COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES
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COMMISSIONER

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December 1, 2007

The Honorable John H. Chichester, Chairman
Senate Finance Committee
General Assembly Building
Room 626
P.O. Box 396
Richmond, Virginia 23218

Dear Senator Chichester:

I am pleased to forward to you the Department's Annual Report on Community Services Board Contracts for Private Inpatient Psychiatric Treatment Services. Item 311 K of the 2007 Appropriation Act directs me to submit a report annually to you regarding community services board (CSB) contracts with private service providers, to include contract amounts paid to each provider, number of patients served, term of inpatient treatment, any savings realized by community-based treatment, and any fiscal impact on state hospitals.

The Department developed a survey in collaboration with the Virginia Association of Community Services Boards, and CSBs submitted the information needed to produce this report with their FY 2006 fourth quarter reports in early October. As this report notes, local inpatient psychiatric treatment services delivered by private providers through contracts with CSBs have had a substantial impact on reducing the potential demand for state hospital services. I hope that you and your staff find the information in this report helpful. My staff and I are available at your convenience to answer any questions you may have about this report.

Sincerely,

James Reinhard

James S. Reinhard, M.D.

JSR/prg
Attachment
pc: The Honorable Marilyn B. Tavenner
The Honorable William C. Wampler, Jr.
Betsey Daley
Joe Flores
Raymond R. Ratke
Frank L. Tetrick, III
Ruth Anne Walker
Paul R. Gilding

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December 1, 2007

The Honorable Vincent F. Callahan, Chairman
House Appropriations Committee
General Assembly Building
Room 947
P.O. Box 406
Richmond, Virginia 23218

Dear Delegate Callahan:

I am pleased to forward to you the Department's Annual Report on Community Services Board Contracts for Private Inpatient Psychiatric Treatment Services. Item 311 K of the 2007 Appropriation Act directs me to submit a report annually to you regarding community services board (CSB) contracts with private service providers, to include contract amounts paid to each provider, number of patients served, term of inpatient treatment, any savings realized by community-based treatment, and any fiscal impact on state hospitals.

The Department developed a survey in collaboration with the Virginia Association of Community Services Boards, and CSBs submitted the information needed to produce this report with their FY 2007 end of the fiscal year reports in early October. As this report notes, local inpatient psychiatric treatment services delivered by private providers through contracts with CSBs have had a substantial impact on reducing the potential demand for state hospital services. I hope that you and your staff find the information in this report helpful. My staff and I are available at your convenience to answer any questions you may have about this report.

Sincerely,

James Reinhard

James S. Reinhard, M.D.

JSR/prg
Attachment
pc: The Honorable Marilyn B. Tavenner
The Honorable Phillip A. Hamilton
Robert P. Vaughn
Susan E. Massart
Raymond R. Ratke
Frank L. Tetrick, III
Ruth Anne Walker
Paul R. Gilding

Annual Report on Community Services Board Contracts for Private Inpatient Psychiatric Treatment Services July 1, 2006 - June 30, 2007

To the Chairmen of the House Appropriations and Senate Finance Committees of the General Assembly

Presented By
James S. Reinhard, M.D.
Commissioner

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

December 1, 2007

Annual Report on Community Services Board Contracts
for Private Inpatient Psychiatric Treatment Services
July 1, 2006 - June 30, 2007

Executive Summary

Item 311 K of the 2007 Appropriation Act requires the Department to submit a report annually to the Chairmen of the House Appropriations and Senate Finance Committees regarding community services board (CSB) contracts with private providers for local inpatient psychiatric treatment services. CSBs contract with private providers of local inpatient psychiatric treatment services in two ways. Historically, a few CSBs have contracted individually with various private providers for local inpatient psychiatric services. Based on survey results, CSBs paid $110,779 to nine private providers for 509 bed days of inpatient psychiatric treatment for 152 individuals in FY 2007. Several CSBs also received 179 bed days for 21 individuals at no cost. CSBs contract with private providers of local inpatient psychiatric services primarily on a regional basis through the Local Inpatient Purchase of Services (LIPOS) mechanism. In FY 2007, CSBs paid $11,981,176 of LIPOS funds to 32 private providers for 20,305 bed days of inpatient psychiatric treatment for 3,193 consumers. Thus, in FY 2007, CSBs reported that they paid a total of $12,091,955 to 32 private providers for 20,993 bed days of inpatient psychiatric treatment for 3,366 individuals.

The purchase of these services by CSBs and the diversion of consumers receiving those services from admission to state hospitals had a significant impact on potential state hospital expenditures, utilization, and operations. Any savings realized by community-based inpatient psychiatric treatment services would be reflected in avoidance of increased state hospital expenditures and in decreased demand for state hospital beds. Of the 3,366 consumers served in FY 2007 through these contracts, only 329 consumers, or 9.8 percent of the total number, were transferred to a state hospital upon their discharge from private providers. These individuals needed longer term extended rehabilitation services offered by state hospitals. As a result of these contracts, 3,037 consumers were diverted from possible admission to state hospitals. In FY 2007, 3,255 individuals were served in state hospital admission units. If all 3,037 diverted consumers had been admitted, this would have increased the number of individuals admitted to state hospital admission units by 93 percent in FY 2007.

In conclusion, CSB contracts for local private inpatient psychiatric treatment services served more individuals than state hospital admission units in FY 2007, 3,366 versus 3,225 consumers. Those contracts obtained services for these individuals at far less cost than they could have been served in state hospitals, $12,091,955 in the community versus up to as much as $78,312,871 in state hospitals, depending on assumptions made about average lengths of stay in state hospital admission units and the proportion of those consumers who might have been admitted to state hospitals. Therefore, 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.

Annual Report on Community Services Board Contracts for Private Inpatient Psychiatric Treatment Services July 1, 2006 - June 30, 2007

Background

Item 311 K of the 2006 Appropriation Act requires the Department to submit a report annually to the Chairmen of the House Appropriations and Senate Finance Committees regarding community services board contracts with private service providers. The Act requires the report to include contract amounts paid to each private psychiatric inpatient provider, the number of patients (consumers) served, the term of inpatient treatment, any savings realized by community-based treatment, and any fiscal impact on state hospitals.

The performance contracts through which the Department funds community services boards and behavioral health authorities (CSBs) require them to submit reports containing financial, service, and consumer information to the Department on October 1 for the previous fiscal year. However, those reports do not contain the information about individual private providers needed for this report. Therefore, the Department collected this information through an additional non-automated report from CSBs. Because it would be much less disruptive for CSBs to submit the additional report with their other Fiscal Year (FY) 2007 reports to the Department on October 1, the Department requested and received an extension of the due date for this report to December 1. This extension allowed Department staff to receive and analyze the information submitted by CSBs before completing this report.

Methodology

The Department developed a survey in collaboration with CSBs to gather the information needed to prepare this report. The survey instructed CSBs to include all funds paid during FY 2007, even if the payment was for services provided in FY 2006, since some bills for FY 2006 services would not be presented or paid until after the end of that fiscal year. The survey also instructed CSBs to include all consumers who received inpatient psychiatric treatment from these private providers, even consumers served in FY 2007 but not paid for in FY 2007 due to services being billed after the end of FY 2007. Finally, the survey instructed CSBs to include all bed days, even bed days provided in FY 2007 that were not paid for in FY 2007, due to services being billed or paid after the end of FY 2007. This tends to balance out FY 2007 payments for FY 2006 services with services but no payments in FY 2007. The survey also instructed CSBs to include payments to reserve beds, some of which might not be occupied always. Information about consumers and bed days was used to address the term of inpatient treatment element in item 311 K for this report.

The Department distributed the survey on September 6, so that CSBs could submit it with their FY 2007 end of the fiscal year reports to the Department in early October. Department staff reviewed the surveys and contacted CSBs to resolve any concerns as surveys were received. The results of the survey are reflected in this report. Department data about state hospital utilization for FY 2007 also was reviewed to prepare this report.

Partnership Planning Regions (PPR): CSB and State Hospital Partnerships		
Region	**CSBs**	**State Hospital**
PPR 1 Northwestern Virginia	Central Virginia Community Services, Harrisonburg-Rockingham CSB, Northwestern Community Services, Rappahannock Area CSB, Rappahannock-Rapidan CSB, Region Ten CSB, Rockbridge Area CSB, Valley CSB	Western State Hospital
PPR 2 Northern VA	Alexandria CSB, Arlington CSB, Fairfax-Falls Church CSB, Loudoun County CSB, Prince William County CSB	Northern VA MH Institute
PPR 3 Southwestern Virginia	Cumberland Mountain Community Services, Dickenson County Behavioral Health Services, Highlands Community Services, Mount Rogers Community Mental Health & Mental Retardation Services Board, New River Valley Community Services, Planning District One Behavioral Health Services	Southwestern Virginia MH Institute
PPR 4 Central Virginia	Chesterfield CSB, Crossroads Services Board, District 19 CSB, Goochland-Powhatan Community Services, Hanover County CSB, Henrico Area Mental Health & Retardation Services, Richmond Behavioral Health Authority	Central State Hospital
PPR 5 Eastern Virginia	Chesapeake CSB, Colonial Services Board, Eastern Shore CSB, Hampton-Newport News CSB, Middle Peninsula-Northern Neck CSB, Norfolk CSB, Portsmouth Department of Behavioral Healthcare Services, Virginia Beach Department of Human Services, Western Tidewater CSB	Eastern State Hospital
PPR 6 Southern VA	Danville-Pittsylvania Community Services, Piedmont Community Services, Southside CSB	Southern VA MH Institute
PPR 7 Catawba	Alleghany Highlands Community Services Blue Ridge Behavioral Healthcare	Catawba Hospital

For FY 2007, the General Assembly appropriated $5.4 million of state general funds to support LIPOS. CSBs used some state reinvestment or system transformation funds to augment the LIPOS appropriations. In FY 2007, CSBs paid $11,981,176 to 32 providers for 20,305 bed days of inpatient psychiatric treatment for 3,193 consumers. The average cost per bed day was $600. Bed days and payments for Memorial Hospital of Martinsville, Rappahannock General Hospital, and Southside Regional Medical Center in Petersburg were excluded from this calculation because the average costs per bed day were unusually low ($403, $388, and $358, respectively) due to the amounts of services provided during FY 2007 that were not billed to the CSBs or to negotiated lower daily rates. Calculated costs per bed day ranged from $494 to $776. The average length of stay per consumer was 6.36 days, and the calculated average length of stay varied from 3.0 to 11.14 days per bed. Calculated average costs and lengths of stay vary among providers depending on several factors noted in the paragraph preceding Table 1. Information derived from the survey about amounts of funds paid to individual private providers and the numbers of consumers they served and bed days they provided is contained in Table 2 on the next page. The University of Virginia Hospital and VCU Medical College of Virginia Hospitals are included in the table, even though they are not private providers in the same sense as the other providers, because they are valuable resources for the CSBs that contract with them.

Table 2: FY 2007 CSB LIPOS Payments to Private Providers			
Name of Private Provider	**Funds Paid**	**Consumers Served**	**Bed Days Purchased**
Arlington Virginia Hospital Center	$233,891	42	329
Augusta Medical Center (Augusta County)	$55,359	17	99
Carilion New River Valley Medical Center (St. Albans - Radford)	$121,594	50	194
Carilion Roanoke Memorial Hospital	$394,560	98	560
Centra Health/Virginia Baptist Hospital (Lynchburg)	$39,600	11	61
Chippenham Hospital (Tuckers Pavilion - Richmond)	$305,891	95	538
Community Memorial Hospital Pavilion (South Hill)	$225,939	66	366
Danville Regional Medical Center	$140,628	71	235
Dominion Hospital (Falls Church)	$571,462	121	815
INOVA - Fairfax [1]	$120,990	14	156
INOVA - Mt. Vernon	$604,631	159	812
John Randolph Hospital (Hopewell)	$138,401	40	280
Lewis-Gale Hospital (Roanoke)	$88,028	27	121
Maryview Behavioral Healthcare Center (Portsmouth)	$1,742,173	477	3,103
Memorial Hospital of Martinsville	$54,378	34	135
Poplar Springs Hospital (Petersburg)	$716,374	151	1,157
Prince William Hospital (Manassas)	$596,027	135	838
Rappahannock General Hospital	$17,462	5	45
Richmond Community Hospital	$722,248	210	1, 323
Riverside Behavioral Health Care Center (Newport News)	$1,725,349	441	3,205
Rockingham Memorial Hospital (Harrisonburg)	$142,543	30	221
Russell County Medical Center: Clearview	$84,559	27	127
Snowdon at Fredericksburg	$272,796	52	366
Southern Virginia Regional Medical Center (Emporia)	$8,250	4	14
Southside Regional Medical Center (Petersburg)	$240,871	66	673
St. Mary's Hospital (Richmond)	$325,739	95	520
Twin Counties Regional Hospital (Galax)	$77,680	36	138
University of Virginia Hospital (Charlottesville)	$150,970	41	247
VCU Medical College of Virginia Hospitals (Richmond)	$ 64,565	27	136
Virginia Beach Psychiatric Center (Virginia Beach CSB)	$1,772,929	463	3,137
Wellmont Bristol Regional Medical Center: Ridgeview	$140,143	75	225
Winchester Medical Center	$85,146	13	129
Totals: 32 Private Providers	$11,981,176	3,193	20,305

Combining the two ways through which CSBs contract for local inpatient psychiatric treatment services, CSBs reported that they paid $12,091,955 in FY 2007 through individual CSB contracts and LIPOS contracts to 32 private providers for 20,993 bed days of inpatient psychiatric treatment for 3,366 individuals. The purchase of these services and the diversion of consumers receiving these services from admission to state hospitals had a significant impact on potential state hospital expenditures, utilization, and operations, reducing the potential demand for state hospital services substantially.

Savings Realized By Community-Based Treatment and Fiscal Impact On State Hospitals

Any savings realized by community-based inpatient psychiatric treatment would be reflected in state hospital expenditures and operations. However, identifying any specific savings realized by community-based inpatient psychiatric treatment or any immediate fiscal impact of these private provider contracts on state hospitals is difficult. The survey gathered information about the numbers of consumers who received local inpatient psychiatric treatment through individual CSB or LIPOS contracts who subsequently were admitted to a state hospital after their discharge from those private providers because they needed longer term extended rehabilitation services that are not offered in local inpatient psychiatric treatment services but are provided by state hospitals. Of the 3,366 consumers served in FY 2007 through these contracts, 329 consumers, or 9.8 percent of the total number, were admitted to a state hospital upon their discharge from private providers. However, 3,037 consumers were not admitted to a state hospital. This represents a considerable diversion of consumers from possible admission to state hospitals.

The two types of impact that could be analyzed are the decreased demand for state hospital admissions and associated bed days that occurred because of the delivery of these local inpatient psychiatric treatment services and the avoidance of projected increased costs. While state hospitals operate within relatively fixed budgets, various costs increase or decrease, depending on the demand for hospital services. For example, if admissions unexpectedly increase significantly, a state hospital may incur substantial unanticipated overtime staffing costs and experience unplanned increases in utilization, sometimes exceeding a utilization rate of 100 percent, which could jeopardize the quality of care in that state hospital.

While it would be logical to assume that all 3,366 consumers served by local private inpatient psychiatric treatment providers would have been admitted to a state hospital if services from these providers had not been available, only 329 consumers were admitted and 3,037 consumers were not admitted. In FY 2007, 3,255 individuals were served in state hospital admissions units at Catawba Hospital, Eastern State Hospital, Northern Virginia Mental Health Institute, Southern Virginia Mental Health Institute, Southwestern Virginia Mental Health Institute, and Western State Hospital. If all 3,037 diverted consumers had been admitted, this would have increased the number of individuals admitted to state hospital admission units by 93 percent in FY 2007. An increase of this magnitude would have had profound adverse effects on the operations of state hospitals and the quality of services received by consumers in them. Overcrowding in hospital wards would have been widespread, creating extreme stresses on consumers and direct care staff. Overtime costs for additional staff time needed to maintain reasonable and therapeutic staff to consumer ratios would have increased significantly.

Local inpatient psychiatric treatment has several advantages over treatment in a state hospital for many consumers. Consumers served in local inpatient treatment services retain closer connections to their home communities and support networks. The involvement of the consumer's family and significant others in treatment is much easier. One of the biggest advantages is that, in most cases, consumers are stabilized and returned to their home environments much more quickly than when they are admitted to state hospitals. In other words, although per day costs are often higher, consumers tend to have shorter lengths of stay in community inpatient psychiatric treatment services than they do in state hospital acute inpatient

admission units, so the overall cost of an episode of care is much smaller. In FY 2007, the average length of stay per consumer for all community psychiatric inpatient beds (LIPOS and individual CSB) was 6.24 days; the average cost per bed day for those beds was $576; and the average cost per consumer for local inpatient psychiatric treatment was $3,592. In FY 2007, the average length of stay per consumer for all state hospital acute inpatient admission beds was 43.95 days; the average cost per day for those beds was $587; and the average cost per consumer in state hospital acute admissions beds was $25,786. The projected total cost if all 3,037 consumers who were diverted from state hospital admission had been admitted would have been an additional $78,312,082. Yet, the total cost of all state hospital admission beds in FY 2007 was only $83,934,266.

In FY 2007, two state hospital admission units had average lengths of stay (ALOS) per consumer that were significantly longer, compared to the other state hospitals. However, even if those two admission units were excluded from calculations, the total ALOS in remaining state hospital admission beds was 37.71 days per consumer, still considerably greater than the ALOS of 6.24 days in community psychiatric inpatient beds. Excluding the costs of those two units would reduce the average cost per bed day to $598 and the average cost per consumer to $22,536. This exclusion would decrease the overall total projected fiscal impact on state hospitals to $68,441,832, if local inpatient psychiatric treatment services purchased from private providers were not available and all 3,037 consumers had been admitted.

In conclusion, CSB contracts for local private inpatient psychiatric treatment services served more individuals than state hospital admission units in FY 2007 3,366 versus 3,255 consumers. Those contracts obtained services for these individuals at far less cost than they could have been served in state hospitals, $12,091,955 in the community versus up to as much as $78,312,082 in state hospitals, depending on assumptions made about average lengths of stay in state hospital admission units and the proportion of those consumers who might have been admitted to state hospitals.

Therefore, 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 strives to transform its public mental health, mental retardation, and substance abuse services system. These funds, combined with additional resources for other innovative services such as Programs of Assertive Community Treatment, Discharge Assistance Projects, and Ambulatory and Residential Crisis Stabilization Services, offer the best chance for Virginia to continue decreasing the size of its state hospitals while building needed community capacity to serve individuals with serious mental illnesses most appropriately and effectively. This will help Virginia to move toward achieving the vision of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life, including work, school, family, and other meaningful relationships.