petersburg					59	491	580	560	503
Pittsylvania									
Poquoson									
Portsmouth	17		1			18	287	368	359
Powhatan									
Prince Edward					1	1	1		
Prince George									

Locality	1998	1999	2000	2001	2002	2003	2004	2005	2006
Prince William	64	65	22	1		148	281	175	170
Pulaski	136	159	65	44	40	61	42	20	27
Radford	26	23	6	5	7	11	10	8	22
Rappahannock									
Richmond City	84		1	382	534	495	587	578	755
Richmond				30	8	23		2	
Roanoke City	176	125	67	157	71	2	4	2	7
Roanoke	292	193	71	48	7	1	4	6	2
Rockbridge				1		4			
Rockingham	11		31	81	90	79	95	110	84
Russell	1	31	80	59	81	46	46	44	31
Salem	113	44	7	10	1				
Scott									
Shenandoah					2				
Smyth	755	461	481	585	679	671	696	806	737
Southampton	8	3	2	3	4	7	9	8	5
Spotsylvania				18					
Stafford									
Staunton	712	679	528	723	702	677	617	380	525
Suffolk	126	119	102	139	78	59	48	40	52
Surry									
Sussex			1		1				
Tazewell								1	
Virginia Beach	294	259	241	258	228	272	253	273	291
Warren					1	1			
Washington	15								1
Waynesboro									
Westmoreland								1	2
Williamsburg				1		2	1		
Winchester	37	32	16	25	7	12	15	37	37
Wise					1				1
Wythe	34	34	14	11	5	18	21	9	14
York	1					1	2	4	

Source: Analysis of data provided by the Virginia Department of State Police.

Appendix H

Financial Description and Analysis of the Three Outlier Licensed Psychiatric Hospitals

As mentioned in Chapter 4, three licensed hospitals accounted for nearly 60 percent of the total amount of unreimbursed costs of $61 million in 2005. JLARC staff contacted these hospitals to verify their total costs and reimbursements reported through the survey, and the hospitals confirmed that the data were accurately reported. However, because these three hospitals represented a disproportionate percentage of the total amount of unreimbursed costs compared to other hospitals, JLARC staff separated them from the remaining 23 hospitals for analysis purposes. Therefore, these three hospitals, which accounted for 12 percent of all psychiatric patients and 10 percent of all psychiatric bed days, are referred to as "outliers" throughout this report. This appendix describes these outlier hospitals in comparison to the other licensed hospitals that responded to the JLARC staff financial survey.

One factor that appears to contribute to the substantial amount of unreimbursed costs of the outlier hospitals is their higher costs. In fact, the three outlier hospitals accounted for 24 percent of the total cost of providing psychiatric services in 2005 (Table 1), and they had the highest average cost per admission.

Table 1: Outlier Hospitals Were Not Reimbursed for $36 Million of Their Total Costs of Providing Psychiatric Services in 2005

Total Costs	$52.4 million
Total Revenue	$16.2 million
Cost Recovery Ratio	31%
Percent of Total Costs	24%
Percent of Total Revenue	10%
Overall Net Loss	$36.2 million
Percent of Net Loss	59%
Number of Psychiatric Patients	4,406 (12%)
Number of Psychiatric Bed Days	24,105 (10%)
Average Cost Per Admission	$11,904.25
Average Revenue Per Admission	$3,678.88
Average Cost Per Bed Day	$2,175.90
Average Revenue Per Day	$672.44

Note: Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

Source: Analysis of psychiatric facility financial survey data (2005).

In addition to having higher costs, on average, compared to other facilities, the outlier facilities had the following characteristics:

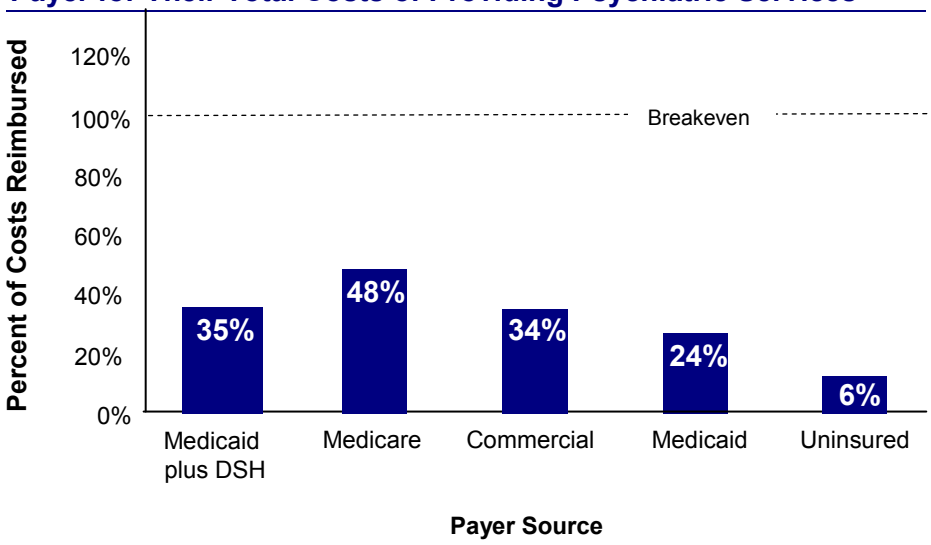
- located in urban areas,
- had more than 50 licensed inpatient psychiatric beds,
- had slightly more uninsured patients, on average,
- either did not receive additional Medicaid payments or received a small amount compared to teaching hospitals, and
- had more adult psychiatric patients with at least one co-occurring medical condition.

However, unlike teaching and general hospitals which also had a large amount of unreimbursed costs as a result of providing psychiatric services in 2005, the outlier hospitals had very few psychiatric patients with an extended length of stay (beyond 14 days).

Outlier Hospitals Experienced Large Amounts of Unreimbursed Costs by All Payers for Providing Psychiatric Services in 2005

In comparison to other hospitals, the three outlier hospitals were reimbursed far less by all payers for their total costs of providing psychiatric services in 2005. Medicare had the highest cost recovery ratio at 48 percent, which indicates that outlier hospitals were only reimbursed 48 percent of their costs of Medicare psychiatric patients.

Figure 1: Outlier Hospitals Were Not Fully Reimbursed by Any Payer for Their Total Costs of Providing Psychiatric Services



Note: This graphic illustrates the cost recovery ratios for the three outlier hospitals, which accounted for 59% of the total unreimbursed costs in 2005.

Source: Analysis of psychiatric facility financial survey data (2005).

Under-Reimbursement from Commercial Insurers Accounted for 36 Percent of the Unreimbursed Costs of Outlier Hospitals

Among the outlier hospitals, 38 percent of psychiatric patients had commercial insurance in 2005. However, these patients accounted for 36 percent of the total amount of unreimbursed costs experienced by the three outlier facilities.

Table 2: More Than One-Third of Outlier Hospitals' Unreimbursed Costs Resulted From Under-Reimbursements From Commercial Insurers

Payer Type	Percent of Psychiatric Patients	Percent of Unreimbursed Costs
Commercial	38%	36%
Uninsured	17	17
Medicare	17	17
Medicaid	9	13
Medicaid plus DSH	3	2
Other[a]	16	15

Note: Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

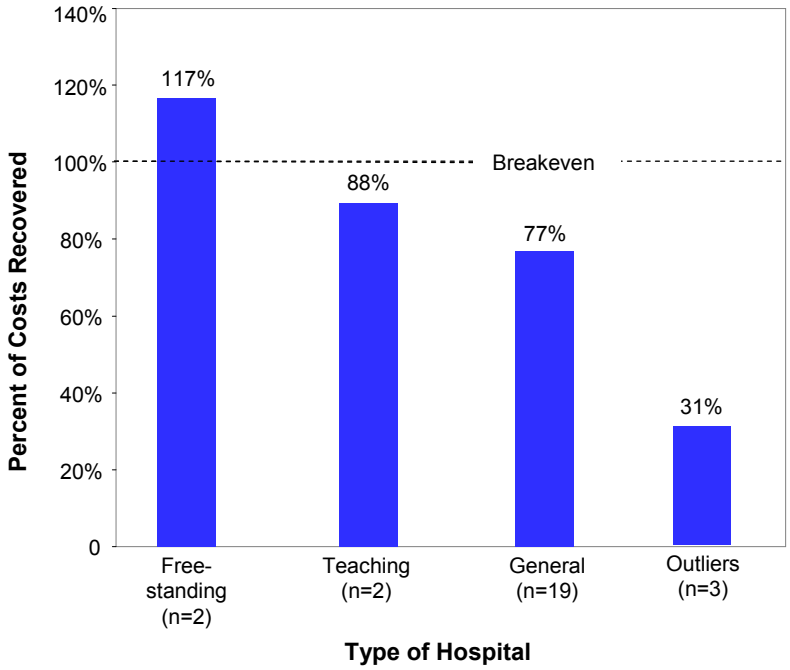
[a] Includes payer sources with less than 10% of psychiatric patients: community services board per diem, CHAMPUS/Military, Medicaid health maintenance organization, temporary detention order, worker's compensation, and other (as specified by the hospital).

Source: Analysis of psychiatric facility financial survey data (2005).

Outlier Hospitals Experienced Substantial Unreimbursed Costs Compared to Other Types of Hospitals

Compared to other facilities, the three outlier hospitals were reimbursed far less for their total costs of providing psychiatric services in 2005. Figure 2 illustrates the wide variation of the overall cost recovery ratios across the different types of hospitals. Not only did the three outlier hospitals have higher costs in 2005, on average, but they also received much lower reimbursements for providing psychiatric services. The cost recovery ratio of 31 percent indicates that the three outlier hospitals were only reimbursed for 31 percent of their costs.

Figure 2: Outlier Hospitals Were Only Reimbursed 31 Percent of Their Costs of Providing Psychiatric Services in 2005



Note: Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

Source: Analysis of psychiatric facility financial survey data (2005).

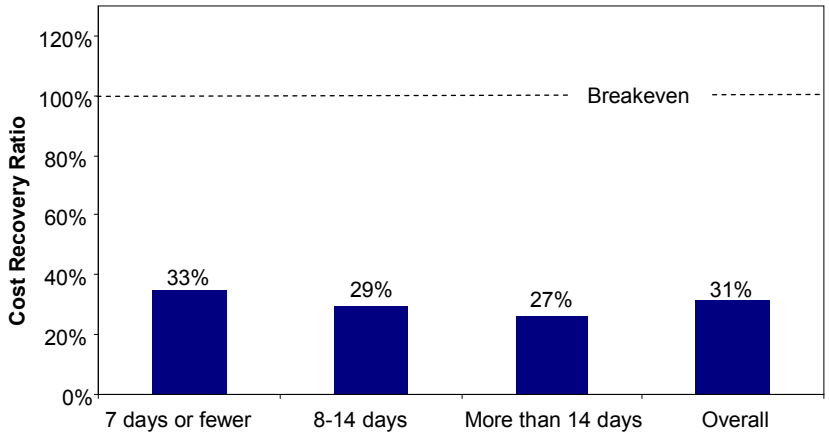
Only 12 Percent of the Net Loss Among Outlier Hospitals Resulted From Psychiatric Patients Who Stayed Beyond 14 Days

Only three percent of psychiatric patients in the outlier hospitals had an extended length of stay beyond 14 days in 2005. Whereas patients with an extended length of stay accounted for a substantial portion of the unreimbursed costs among the non-outlier hospitals (described in Chapter 4), they only account for 12 percent of the loss experienced by the outlier hospitals. However, outlier hospitals were only reimbursed for 27 percent of their costs of psychiatric patients with an extended length of stay (Figure 3).

Reimbursements for Patients in Outlier Hospitals With Secondary Medical Conditions Varied Between Payers

In contrast to the non-outlier hospitals, the three outlier hospitals received a *higher* proportion of reimbursements from almost payers for psychiatric patients *with* a secondary medical condition (Figure 4). Regardless, no payer source fully reimbursed the outlier hospitals for their total costs of patients with a secondary medical condition.

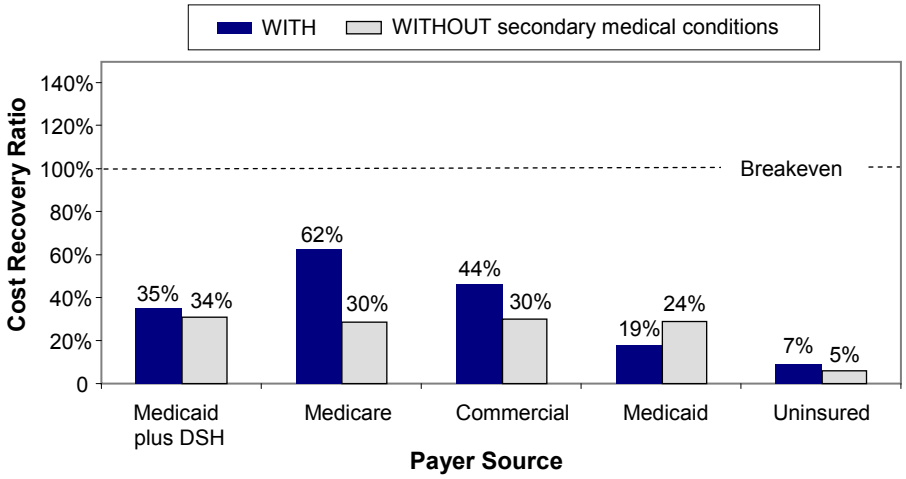
Figure 3: Outlier Hospitals' Cost Recovery Ratio Was Lower for Patients With an Extended Length of Stay



Note: Excludes 33 admissions with a length of stay of 100 days or more, the majority of which were admitted at VCU, covered by Medicaid, and had a cost recovery ratio of more than 300%. Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

Source: Analysis of psychiatric facility financial survey data (2005).

Figure 4: No Payer Source Reimbursed Outlier Hospitals for Psychiatric Patients With a Secondary Medical Condition (2005)



Note: Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

Source: Analysis of psychiatric facility financial survey data (2005).

Uninsured Psychiatric Patients and Under-Reimbursements From Commercial Insurers Also Create an Adverse Financial Situation for Emergency Departments in Outlier Hospitals

The two primary sources of the unreimbursed costs experienced by emergency departments in the outlier hospitals resulted from treating uninsured psychiatric patients and under-reimbursement from commercial insurers (Table 3). Figure 5 illustrates the cost recovery ratio by primary payer source which shows that EDs in the outlier hospitals were only reimbursed for six percent of the costs of the uninsured and 31 percent of the costs of patients with commercial insurance.

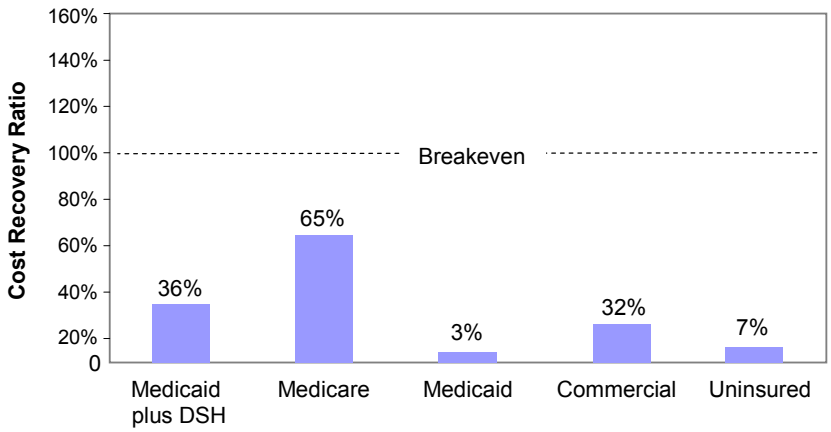
Table 3: Uninsured Patients Resulted in Largest Amount of Unreimbursed Costs for Emergency Departments in Outlier Hospitals

Payer Type	Percent of Psychiatric Patients	Percent of Unreimbursed Costs
Uninsured	30%	39%
Commercial	38	34
Medicare	17	11
Medicaid	2	4
Medicaid plus DSH	6	5
Other [a]	7	7

Note: Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.
[a] Includes payer sources with less than 10% of psychiatric patients: community service board per diem, CHAMPUS/Military, Medicaid health maintenance organization, temporary detention order, Worker's Compensation, and other (as specified by the hospital).

Source: Analysis of emergency departments' financial data (2005).

Figure 5: Emergency Departments in Outlier Hospitals Were Only Reimbursed for Seven Percent of the Costs of Uninsured Psychiatric Patients



Note: Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

Source: Analysis of emergency departments' financial data (2005).

Appendix

Additional Financial Analyses Including the Outlier Hospitals

This appendix provides some additional financial analyses that JLARC staff performed, which illustrate the differences if the three outlier hospitals (described in Appendix G) are included. JLARC staff used the cost and reimbursement data obtained through the survey of hospitals with licensed inpatient psychiatric beds and their emergency departments.

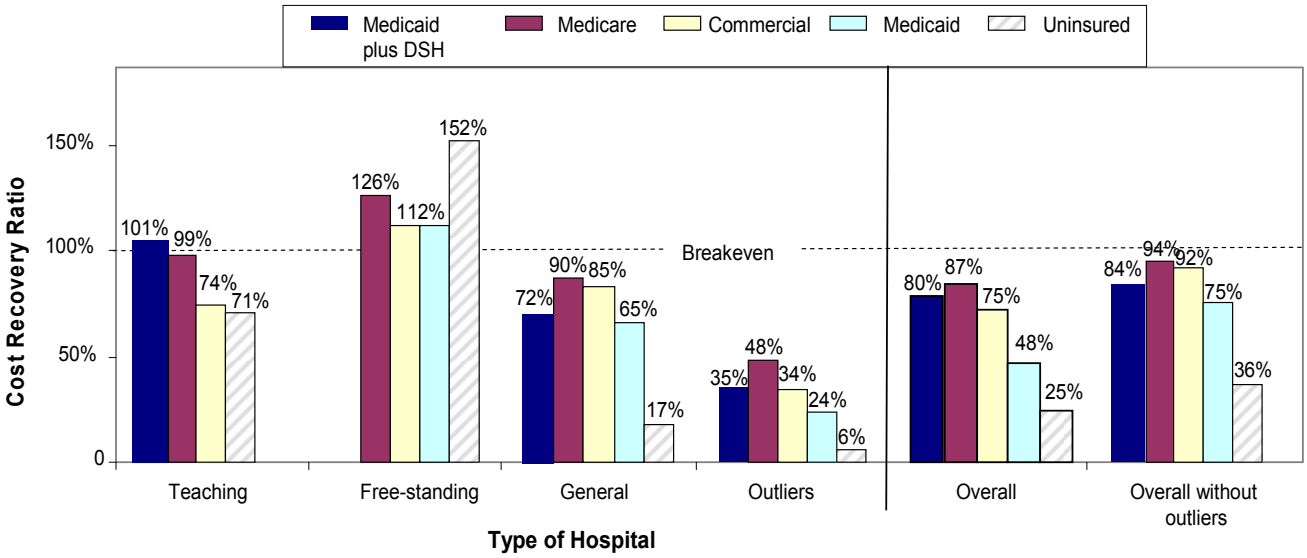
Level of Reimbursement for Psychiatric Services Varies by Type of Hospital

The payer-specific CRRs presented above represent the extent to which these payers reimbursed costs across all hospitals. But since each hospital has a different mix of these payers, each hospital will have a different hospital-specific CRR. In order to preserve the confidentiality of the analysis, this section discusses hospital-specific CRRs by the type of hospital: teaching, general, freestanding, and outlier. As illustrated in Figure 1, the analysis shows that the teaching hospitals were only fully reimbursed by Medicaid plus.

The freestanding hospitals were fully reimbursed by all payer sources, including uninsured patients (who accounted for only two percent of their patients). (The cost recovery ratio of 152 percent for freestanding facilities suggests that their uninsured patients are able to pay for more of their care compared to those treated in other facilities. In addition, charges that appear on a patient's bill are typically higher than the actual costs of the services provided, which further indicates that uninsured patients in freestanding hospitals are able to pay a higher percentage of charges compared to uninsured patients in other types of hospitals.)

In contrast, neither the 19 general hospitals nor the three outlier facilities were fully reimbursed by any of the various payers. This is illustrated in Figure 1 by the CRRs that fall below 100 percent (the dotted line).

Figure 1: Freestanding Hospitals Were Fully Reimbursed By All Payers (2005)



Note: This graphic only includes the payer sources with 10% or more of psychiatric admissions.
Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

Source: Analysis of psychiatric facility financial survey data (2005).

Payer Mix of Psychiatric Patients Also Varies by Type of Hospital

The payer mix varies substantially by type of hospital (Table 1). For example, only two percent of patients in freestanding hospitals were uninsured, whereas 18 percent of patients in teaching hospitals were uninsured. In addition, freestanding hospitals had sub stantially more patients with commercial insurance in 2005 (59 percent) than other types of hospitals. Lastly, teaching hospitals had more Medicaid plus (15 percent) patients than other types of hospitals.

Table 1: Payer Mix Varies Between the Different Types of Hospitals

	Payer Mix (Percentage of Psychiatric Patients)				
Payer Type	Teaching Hospitals	Freestanding Hospitals	General Hospitals	Outlier Hospitals	Overall
Uninsured	18	2	10	17	10
Commercial	24	59	32	38	36
Medicaid	0	4	4	9	4
Medicaid plus DSH	15	0	9	3	8
Medicare	27	18	26	17	24
Other[a]	16	17	19	16	18

Note: Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.
[a] Includes payer sources with less than 10%of psychiatric patients: community services board per diem (LIPOS), CHAMPUS/Military, Medicaid health maintenance organization, temporary detention order, worker's compensation, and other (as specified by the hospital).

Source: Analysis of psychiatric facility financial survey data (2005).

Uninsured Psychiatric Patients Appear to Create a Financial Burden for Hospitals

General hospitals were only reimbursed for 17 percent of the total costs resulting from uninsured psychiatric patients (Table 2). In contrast, freestanding hospitals were fully reimbursed for their uninsured psychiatric patients (described above). Teaching hospitals received the largest amount of additional Medicaid payments (DSH) to help offset some of the uncompensated care provided to uninsured psychiatric patients. As a result, teaching hospitals were reimbursed 71 percent of their costs of uninsured psychiatric patients.

Table 2: Financial Impact of Uninsured Psychiatric Patients Varies by Type of Hospital

	Uninsured Psychiatric Patients			
Type of Facility	**Cost Recovery Ratio**	**Percent of Unreimbursed Costs**	**Percent of Total Psychiatric Patients**	**Percent of Total Psychiatric Bed Days**
Freestanding	152%	0%	<1%	< 1%
Teaching hospitals	71	1	2	1
General hospitals	17	10	6	4
Outliers	6	9	2	1
Overall	**25**	**22**	**10**	**7**
Overall without outliers	**36**	**29**	**9**	**6**

Note: Outliers include three psychiatric facilities that accounted for 59 percent of the total unreimbursed costs in 2005.

Source: Analysis of psychiatric facility financial survey data (2005).

Under-Reimbursement from Commercial Insurers Accounted for 22 Percent of Unreimbursed Costs

More than one-third of all psychiatric patients in 2005 had commercial insurance. Overall, these patients accounted for 36 percent of the total amount of unreimbursed costs across all licensed hospitals (Table 3). However, when excluding the three outlier facilities, psychiatric patients with commercial insurance accounted for 22 percent of the unreimbursed costs. As indicated in Table 3, under-reimbursement from commercial insurers experienced by general hospitals accounted for seven percent of the total amount of unreimbursed costs across all hospitals.

If the general hospitals are examined separately, psychiatric patients with commercial insurance accounted for 17 percent of their unreimbursed costs. A third-party administrator of a commercial insurance company reported that some mental health benefits are not covered for any days beyond the average length of stay of their patients, which may be a primary reason for this portion of the financial loss.

Table 3: Psychiatric Patients With Commercial Insurance Accounted for 22 Percent of Non-Outlier Hospitals' Unreimbursed Costs

	Psychiatric Patients With Commercial Insurance			
Type of Hospital	**Cost Recovery Ratio**	**Percent of Unreimbursed Costs**	**Percent of Total Psychiatric Patients**	**Percent of Total Psychiatric Bed Days**
Freestanding	112%	n/a	9%	10%
Teaching hospital	74	2%	2	3
General hospital	85	7	20	15
Outlier	34	20	4	4
Overall	**75%**	**28%**	**36%**	**31%**
Overall without outliers	**92%**	**16%**	**36%**	**28%**

Note: Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

Source: Analysis of psychiatric facility financial survey data (2005).

Extent of Financial Loss Varies by Type of Psychiatric Facility

As noted in Chapter 4, when excluding the three outliers from the group of facilities that experienced unreimbursed costs, the total amount of unreimbursed costs of the 19 general hospitals and two teaching hospitals totaled $25.6 million in 2005 (Table 4). Four facilities accounted for more than half of this loss.

The outlier hospitals incurred $52 million in total costs providing psychiatric services in 2005, and only received $16 million in reimbursements. Consequently, this resulted in $36 million in unreimbursed costs.

Table 4: Extent of Unreimbursed Costs Varies by Type of Psychiatric Facility

Type of Facility	**Number of Facilities**	**Number of Psychiatric Patients**	**Percent of Psychiatric Bed Days**	**Total Costs (Millions)**	**Total Revenue (Millions)**	**Recovery of Costs (Millions)**
General hospital	19	23,491	59%	$111.7	$86.1	($25.6)
Outlier	3	4,406	10	52.4	16.2	(36.2)
Freestanding	2	5,923	18	23.7	27.7	4
Teaching hospital	2	3,799	14	29.4	25.9	(3.5)
Overall	**26**	**37,619**	**100%**	**$217.2**	**$155.9**	**($61.2)**
Overall without outliers	**23**	**33,213**	**90%**	**$164.8**	**$139.7**	**($25.1)**

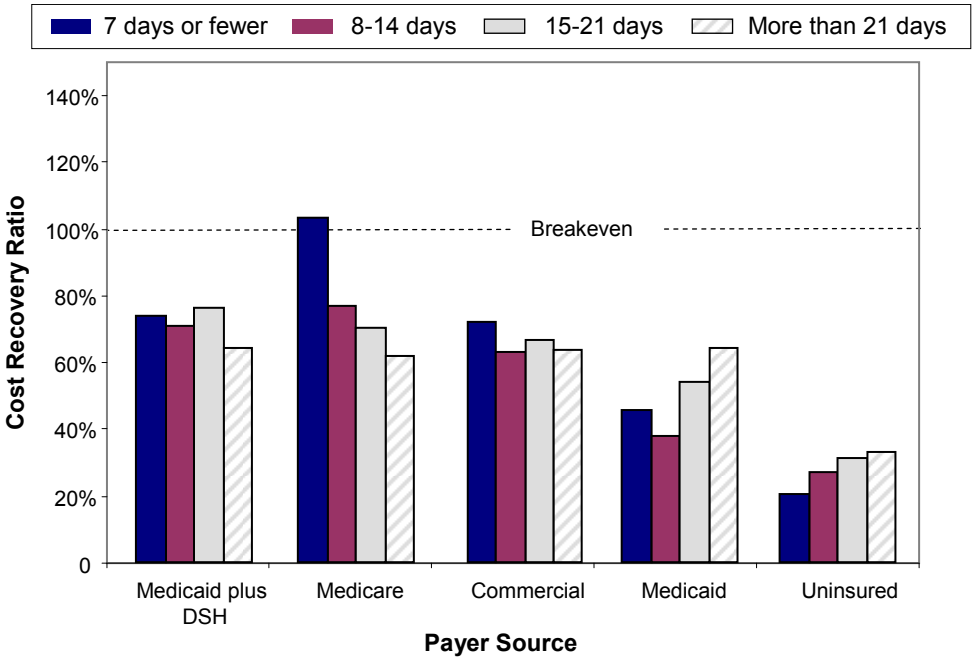
Note: Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.
General hospitals do not include teaching hospitals.

Source: Analysis of psychiatric facility financial survey data (2005).

Although Most Psychiatric Patients With an Extended Length of Stay Were Insured, Only 70 Percent of Costs Were Reimbursed

Most of the psychiatric patients with an extended LOS had some form of insurance, but licensed hospitals still had a significant amount of unreimbursed costs as a result of caring for these patients. In particular, about 20 percent of psychiatric patients with an extended LOS had commercial insurance, but hospitals were still not reimbursed for their total costs of providing care to these patients (Figure 2).

Figure 2: Cost Recovery Ratio Varies With Length of Stay



Note: Excludes 33 admissions with a length of stay of 100 days or more, the majority of which were admitted at VCU, covered by Medicaid, and had a cost recovery ratio of more than 300%.

Source: Analysis of psychiatric facility financial survey data (2005).

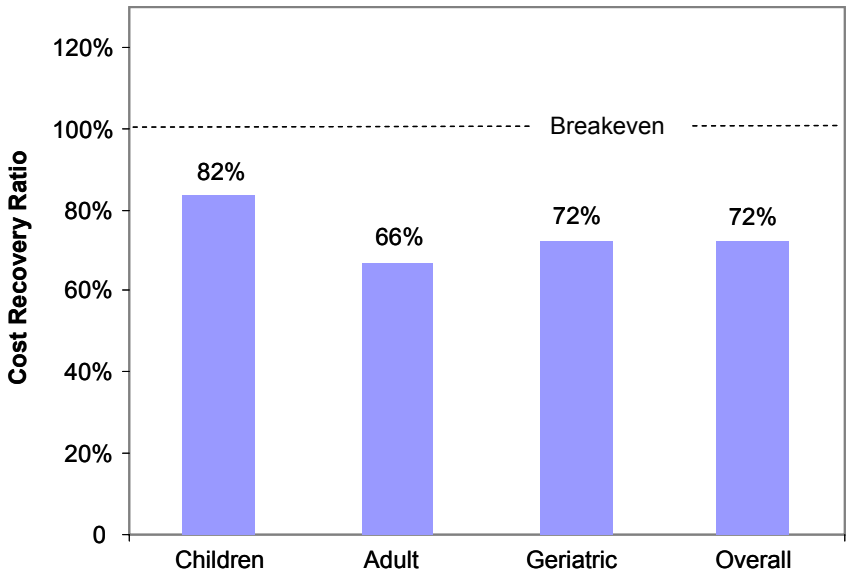
As illustrated in Figure 1 above, the CRR for commercial insurance was about 90 percent. This CRR does not take into account the patient's LOS. However, as shown in Figure 2, the CRR for commercial insurers generally decreases as the LOS increases.

About ten percent of psychiatric patients with an extended LOS had Medicaid or Medicaid plus DSH as their primary payer source. However, as shown in Figure 2, neither Medicaid plus DSH nor Medicaid reimbursed hospitals for the costs of their Medicaid psychiatric patients with an extended LOS.

Reimbursements for Psychiatric Patients With an Extended Length of Stay Vary By Age

The age of a psychiatric patient also affects a hospital's cost recovery ratio. Among psychiatric patients with an extended LOS, ten percent are children and adolescents (17 years old or younger), 61 percent are adults (between 18 and 64 years old), and 29 percent are geriatric patients (65 years old and older). If the outliers are included, reimbursements covered 82 percent of the costs of children with an extended LOS, but only 66 percent of adult patients and 72 percent of geriatric patients (Figure 3). However, if the outliers are excluded, hospitals were fully reimbursed for the costs of children, but for only 81 percent of the cost of adults and 79 percent of the cost of geriatrics.

Figure 3: Hospitals Were Reimbursed for 82 Percent of the Costs of Children With an Extended Length of Stay



Note: Excludes 33 admissions with a length of stay of 100 days or more, the majority of which were admitted at VCU, covered by Medicaid, and had a cost recovery ratio of more than 300%. Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

Source: Analysis of psychiatric facility financial survey data (2005).

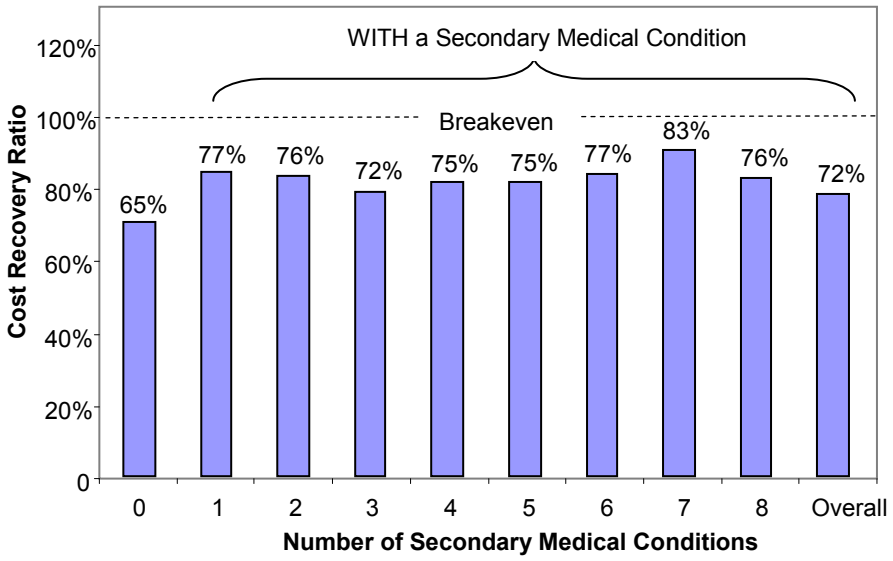
Hospitals Were Reimbursed Proportionately More for Their Costs of Patients With a Secondary Medical Condition, but Total Costs Were Still Not Covered

As mentioned in Chapter 4, psychiatric patients with a secondary medical condition accounted for more than 60 percent of all psychiatric patients in 2005. However, these patients also accounted for half ($32.7 million) of the total amount of unreimbursed costs experienced by all licensed hospitals. If the outlier hospitals are

excluded, these patients accounted for 82 percent ($20.5 million) of the unreimbursed costs experienced by the non-outlier hospitals.

Although hospitals incurred higher costs for patients with a secondary medical condition, they also received a larger reimbursement which resulted in a higher CRR in comparison to patients without secondary conditions (Figure 4). Patients without a secondary medical condition had a CRR of 65. In contrast, patients with multiple secondary medical conditions had higher CRRs. (This analysis does not distinguish between payer types.)

Figure 4: Cost Recovery Ratio By Number of Secondary Medical Conditions



Note: This trend does not apply to Medicaid reimbursements since Medicaid pays a fixed per diem rate, regardless of the number of medical conditions a psychiatric patient may have. Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

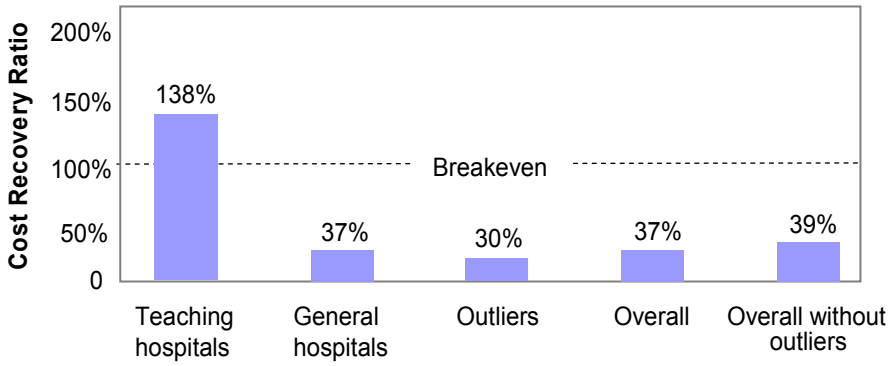
Source: Analysis of psychiatric facility financial survey data (2005).

Extent of Unreimbursed Costs Incurred by Emergency Departments Varied by Type of Hospital

Although emergency departments (EDs) also incurred unreimbursed costs in 2005 by providing psychiatric services, some EDs experienced greater losses than others, and a few were able to recover their costs. Among the 22 EDs that responded to the JLARC staff survey, those in teaching hospitals were fully reimbursed for the total cost of providing psychiatric services. However, reimbursements fell short of total costs for EDs in general hospitals.

Figure 5 presents the cost recovery ratio (CRR) for emergency departments in each type of hospital. Using this measurement, ERs in teaching hospitals had a CRR of 138 percent, indicating that they were able to completely recover their costs of providing psychiatric services. Conversely, EDs in general hospitals had a CRR of 37 percent, meaning that they were only reimbursed for 37 percent of their total costs of providing psychiatric services.

Figure 5: Cost Recovery Ratio in the Emergency Department Varies by Type of Hospital



Note: Outliers include three psychiatric facilities that accounted for 59% of the total unreimbursed costs in 2005.

Source: Analysis of emergency departments' financial data (2005).

Emergency Departments Were Reimbursed a Lower Proportion of Costs for Providing Outpatient Psychiatric Services in 2005

Licensed hospital administrators expressed the concern that EDs treat a large volume of psychiatric patients on an outpatient basis, which may account for a significant portion of the financial losses they incurred from providing psychiatric services. In addition, many of these patients may repeatedly visit an emergency department for psychiatric treatment instead of accessing services through a local community services board or an outpatient clinic.

Although the survey data did not allow an analysis of repeat visits, the analysis does indicate that 84 percent of psychiatric patients treated in an ED were seen on an outpatient basis and were subsequently discharged to their home. This is similar to VHI data, which indicate that 78 percent of all ER visits did not result in an inpatient admission in 2005.

Because a significant percentage of patients who were not admitted were either uninsured or had commercial insurance (the two primary sources for the unreimbursed costs), EDs were only reimbursed for 36 percent of their costs of providing outpatient psychi-

atric services. In comparison, EDs were reimbursed for half of their costs incurred in treating psychiatric patients who were subsequently admitted to the hospital's psychiatric unit.

Appendix J

Average Daily Census of State Mental Hospitals

Year	Average Daily Number of Persons
1880	1,055 [a]
1890	1,850 [a]
1900	2,757 [a]
1910	3,715 [a]
1920	4,942 [a]
1930	7,193 [a]
1940	9,213
1942	9,342
1944	9,370
1946	9,435
1948	9,704
1950	9,909
1952	10,329
1954	11,080
1956	11,029
1958	11,027
1960	11,220
1962	11,532
1964	11,492
1966	11,467
1968	11,103
1970	10,811
1972	8,290
1974	6,599
1976	5,967
1978	5,218
1980	4,835
1982	4,165
1984	3,576
1986	3,110
1988	3,047
1990	2,956
1992	2,775
1994	2,482
1996	2,222
1998	2,089
2000	1,694
2002	1,654
2004	1,528
2006	1,519

[a] Data for 1880-1930 include persons with mental retardation and persons with epilepsy who were reported by Central State Hospital. Data for 1920 and 1930 include persons reported by the State Colony for Epileptics and Feebleminded (Central Virginia Training Center), which opened in 1910.

Source: For 1880-1930, data are from *Virginia State Hospitals for Mental Patients* (State Department of Public Welfare) 1934. For 1940, data are from *Trends in Hospitalization for Mental Disease and Mental Deficiency in Virginia* (Virginia State Planning Board) 1942. For 1942-1962, data are from *Report of The Virginia Mental Health*

Study Commission (Cary Commission) 1965. For 1964-1972, data are from *Mental Health in Virginia*, volumes 9-23 (State Hospital Board, Department of Mental Hygiene and Hospitals). For 1974, data are from *The Effects of Deinstitutionalization* (House Document Number 14) 1997. For 1976 -2006, data are from DMHMRSAS.

Appendix K

Agency Responses

As a part of the extensive evaluation process, State agencies and other entities involved in a JLARC assessment effort are given the opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from comments provided by these entities have been made in this version of the report. This appendix includes written responses from

- Department of Mental Health, Mental Retardation and Substance Abuse Services,
- Department of Medical Assistance Services,
- Department of Health,
- Virginia Hospital and Healthcare Association, and
- Virginia Commonwealth University.

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dmhmrsas.state.va.us

October 2, 2007

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capital Square
Richmond, VA 23219

Dear Mr. Leone:

I want to express appreciation for the opportunity to review and comment on the *Availability and Cost of Licensed Psychiatric Services in Virginia* exposure draft. The JLARC team, led by Ashley Colvin, Principal Legislative Analyst, worked closely with Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) staff throughout this study and all comments point to this being a well-organized study that was very collaborative.

The report addresses a number of key issues involving our Department's role in the full continuum of behavioral health services, including operation of State Facilities, our interface with Community Services Boards and Behavioral Health Authorities, the role and responsibilities of our State Board, and our leadership role in several initiatives. Given the range of the study, I want to be certain that our formal response is thoughtful and complete. We are preparing that response and it will be delivered in advance of the Commission meeting. I appreciate this flexibility and look forward to joining you next Tuesday.

Sincerely,

James Reinhard

James Reinhard, M.D.
Commissioner

cc: The Honorable Marilyn B. Tavenner, Secretary of Health and Human Services
Ray Ratke, Deputy Commissioner

OCT - 5 2007

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

JAMES S. REINHARD, M.D.
COMMISSIONER

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dmhmrsas.virginia.gov

October 5, 2007

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Capital Square
Richmond, VA 23219

Dear Mr. Leone:

Thank you for the opportunity to review and comment on the exposure draft of *Availability and Cost of Licensed Psychiatric Services in Virginia*. The exposure draft reflects a tremendous amount of time and effort on the part of your staff in addressing this very complex and broad topic. I hope your staff found the comments submitted via email by Frank Tetrick last Friday on various details of an earlier copy of the exposure draft helpful in correcting some errors or misconceptions in that draft; I have enclosed a copy of those detailed comments for the record. The Department appreciates your willingness to incorporate those clarifications in the final draft of the report.

I will focus my more general comments on the recommendations in the exposure draft that may affect the Department or community services boards (CSBs), recognizing that some of my comments may have implications for text or discussions in other parts of the exposure draft. However, before commenting on these particular recommendations, I would like to offer three broader observations related to the report.

First, the Department and CSBs, together with our system's stakeholders, have been involved in a massive effort to transform the public mental health, mental retardation, and substance abuse services system fundamentally over the past several years in order to achieve a consumer-driven system of care that supports consumer recovery, self-determination, and empowerment. An effort this effort sweeping will continue of necessity for many years. A key element in this system transformation initiative has been a deliberate focus on a regional approach to move this effort forward. In particular, regional approaches to state facility and local inpatient utilization management and the implementation and management of certain specialized community services or programs, such as discharge assistance projects and crisis stabilization programs, are the most effective way to transform the public services system and use scarce resources most efficiently.

The exposure draft acknowledges the value of this approach, while raising some concerns about it. Some of those concerns may reflect an incomplete understanding of the nature, purposes, and structure of the partnership planning regions (PPRs). A PPR is not a legal entity with operational powers or duties; it is a mechanism to structure and enhance the communication, cooperation, and collaboration between a state facility and the CSBs that it serves in a geographic area and among the other stakeholders in that region, such as consumers, family members, and affected public and private providers. Unavoidably, in an effort this broad and far-reaching, progress has varied considerably among the regions, and it will continue to do so, in part because of the wide diversity among regions in terms of public and private resources that are available and services that are needed. Finally, the Department did not create the PPRs, the individual CSBs and state facilities in a region established the regional partnership.

Second and related to this first observation, the Department does not fund PPRs and those regions are not assuming the statutory roles and responsibilities of CSBs or state facilities, such as preadmission screening or discharge planning. The Department may allocate certain funds appropriated by the General Assembly for system transformation activities to CSBs or BHAs that comprise a PPR for planning and management purposes, but it does not and cannot disburse state or federal funds appropriated for these activities from the Grants to Localities appropriation to PPRs. Similarly, while components of PPRs, such as regional authorization committees, may conduct regional utilization management activities related to CSB use of state or local private psychiatric hospital beds, PPRs do not admit individuals to state facilities or local hospital beds. Individuals are admitted to state facilities through the civil admissions process in which individual CSBs play a crucial role, and each CSB admits individuals to its services, including purchased local hospital beds. In carrying out some of their utilization management activities through these PPRs, the Department strongly encourages CSBs and state facilities to fully involve their local private providers consistently whenever this is appropriate. In a long-term and far-reaching fundamental change process, forward movement is not always uniform, and the process will exhibit unavoidable and sometimes necessary variations in different areas of the state. We need to strive for more consistent practices within regions, rather than complete uniformity across the state.

Third, while local governing bodies (city councils or boards of supervisors) established all 40 CSBs, most CSBs are not actual city or county departments or agencies. Twenty-eight CSBs are operating boards, and one is a behavioral health authority, which functions like an operating CSB; all of these function somewhat autonomously or independently from local governments. Ten CSBs are administrative policy boards, seven of which are actual city or county government departments, and one is a local government department with a policy-advisory CSB. Thus, mandates in Chapters 5 and 6 of Title 37.2 of the *Code of Virginia* generally apply to CSBs, rather than to the city councils or boards of supervisors that established them.

Regarding the recommendations in the exposure draft that affect the Department, I offer the following comments for your consideration.

Recommendation 10: The State Mental Health, Mental Retardation and Substance Abuse Services Board should develop regulations to institute preadmission screening as directed by § 37.2-823 of the *Code of Virginia* and use these regulations to establish admission criteria.

Comments: This statutory provision regarding preadmission screening regulations has remained undisturbed in the *Code* since at least 1980. However, in the intervening years, the Department has implemented and now will be re-examining and revising Discharge Planning Protocols and Continuity of Care Procedures, both part of the performance contract with CSBs, and training for preadmission screeners; all of these structure and guide preadmission screening activities of CSBs. The Department, state facilities, and CSBs also are working to bring more consistency to utilization management through the Regional Utilization Management Guidance document and process, which will produce utilization management standards in the near future. The Department believes these efforts can address legitimate concerns about the preadmission screening process. The Department does not believe that the cited statute requires, nor would it be helpful to develop, admission criteria for state facilities as part of this effort. Variations in resources and the need for inpatient services and differing and evolving roles of state facilities in each region and the ongoing need for flexibility in the operation of state facilities in response to changing demands and service availability in the community argue against incorporating admission criteria in regulation. Instead, admission criteria should be incorporated in regional utilization management standard or procedures. If the General Assembly believes that regulations are still necessary, the Department will develop regulations to govern the preadmission screening process, once any recommendations of the Commission on Mental Health Law Reform that may affect this process have been acted upon by the legislature.

Recommendation 11: The Department of Mental Health, Mental Retardation, and Substance Abuse Services should initiate formal planning tied to the state capital funding process to project the number of civil and forensic beds provided in each State hospital, and publish an annual report on bed need projections for each facility. This should be done collaboratively with agencies in the criminal justice system to adequately plan for forensic bed needs.

Comments: The goal of system transformation is to expand the availability of services in the community, rather than increase the bed capacities of state facilities. Virginia already places a disproportionate share of its resources in these facilities, and this limits its ability to increase the availability of urgently needed community services. Also, most projection methodologies are too simplistic to accommodate the tremendous variety of factors and influences that would need to be included to produce meaningful projections. The Department would prefer using its staff resources to increase service capacity in the community. However, if the General Assembly believes developing bed projections for state facilities is an effective and efficient use of scarce staff resources, the Department will work with other system stakeholders to develop them.

Recommendation 12: The Department of Mental Health, Mental Retardation and Substance Abuse Services should issue guidelines which outline the purpose of the Local Inpatient Purchase of Services program and clearly indicate which, if any, services other than acute psychiatric beds in licensed hospitals may be purchased with these funds.

Comments: The Department has provided guidance to CSBs on the purpose and use of Local Inpatient Purchase of Services funds and related appropriations. However, the Department has recently initiated a process with CSBs to develop standards and expectations for services, and this, together with regional utilization standards, will provide more formal guidance on the purposes and uses of funds appropriated for purchases of local inpatient services.

Recommendation 13: The Department of Mental Health, Mental Retardation and Substance Abuse Services should provide guidance to community services boards on eligibility requirements, and whether the procedures and eligibility definitions are consistent with the purpose of the program.

Comment: The Department agrees that additional clarification about eligibility requirements and procedures for purchases of local inpatient services would be helpful as long as variations among regions that reflect the availability of other services, the roles of state facilities, and the needs of consumers are recognized and incorporated. The goal should be a reasonable level of consistency across the state with regional variations where they are necessary and appropriate. The Department is involved in providing this clarification in collaboration with CSBs and state facilities, along with other stakeholders, through the evolving regional utilization management guidance and standard setting process.

Recommendation 14: The Department of Mental Health, Mental Retardation and Substance Abuse Services should work collaboratively with the community services boards to develop a common data submission system for reporting on individuals served through the Local Inpatient Purchase of Services program. This reporting system should be designed to allow the department to determine whether Local Inpatient Purchase of Services programs are being operated according to the department's guidelines and whether regions are consistently applying their own guidelines.

Comments: The Department concurs with this recommendation and will develop a system that is consistent with the Community Consumer Submission data collection and reporting system.

Recommendation 15: The General Assembly may wish to consider amending § 37.2-512 of the Code of Virginia to clarify whether joint agreements between community services boards can be used to form regional partnerships. The General Assembly may wish to further clarify whether regional partnerships of community services boards may make decisions regarding State hospital admissions, and whether these admission decisions conform to the duties assigned to the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services pursuant to § 37.2-840 and to the community services boards pursuant to § 37.2-805.

Comments: The Department has serious concerns about this recommendation. As noted in my general observations, the Partnership Planning Regions (PPRs) are not legal entities and do not admit consumers to state hospitals. The PPRs are merely a convenient mechanism through which CSBs and state facilities communicate, cooperate, and collaborate to carry out some of their statutory or contractual responsibilities and advance the goal of system transformation. The Department does not believe additional legislation is needed at this time to address this issue.

Recommendation 16: To allow for the Department of Mental Health, Mental Retardation and Substance Abuse Services to more fully monitor state hospital admissions and denials, the General Assembly may wish to modify Section 37.2-703 as follows: (b) An efficient system of keeping records concerning the consumers admitted to or residing in each state facility, and *of all requests for admission which were denied and the reasons for their denial.*

Comments: The Department agrees that more complete and consistent information about the utilization of state hospital and local purchased inpatient psychiatric beds, including patterns of use in admissions or denials, would be useful. However, the Department is concerned that this recommendation appears to perpetuate a counterproductive distinction between state hospital and local purchased inpatient beds; the focus should be on the services needed by consumers, not the location of those services. Therefore, the Department does not believe inserting the additional language in the statute is necessary at this time. Instead, I suggest that the recommendation should direct the Department to issue regional utilization management standards as part of the community services performance contract and address this concern in those standards. The performance contract is subject to a 60-day public review and comment process, and this would provide for the public participation and involvement that could benefit the development of these standards. The ultimate goal is for CSBs and state facilities, participating collaboratively to fulfill their statutory roles through regional utilization management processes and involving their private partners in those processes, to control all admissions to state hospitals. This has been achieved to a great extent in PPRs 4 and 5. Also, secure on-line discharge planning, which will be possible at all state hospitals by the end of this calendar year, will address this issue by improving local and regional utilization management capacity and statewide oversight.

Recommendation 17: The Department of Mental Health, Mental Retardation and Substance Abuse Services should seek to encourage interregional planning with regard to State hospital bed usage. In order to determine whether interregional cost-shifting is or will be a significant issue, the Department of Mental Health, Mental Retardation and Substance Abuse Services should annually monitor the extent to which individuals are placed in State hospitals outside of the consumer's home region.

Comments: The Department concurs with this recommendation and would propose addressing it through the development and implementation of regional utilization management standards, as noted in the preceding comment.

The Department will work with all involved stakeholders to explore any actions or alternatives that the Governor and the General Assembly determine are appropriate responses to these recommendations. I also look forward to attending the Commission's meeting next Tuesday to be available to answer any questions or concerns about these comments or the recommendations. Again, thank you for the opportunity to review and comment on this exposure draft and for your consideration of my comments.

Sincerely,

James Reinhard

James S. Reinhard, M.D.

Enclosure (1)
JSR/prg
pc: The Honorable Marilyn B. Tavenner
Patrick W. Finnerty

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

October 1, 2007

Mr. Philip A. Leone
Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building, Capital Square
Richmond, VA 23219

Dear Mr. Leone:

Thank you for the opportunity to review and comment on the exposure draft of the report titled *Availability and Cost of Licensed Psychiatric Services in Virginia*. I commend you and your staff's effort in its extremely broad examination of the issues surrounding psychiatric services in the Commonwealth. We greatly appreciate the staff's willingness to incorporate many of our suggested clarifications in the final draft.

Much of the discussion in the draft report related to Medicaid revolves around an analysis of cost recovery by Medicaid providers. It is our understanding, based on discussions with the project staff that the great majority of the data utilized in this analysis was self-reported by the providers in response to a JLARC survey. This data was then supplemented with payment information, primarily for Disproportionate Share Hospital (DSH) payments, from the Department of Medical Assistance Services (DMAS). Therefore, it is impossible at this time for DMAS to make any assessment as to the accuracy of the analysis utilizing these separate and distinct data sources. For example, while the reported Medicaid cost coverage for psychiatric care delivered in hospital emergency departments is not intuitive to DMAS staff based on our understanding of Medicaid reimbursement, we are not in a position within the time frame allowed for review to comment on the results of the analysis.

Regarding the Medicaid-specific recommendations, I offer the following comments:

Recommendation 3: The General Assembly may wish to direct the Department of Medical Assistance Services to study and report back to the House Appropriations and Senate Finance Committees prior to the 2009 General Assembly Session on the advisability of adopting regional adjustments in the rates for physician services in order to attract physicians to medically underserved areas.

The Department will comply with any directive from the Governor and General Assembly to examine the feasibility and cost of modifying the reimbursement methodology to include regional adjustments for physician services in medically underserved areas.

Recommendation 4: The General Assembly may wish to direct the Board of Medical Assistance Services to amend the State Plan of Medical Assistance Services governing Medicaid reimbursements for freestanding psychiatric hospitals, licensed as hospitals, to include the rates in the hospital rebasing process.

These rates are legislatively excluded from rebasing, and current regulations reflect this practice. To the extent the Governor and General Assembly direct modification to this approach, the Department will comply.

Recommendation 5: The General Assembly may wish to direct the Department of Medical Assistance Services to study and report back to the House Appropriations and Senate Finance Committees prior to the 2009 General Assembly Session on the advisability of adopting weighted per diem rates and outlier payments for inpatient acute care psychiatric services.

The Department will comply with any directive from the Governor and General Assembly to examine the feasibility and cost of modifying the reimbursement methodology for inpatient psychiatric services.

Recommendation 6: The General Assembly may wish to amend § 37.2-809 (E) of the *Code of Virginia* to state that "The costs incurred as a result of the hearings and by the facility in providing services during the period of *emergency custody and* temporary detention shall be paid and recovered pursuant to § 37.2-804." This amendment would clarify that licensed hospitals may be paid for services rendered during an emergency custody order.

Effective July 1, 2006, DMAS has provided reimbursement for the four hour emergency custody order for assessment and evaluation services performed by the hospital and physician associated with the emergency room through the IMCF.

Recommendation 7: The Department of Medical Assistance Services should revise the language in Appendix B of its Hospital Provider Manual, which pertains to Temporary Detention Orders, to clarify whether the Department will reimburse providers from the Involuntary Mental Commitment Fund for services provided as part of a medical screening, and to provide a definition of a medical screening. In developing this definition, the Department of Medical Assistance Services should consult with the Department of Mental Health, Mental Retardation and Sub-stance Abuse Services.

DMAS is currently in the process of updating the Hospital Manual to reflect that medical screenings are covered.

Recommendation 8: The Board of Medical Assistance Services should adopt the regulations to establish a reasonable rate per day for payments from the Involuntary Mental Commitment Fund for services rendered during temporary detention orders, as required by § 37.2-809 of the *Code of Virginia*, and use the regulatory process to establish reasonable reimbursement criteria.

While the Department is not necessarily opposed to the idea of further clarifying that the rate paid for Temporary Detention Orders (TDO) is the same per diem rate as paid for inpatient psychiatric services under the Medicaid program, the Department does not agree with the JLARC implication that the relevant statute has not been followed. As JLARC staff cite, Section 37.2-809 states that the "State Board of Medical Assistance Services shall, by regulation, establish a reasonable rate per day of inpatient care for temporary detention". JLARC concludes that this language requires *separate* regulation specific to the TDO, however the Department has not interpreted the statute similarly.

When DMAS was asked to administer the Involuntary Mental Commitment Fund in 1995, the decision was made to apply the per diem rates established for Medicaid inpatient psychiatric providers to the TDO services. While no *new* regulations were created, the methodology for the development of inpatient psychiatric rates is in fact established in regulation. This decision was communicated and is currently reflected in the Hospital Provider Manual, Appendix B – Temporary Detention Orders, which states that payments for services rendered will be paid at the "*Medicaid allowable* reimbursement rates established by the Board of Medical Assistance Services" (emphasis added).

Therefore, the Department believes it has met the statutory requirement of a reasonable rate methodology for TDOs established in regulation. While there may be concern expressed by providers as to the adequacy of the per diem rate for TDO, there is no ambiguity regarding the rate itself and the methodology used to calculate the rate. It should also be noted that while DMAS cannot verify this result, the JLARC survey appears to indicate that the inpatient psychiatric rate applied to TDOs actually reimburses a higher percentage of the TDO cost than does the same per diem applied against inpatient psychiatric care costs (Page 53 of the draft indicates cost coverage of TDO services at 94 percent, compared to cost coverage at 75 percent for inpatient psychiatric hospitals listed on page 54 of the draft).

Recommendation 9: The General Assembly may wish to direct the Department of Medical Assistance Services to amend the State Plan of Medical Assistance Services to include inflation adjustments for the rates for physician psychiatric services.

If directed, DMAS will determine the fiscal impact of inflationary adjustments for physician psychiatric services for funding consideration by the Governor and General Assembly.

DMAS stands ready to work with all interested parties to further explore whatever options the Governor and General Assembly believe appropriate in response to this report. Again, thank you for the opportunity to comment on the draft report.

Sincerely,

PWFinnerty

Patrick W. Finnerty
Director

PWF/sf

cc: The Honorable Marilyn B. Tavenner, Secretary of Health and Human Resources

OCT - 2 2007

COMMONWEALTH of VIRGINIA

Department of Health

ROBERT B. STROUBE, M.D., M.P.H.
STATE HEALTH COMMISSIONER

P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

September 26, 2007

Phillip A. Leone, Director
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for the opportunity to review the exposure draft entitled *Availability and Cost of Licensed Psychiatric Services in Virginia* in response to Senate Joint Resolution 185 (2006). My staff has reviewed the report and finds no errors or inconsistencies in the information or data reported concerning the Certificate of Public Need (COPN) program.

In response to Recommendation 1, that VDH begin using a "geographic information system (GIS) software to determine the extent to which 95 percent of the population lives within one hour of the medical service under consideration" as part of determining public need, we concur in principle. We are aware that there are several GIS programs available. Recognizing that such a program must be accessible for all COPN stakeholders, our preliminary inquiries have indicated such software may not be publicly accessible or may be cost prohibitive for some individual stakeholders. Nonetheless, I have directed staff in the VDH Division of COPN to continue their investigation into the feasibility of using GIS software.

You will be interested to know that, in collaboration with the Department of Mental Health, Mental Retardation and Substance Abuse Services, VDH is proposing that the current 90 percent occupancy rate for determining need for psychiatric services be lowered to 75 percent in our proposed revision to the *State Medical Facilities Plan*. Lowering the required occupancy rate appropriately eases the requirement for adding or opening additional psychiatric beds in areas in need of such beds.

Thank you again for the opportunity to review the exposure draft.

Sincerely,

Robert B. Stroube, M.D., M.P.H.

cc: The Honorable Marilyn B. Tavenner

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
www.vdh.virginia.gov

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

4200 INNSLAKE DRIVE, SUITE 203, GLEN ALLEN, VIRGINIA 23060-6772
P.O. BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 965-1227 FAX (804) 965-0475

October 1, 2007

Mr. Philip Leone
Director
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
Richmond, Virginia 23219

Dear Mr. Leone:

On behalf of the private inpatient psychiatric facilities in Virginia, thank you for the opportunity to comment on the exposure draft of the Joint Legislative Audit and Review Commission's study of the *Use and Financing of Licensed Inpatient Psychiatric Facilities*. In particular we would like to thank Howard E. (Hal) Greer, III, Ashley Colvin, Paula Lambert, Eileen Fleck and Bradley Marsh for the comprehensive and thoughtful approach they have taken to this complex topic.

Virginia's acute inpatient psychiatric hospitals have become an increasingly important part of the mental health care delivery system. The degree of interdependence between the public and private segments of the system is greater than ever before, and the two segments must work together for individuals to receive the care they need. The state has undertaken several rounds of deinstitutionalization and restructuring, but it has not always modified the legal, regulatory and financial framework of the system to reflect the changes that have been implemented at the state and community level. The JLARC report does a good job of identifying steps that could be taken to bring these elements into alignment, thereby strengthening the mental health system and its ability to provide care in the future.

We commend the General Assembly for directing JLARC to undertake this study, and we look forward to working with the administration and the legislature as they identify steps that should be taken based on the study recommendations.

Sincerely,

Betty Long

Betty Long
Vice President

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

4200 INNSLAKE DRIVE, SUITE 203, GLEN ALLEN, VIRGINIA 23060-6772
P.O. BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 965-1227 FAX (804) 965-0475

October 1, 2007

Mr. Ashley S. Colvin
Project Leader
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
Richmond, Virginia 23219

Dear Ashley:

During the exposure draft review of the *Use and Financing of Licensed Inpatient Psychiatric Facilities* several questions arose regarding the cost recovery ratios related to services provided to psychiatric patients in the emergency department. In particular, concerns were expressed that reimbursements associated with these patients may not have been included in the survey data submitted to JLARC by hospitals.

In an effort to confirm the reliability of the data submitted to JLARC, VHHA contacted three hospitals (Carilion, HCA and Inova) who participated in the survey. Below is a summary of the issues that were raised with the hospitals and their responses.

The cost recovery ratio for psychiatric patients seen in emergency departments but not admitted is significantly lower than that for inpatient psychiatric patients.

- This is not surprising. The number of psychiatric patients seen in the emergency department who are not admitted is much higher than the number of patients who are admitted.
- It is not unusual for a patient to present in the emergency department with what appear to be medical issues, thus necessitating a medical assessment, but the ultimate diagnosis is psychiatric. For patients who are not admitted, many of the costs associated with the medical assessment will not be reimbursed, even if there is a payer source.
- Many of the patients seen in the emergency department are uninsured, so there is little or no payment received for any of the services rendered. However, services rendered to uninsured patients that are TDO'd to the inpatient unit will be covered in part by payment from the TDO Fund.
- The cost recovery for most patients seen in the emergency department is low, regardless of payer source.
- The difference between the ratio of direct to indirect costs in the emergency department compared to the inpatient setting may also help explain the lower cost recovery ratio in the emergency department. For the hospitals we consulted, indirect costs accounted for between 50 percent and 70 percent of total costs.

The data submitted by hospitals resulted in a low cost recovery ratio because hospitals bill separately for services such as laboratory and diagnostic tests and physician services, and the data they submitted captured the costs but not the associated reimbursement for these services.

- All of the hospitals confirmed unequivocally that the data they submitted reflected not only the costs associated with a given patient but any associated payments received for that patient. This included lab and diagnostic work, pharmacy and physicians.

Based on the feedback we received from these hospitals, VHHA is confident that the emergency department data submitted by hospitals to JLARC is reliable and reflects an accurate picture of the financial losses incurred as a result of psychiatric patients who are treated in the emergency department but not admitted. We believe that eliminating this data from the final report would significantly understate the magnitude of the financial impact of providing psychiatric services in Virginia's acute care hospitals.

It is also important to note that the survey data reflects only the emergency department impact associated with hospitals with an inpatient psychiatric unit. There are many other acute hospitals in the state that operate emergency departments that treat psychiatric patients. This larger universe was beyond the scope of the JLARC study, but it may be appropriate to recognize that there are additional costs associated with the services provided to psychiatric patients in the acute care setting that could not be addressed in the report.

Thank you for the opportunity to seek clarification from our hospitals regarding this key point related to the inpatient psychiatric study. We would be happy to answer any additional questions you may have regarding this issue.

Sincerely,

Betty Long

Betty Long
Vice President

MCV Campus

Virginia Commonwealth University

Medical Center

In the tradition of the Medical College of Virginia

School of Medicine
Department of Psychiatry

1200 East Broad Street
P.O. Box 980710
Richmond, Virginia 23298-0710

804 828-9157
Fax 804 828-1472
TDD: 1-800-828-1120

October 1, 2007

Mr. Philip Leone, Director
Joint Legislative Audit and Review Commission
General Assembly Building
Suite 1100
Richmond, VA 23219

Dear Mr. Leone:

Thank you for letting us review the draft report on *The Availability and Cost of Licensed Psychiatric Services in Virginia*. We appreciate the value such a review can bring mental health services in Virginia and we plan to attend the presentation of the study on October 9.

As a leading provider of psychiatric care to the citizens of Richmond and the entire Commonwealth, we are deeply committed to quality care for all in need. As Chairman of Department of Psychiatry at Virginia Commonwealth University, my faculty and staff are working to raise the level of care to those with mental illness. We provide this through patient care and the education of the full spectrum of future mental health providers, most of whom remain in Virginia to practice. Our clinical and educational missions can only be accomplished with adequate resources. Your report is most helpful in educating our legislators about the needs in this area.

VCU, as a major academic medical center, treats those with limited resources. As the report notes, VCU Health System receives Medicaid reimbursement and DSH funds. This reimbursement through DMAS covers the hospital costs associated with Medicaid patients and those uninsured patients who quality under state guidelines for Indigent Care. However, DMAS plus DSH funds do not cover a large amount of our unreimbursed costs. Current reimbursement does not cover the costs of those patients who do not qualify under Virginia's Indigent Care programs such as those who are under-insured, those who are uninsured who do not meet the income criteria, foreign patients, etc.

Since only 43% of our psychiatric in-patients fall into the Indigent Care and Medicaid categories, MCVH loses millions each year from caring for non-Indigent Care, non-Medicaid patients. Large additional losses occur on the provider side.

The most disturbing part about our unreimbursed care is the amount that is associated with third party reimbursement for insured patients where payment for facility and professional services is below cost. Many of our patients with commercial insurance have contractual rates so poor that reimbursement rarely meets our costs. Our psychiatric inpatient service operates at a loss, which translates into a lack of adequate facilities and personnel to meet the needs we are asked to address.

As you know, the Health System operates one of the busiest Emergency Departments in the Commonwealth. Our hours on Psychiatric Diversion exceed any reasonable limit. This equates to many patients being sent elsewhere (often out of town) for care.

I am also concerned that although the report addresses facility care, it does not bring to light the situation of hugely inadequate physician reimbursement from Medicaid and private payors. It is quite challenging to try to recruit and retain faculty physicians to provide care, and train residents and students, and conduct research with compensation below cost and below that provided to non-psychiatric physicians providing similar services. A similar study focusing on the adequacy of professional compensation is recommended in order to obtain a more complete picture of the challenges our mental health system faces today.

I would ask that your report clarify these challenges for teaching facilities and faculty in Virginia. Thank you again for your staff's tremendous effort in delivering such an important study. Please do not hesitate to call me if I can assist in educating the legislature, administration and public about these important needs.

Sincerely,

Joel J. Silverman, M. D.
James Asa Shield Jr., M.D.Professor and Chair
Department of Psychiatry

:jd

JLARC Staff

Executive Staff

Philip A. Leone, Director
Glen S. Tittermary, Deputy Director

Division Chiefs

Robert B. Rotz, Senior Division Chief
Harold E. Greer III, Division Chief

Section Managers

Patricia S. Bishop, Fiscal & Administrative Services
Gregory J. Rest, Research Methods
Walter L. Smiley, Fiscal Analysis

Project Leaders

Aris W. Bearse
Justin C. Brown
Ashley S. Colvin
Martha L. Erwin
Eric H. Messick
Nathalie Molliet-Ribet
Kimberly A. Sarte

Project Staff

Janice G. Baab
Jamie S. Bitz
Jennifer K. Breidenbaugh
Mark R. Gribbin
Paula C. Lambert
Bradley B. Marsh
Ellen J. Miller
Stefanie R. Papps
Tracey R. Smith
Elisabeth M. Thomson
Christine D. Wolfe

Administrative and Research Support Staff

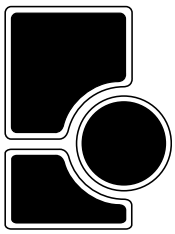
Joan M. Irby
Betsy M. Jackson

Recent JLARC Reports

2007 Reports

352. Follow-Up Report: Custody Relinquishment and the Comprehensive Services Act
353. Semi-Annual VRS Investment Report No. 28
354. Evaluation of House Bill 2156: Mandated Coverage of Second Opinions for Primary Malignant Brain Tumor Patients at NCI Comprehensive Cancer Centers
355. Final Report: Impact of Assisted Living Facility Regulations
356. Evaluation of House Bill 2877: Mandated Coverage of Human Papillomavirus (HPV) Vaccine
357. Evaluation of SB 991 and HB 2426: Repeals of Mandated Offer for Autologous Bone Marrow Transplant or Stem Cell Transplant for Breast Cancer
358. Evaluation of Senate Bill 931: Mandated Coverage of Prosthetic Devices
359. 2007 Report to the General Assembly
360. Access to State-Funded Brain Injury Services in Virginia
361. Review of State Spending: 2007 Update
362. Semi-Annual VRS Investment Report No. 29
363. State Spending on Standards of Quality (SOQ) Costs

These reports are available on the JLARC website at http://jlarc.state.va.us



Joint Legislative Audit and Review Commission
Suite 1100
General Assembly Building
Capitol Square
Richmond, Virginia 23219
804-786-1258 Fax 804-371-0101
http://jlarc.state.va.us