COMMONWEALTH of VIRGINIA

Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

December 15, 2017

The Honorable Thomas K. Norment, Jr.,
The Honorable Emmett W. Hanger, Jr.
Senate Finance Committee
Pocahontas Building, 14th Floor
900 East Main Street
Richmond, VA 23219

Dear Senator Norment and Senator Hanger:

Pursuant to Item 284 E.2 of the 2017 Appropriation Act, I submit to you an implementation plan for the financial realignment of Virginia's public behavioral health system. In developing the report, the Department of Behavioral Health and Developmental Services worked with community services boards, national consultants, other state agencies, and stakeholder groups representing individuals receiving services and family members, system advocates, local governments and private providers.

Sincerely,

William A. Hazel Jr., M.D.

Enc.

Cc: Jack W. Barber, MD
Mike Tweedy
Susan Massart

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William A. Hazel, Jr., MD
Secretary of Health and Human Resources

December 15, 2017

The Honorable S. Chris Jones, Chair
House Appropriations Committee
Pocahontas Building, 13th Floor
900 East Main Street
Richmond, Virginia 23219

Dear Delegate Jones:

Pursuant to Item 284 E.2 of the 2017 Appropriation Act, I submit to you an implementation plan for the financial realignment of Virginia's public behavioral health system. In developing the report, the Department of Behavioral Health and Developmental Services worked with community services boards, national consultants, other state agencies, and stakeholder groups representing individuals receiving services and family members, system advocates, local governments and private providers.

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William A. Hazel, Jr., MD
Secretary of Health and Human Resources

December 15, 2017

The Honorable R. Creigh Deeds, Chair
Joint Subcommittee to Study Mental Health Services in the Twenty-First Century
Pocahontas Building
900 East Main Street, Room E503
Richmond, Virginia 23219

Dear Senator Deeds:

Pursuant to Item 284 E.2 of the 2017 Appropriation Act, I submit to you an implementation plan for the financial realignment of Virginia's public behavioral health system. In developing the report, the Department of Behavioral Health and Developmental Services worked with community services boards, national consultants, other state agencies, and stakeholder groups representing individuals receiving services and family members, system advocates, local governments and private providers.

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Plan for the Financial Realignment of Virginia's Public Behavioral Health System

(Item 284.E, 2017 *Appropriation Act*)

December 1, 2017

DBHDS Vision: A Life of Possibilities for All Virginians

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Plan for the Financial Realignment of Virginia's Public Behavioral Health System

Preface

This report was developed in accordance with Item 284.E of the 2017 *Appropriation Act*, which calls for an implementation plan for the financial realignment of Virginia's public behavioral health system. Specifically, the language states:

> *E.1. It is the intent of the General Assembly that the Department of Behavioral Health and Developmental Services (DBHDS) transform its system of care into a model that embodies best practices and state-of-the art services by treating, where appropriate, individuals in the community. As part of this effort, DBHDS state hospitals shall be structured to ensure high quality care, efficient operation, and sufficient capacity to serve those individuals needing state hospital care.*
>
> *2. Out of this appropriation, $250,000 from the general fund the first year shall be provided to the Office of the Secretary of Health and Human Resources (OSHHR) to prepare an implementation plan for the financial realignment of Virginia's public behavioral health system. This plan shall include: (i) a timeline and funding mechanism to eliminate the extraordinary barriers list in state hospitals and to maximize the use of community resources for individuals discharged or diverted from state facility care; (ii) sources for bridge funding, to ensure continuity of care in transitioning patients to the community, and to address one-time, non-recurring expenses associated with the implementation of these reinvestment projects; (iii) state hospital appropriations that can be made available to community services boards to expand community mental health and substance abuse program capacity to serve individuals who are discharged or diverted from admission; (iv) financial incentive for community services boards to serve individuals in the community rather than state hospitals; (v) detailed state hospital employee transition plans that identify all available employment options for each affected position, including transfers to vacant positions in either DBHDS facilities or community services boards; (vi) legislation and Appropriation Act language needed to achieve financial realignment; and (vii) matrices to assess performance outcomes.*
>
> *3. In developing the plan, the OSHHR shall seek input from and participation by DBHDS, community services boards and behavioral health authorities, individuals receiving services and their family members, other affected state agencies, local governments, private providers and other stakeholders. OSHHR shall present the implementation plan to the Chairmen of the House Appropriations and Senate Finance Committees and the Chairman of the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by December 1, 2017.*

Plan for the Financial Realignment of Virginia's Public Behavioral Health System

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Executive Summary

In the past several years, Virginia has been making concentrated and meaningful efforts to reform its strained behavioral health system. Virginia's funding has historically placed the greatest emphasis on state hospital beds, leading to insufficient community services that would allow people to treat behavioral health symptoms early and maintain wellness in their own communities. Most notably, the System Transformation Excellence and Performance (STEP-VA) effort requires all of Virginia's 40 community services boards (CSBs) to provide the same services, such as same day access, outpatient services for mental health and addictions, crisis services, and other critical services. This will help people to access services promptly and head off crisis situations leading to emergency department visits, hospitalization, homelessness or interaction with the criminal justice system.

However, the hydraulics of Virginia's complicated behavioral health system often cause actions that help in one area to create challenges in others. In fact, consequent to changes made to fix system gaps through last resort legislation (which requires individuals under a temporary detention order (TDO) to be admitted to a state hospital at the end of the eight-hour emergency custody order (ECO) period if no alternative bed is found), Virginia's short ECO period, and obligations to the forensic population, Virginia cannot fully control the admissions to its state hospitals. As a result, Virginia's nine state mental health hospitals are under tremendous strain as they are weathering a 224 percent increase in TDO admissions and a 58 percent increase in total admissions since FY 2013. There are additional pressures as the state hospitals maintain a list of individuals residing in state hospitals who have been clinically ready for discharge for more than 14 days but are unable to leave because the necessary community housing and support services are not available to ensure a safe discharge. This list (called the extraordinary barriers to discharge list or EBL) has recently averaged about 170 individuals, or 13 percent of the total state hospital census.

In Virginia's current public behavioral health system, 50 percent of the general fund dollars support just three percent of the individuals the system serves because of the Commonwealth's historic emphasis on costly state hospital services. While efforts have been made in the past to shift state hospital resources to build needed community services, none has been far-reaching enough to correct Virginia's imbalance. Also, an analysis of more encompassing efforts in other states has revealed a number of lessons, including that significant upfront investment in community housing and support services are necessary to rebalance systems away from psychiatric hospital-based care.

To help address this issue, the 2017 General Assembly required the development of a plan for the financial realignment of Virginia's public behavioral health system, including the elimination of the EBL. Notably, however, the EBL is not static but features constant additions (nearly 600 per year) so the list cannot be fully eliminated. DBHDS' goal would be to reduce the EBL and ensure that no one remain on the list beyond 60-90 days. This goal results in better outcomes for individuals and fewer bed days spent at the state hospitals.

The Department of Behavioral Health and Developmental Services (DBHDS) has been working with stakeholders, including the CSBs, to develop the financial realignment plan. The intention of financial realignment is to shift Virginia's imbalanced system from costly state hospital beds towards community services. Through redistributing a portion of state hospital funds to the community, the community behavioral health system would finally be positioned to purchase the services required for each individual, whether the appropriate care be state hospital services or specific community services. If the community could provide the right amount of services for individuals at a lesser cost than state hospital care, then a balance of dollars would be available for the community to build and sustain additional capacity to serve more individuals in the community.

DBHDS crafted a four-year phased plan to reduce the EBL and implement financial realignment across the Commonwealth. A general overview of DBHDS' four year plan includes:

- **FY 2019** – As preparation for the financial realignment plan, a community integration plan is implemented to discharge clinically-ready individuals from state hospitals and reduce the EBL. The investment of community-based residential and permanent supportive housing services facilitates the prompt discharge of individuals who are clinically ready to leave state hospitals. DBHDS included funds in its budget request for these services. These plans include specific funding for permanent supportive housing to facilitate individuals transitioning from new supervised living homes and assisted living facilities to integrated placements. In a separate budget item, DBHDS requested funds for four safe and appropriate transitional supervised living homes specifically for the individuals who have been found Not Guilty by Reason of Insanity (NGRI) and are court-determined to be ready for discharge from state hospitals. These two elements together constitute the community integration plan for start-up and ongoing support. The community integration plan steps in FY 2019 pave the way for financial realignment and make its implementation significantly less challenging. Also in FY 2019, DBHDS will begin a standard utilization review process to ensure that individuals no longer meeting continued stay criteria in state hospitals are promptly identified.
- **FY 2020** – Once the community integration plan services are in place, DBHDS will continue to work with the CSBs in FY 2020 to make final determinations on the target state hospital bed reduction for each CSB along with other procedural decisions. DBHDS and the CSBs have started work on preliminary estimates for these targets – for each CSB, these targets will be based on factors such as the CSB's utilization of state hospitals per 100,000 population, the local state hospital's average daily census, access to private hospitalization, regional and geographic factors, and judicial practices. In addition, at DBHDS' request in 2017, CSBs submitted plans for what housing and support services they believe will be necessary to reach these targets; however, DBHDS understands that the needs may change once the effects are measured of the community integration plan and other community services required by STEP-VA. As a result, CSBs' final plans will be due in FY 2020 to be reviewed and approved by DBHDS.
- **FY 2021** – Importantly, following the community integration plan mentioned above, there will need to be an additional start-up and building phase for community services for financial realignment that the CSBs believe will be necessary to meet their state hospital bed reduction targets. The plans for these community housing and support services that were approved by in FY 2020 by DBHDS will be built in FY 2021. *Also, the end of FY*

2021 marks the goal of reducing the state hospital average daily census (ADC) by 80 "units." An ADC unit is equivalent to 365 bed days and approximately four individual discharges.

- **FY 2022** – The payment for bed utilization targets are established in FY 2022 for each CSB. State hospital usage above the monthly target will result in the CSB being billed for the additional beds days, and usage below the target will result in a refund the CSBs can use to build additional community services. Today, DBHDS projects that the rapidly increasing state hospital census will lead to a census on 1,460 in FY 2022, which would be 99 percent of the total state hospital capacity. *With the full implementation of financial realignment, the inpatient census during FY 2022 should be 1,280.*

The following pages detail a plan that would realign the financial structure of Virginia's behavioral health system. With implementation of this plan, instead of unsustainable state hospital utilization rates exceeding 100 percent capacity, state hospital utilization would decline to closer to the best practice rate of 85 percent, where safety levels are improved for patients and staff alike. Financial realignment would work alongside STEP-VA to build the comprehensive community services needed to ensure that state hospital care is used only when clinically necessary and is available and effective when it is necessary. Through STEP-VA and by starting by building the community housing capacity needed to target discharge-ready individuals in state hospitals, Virginia's imbalanced system will steadily evolve toward one with stronger community services and more integrated housing and supports for individuals. This shift permits and enables the successful implementation of the significant changes called for in financial realignment, leading to better use of limited state general fund dollars and far better outcomes for individuals.

Introduction

Financial Realignment Concept

In its purest form, a financial realignment of a public behavioral health system would redistribute funds currently used to support state mental health hospitals to the community. The community system would then be positioned to purchase the services required for each individual, whether the appropriate care be state hospital services or specific community services. If the community could provide the right amount of services for individuals at a lesser cost than state hospital care, then a balance of dollars would be available for the community to build additional capacity to serve more individuals in the community.

In Virginia, the structure of the public behavioral health system and the variety of individuals it serves prevents such a pure financial realignment model to be implemented. Yet, there are very compelling reasons for Virginia to examine such a change in alignment, including:

- The state mental health hospitals are over their safe operating capacity and utilization is rapidly increasing.
- Virginia faces a classic "catch 22" in that it cannot safely discharge individuals from state hospitals without adequate community capacity and it cannot build adequate community capacity without sufficient funds in the community to do so. Yet, present dynamics are

pushing toward more funding for state hospitals and beds at the expense of community investment, thus driving the system in the wrong direction.

- The statewide extraordinary barriers to discharge list (EBL) recently averaged about 170 individuals, or 13 percent of the total state hospital census. This list is comprised of individuals who are clinically ready to be discharged from state hospitals but for whom appropriate community services are unavailable to facilitate a safe discharge. In FY 2017, this list grew to over 200 people. The average daily cost per patient at state hospitals is nearly $650; at an average of 170 people on the list, the annualized cost would be approximately $40.3 million over the course of a fiscal year. All of the investments used to purchase private hospital beds (a program referred to as Local Inpatient Purchase of Services, or LIPOS), the Discharge Assistance Program (DAP), and permanent supportive housing over the past two to three years have not slowed the increases in either the hospital census or the EBL.
- More hospital staff is needed to address the increasing utilization and flow-through in state hospitals. Absent alternative options, Virginia will need to invest in more state hospital beds despite almost 15 percent of the people no longer needing to be in the hospital.
- Spending for state hospital level of care when it is not needed is not good fiscal stewardship for the present and may be unwise for the future given the high operational and capital costs of maintaining hospitals and given ever-changing federal certification and accreditation standards requiring more investment to meet required staffing levels, ensure active treatment, and upgrade aging hospitals to ensure safe environments of care.
- While the state is spending nearly $650/day, on average, for inpatient care at state hospitals, this care is provided at no cost and with no disincentives to CSBs, jails, and Medicaid (for adults, with exceptions related to Commonwealth Coordinated Care Plus (CCC Plus). While virtually all of health care has, or will, transition to managed care, state general fund dollars for behavioral healthcare is not under a managed system.
- Virginia's spending, relative to other states, is much more heavily balanced toward hospitals. Virginia spends approximately half of its general fund resources on community-based behavioral health services whereas other states spend three times more in the community than for state hospital care.
- Requiring individuals to be hospitalized longer than clinically necessary is neither recovery oriented nor respectful and, more importantly, is inconsistent with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, a federal ruling requiring states to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. That is also a requirement of the Americans with Disabilities Act.

The Need for Financial Realignment in Virginia

Over the past several years, Virginia has made significant improvements in the quality and accountability of community services through legislative and administrative efforts. These accomplishments have ensured that no person has been turned away from a psychiatric hospital bed when needed. In addition, system improvements have increased qualifications of emergency custody and preadmission screening evaluators, updated communications infrastructure between the courts and behavioral health care providers, eliminated the jail waiting list for state hospital admissions, improved outcome and performance measures in the Secretary of Health and Human Resources' data dashboard, and strengthened CSB performance contracts by increasing administrative requirements and outcome and performance reporting. Also, the administration has

initiated efforts to address Virginia's opioid crisis and substance-use disorder (SUD) challenges and supported a successful application for a federal SUD waiver.

These efforts represent meaningful progress in strengthening the behavioral health system and Virginia's safety net. However, the hydraulics of Virginia's complicated behavioral health system often cause actions that help in one area, such as the General Assembly's last resort legislation, to create challenges in others, such as increasing state hospital census. Also, Virginia's funding has historically placed the greatest emphasis on state hospital beds, leading to insufficient community services that would allow people to treat behavioral health symptoms early and maintain wellness in their own communities.

Unsustainable Hospital Census – Virginia's nine state mental health hospitals are under tremendous strain as they are weathering a 224 percent increase in temporary detention order (TDO) admissions and a 58 percent increase in total admissions since FY 2013. This follows "last resort" legislation passed in 2014 *(§37.2-809*) requiring state hospitals to accept admissions of individuals under a TDO if no alternate treatment location is found within the eight hour emergency custody order period. As the percentage of individuals on TDO status accepted by private hospitals has declined from almost 93 percent in FY 2013 to 84.5 percent in FY 2017, the burden has increasingly fallen to the state hospitals. Also, more individuals are being sent to the state hospitals who have health insurance, whether commercial, Medicaid or Medicare. For example, in July 2017, 52 percent of the admissions to Northern Virginia Mental Health Institute had insurance and in October 2017 69 percent of civil TDO admissions to Western State Hospital had insurance. Historically, the majority of state hospital beds served individuals with no insurance who would need to be covered through a pool of state general fund dollars. Figure 1 below lists Virginia's nine state mental health hospitals, their locations and number of beds.

Figure 1. Virginia's State Mental Health Hospitals

Hospital	Location	Number of Beds
Catawba Hospital	Catawba	110
Central State Hospital (CSH)	Petersburg	277
Commonwealth Center for Children & Adolescents (CCCA)	Staunton	48
Eastern State Hospital (ESH)	Williamsburg	302
Piedmont Geriatric Hospital (PGH)	Burkeville	123
Northern Virginia Mental Health Institute (NVMHI)	Falls Church	134
Southern Virginia Mental Health Institute (SVMHI)	Danville	72
Southwestern Virginia Mental Health Institute (SWVMHI)	Marion	179
Western State Hospital (WSH)	Staunton	246

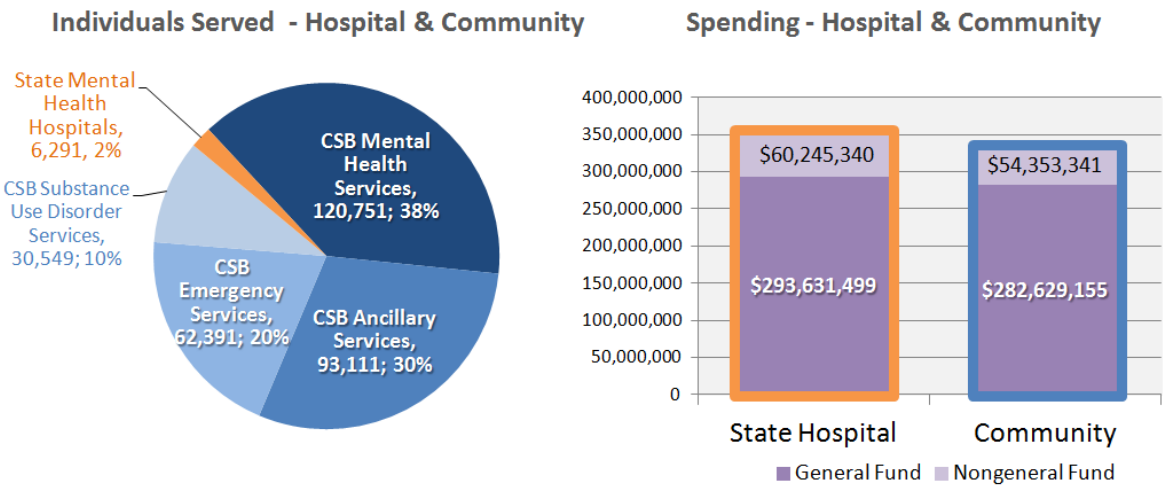
The hospitals are now consistently running at an unsustainable 95 percent occupancy or higher. During early 2017, the state hospitals reached a peak of 99 percent occupancy with three hospitals over their bed capacity. Best practices show that occupancy rates over 85 percent are considered less safe for patients and staff. In addition to significant safety concerns, sustaining such high occupancy rates compounds the workload for staff and has led to increases in turnover rates and overtime among critical staff. For example, direct care turnover rates across the state hospitals increased 30 percent from FY 2014 to FY 2015, the highest turnover in 10 years. Virginia's increasing state hospital census is converse to what is happening in states nationwide.

Additional Hospital Pressures – In addition to increases in admissions, state hospitals maintain a list of individuals residing in state hospitals who have been clinically ready for discharge for

more than 14 days but are unable to leave because the necessary community services are not available to ensure a safe and sustainable discharge. This list is called the extraordinary barriers to discharge list, or EBL. In August 2017, there were 179 individuals on the statewide EBL. This is difficult for individuals who are waiting in jail for admission to a state hospital, for individuals waiting to get out of hospitals, and for the hospitals who are struggling with staffing issues and trying to maintain a manageable census. As part of efforts to reduce the EBL, DBHDS initiated a collaboration project with the CSBs with the target of discharging 131 people from the state hospital EBL in 2017. DBHDS has also collaborated with the Western Tidewater CSB to develop 50 assisted living beds to ease pressures on Eastern State Hospital. However, as new individuals are constantly added to the EBL (643 during FY 2017), neither effort is considered a long-term strategy to eliminate the list. However, it is essential to "buy time" for a more definitive and sustainable process to manage the hospitals' census, try to curtail the EBL and build community capacity.

Financial Imbalance Leading to Lack of Community Services – Virginia's public funding for its behavioral health system is significantly tilted towards inpatient services, the most restrictive and most costly care available. While Virginia spends roughly equal amounts on its CSBs and state hospitals, hospital care is substantially more expensive and therefore serves far fewer people. As a result, half of Virginia's general fund dollars for its behavioral health system supports just three percent of those served by the system. A more consistent, robust and accessible community services system would reduce psychiatric crises, emergency department visits, avoidable incarcerations, and admissions to state hospitals. Because better outcomes such as these are achieved through a stronger community system, states across the nation spend an average of three times more on community services than on their state hospitals. However, Virginia will spend 48.5 percent of its general fund dollars on community care in FY 2018, while the national average has now reached 73 percent. Additionally, Virginia will spend 49 percent of the system's general fund dollars on state hospitals but nationally states only spend about 25 percent on state hospital services. Figure 2 below shows individuals served and spending for state hospitals and community services in FY 2017.

Figure 2. FY 2017 Individuals Served and Spending – State Hospitals and Community Services[1]



[1] Ancillary services are motivational treatment, consumer monitoring, early intervention, and assessment and evaluation.

Further compounding Virginia's system imbalance, state hospital care is provided at no cost to CSBs, jails, and Medicaid (for adults, with pending exceptions related to CCC Plus), so the financial dynamics are not aligned to best facilitate community-based care. As state hospital census increases continue to cause alarm, it is critical that care is managed from both a clinical and financial standpoint. Importantly, the vast majority of behavioral health system experts do not believe adding state hospital beds is the wisest or even the correct solution to this challenge.

Current System Reform Efforts

In an effort to reform the system, DBHDS worked with Virginia stakeholders and drew from national best practices to design System Transformation Excellence and Performance (STEP-VA). STEP-VA requires all CSBs to provide the same services such as same day access, primary care screening for all patients, outpatient services for mental health and addictions, targeted case management, crisis services, and other critical services. Services for all age groups and veterans are an integral part of the model. Also, STEP-VA integrates psychiatric care with medical care, housing, employment, education, and social services to a degree only inconsistently achieved today. Per the *Code of Virginia,* these essential services will be available consistently across all 40 CSBs by FY 2021. This will allow people to access services promptly and help head off crisis situations.

In 2017, the General Assembly required that the first two phases of STEP-VA, same day access and primary care screening, be implemented by FY 2019. It also required that the remaining STEP-VA services be implemented by FY 2021. This action signaled intent for serious reforms to Virginia's behavioral health system and also signaled a commitment to a long-term infusion of funds to build and sustain these critical community services. Given the expense that will be required to implement STEP-VA, it becomes even more essential that state funds related to hospital care be better structured to ensure state general fund dollars are used in a cost-effective manner. A more balanced and strategic funding structure will boost the development of the community services that are needed to treat people before state beds and other more costly interventions are needed.

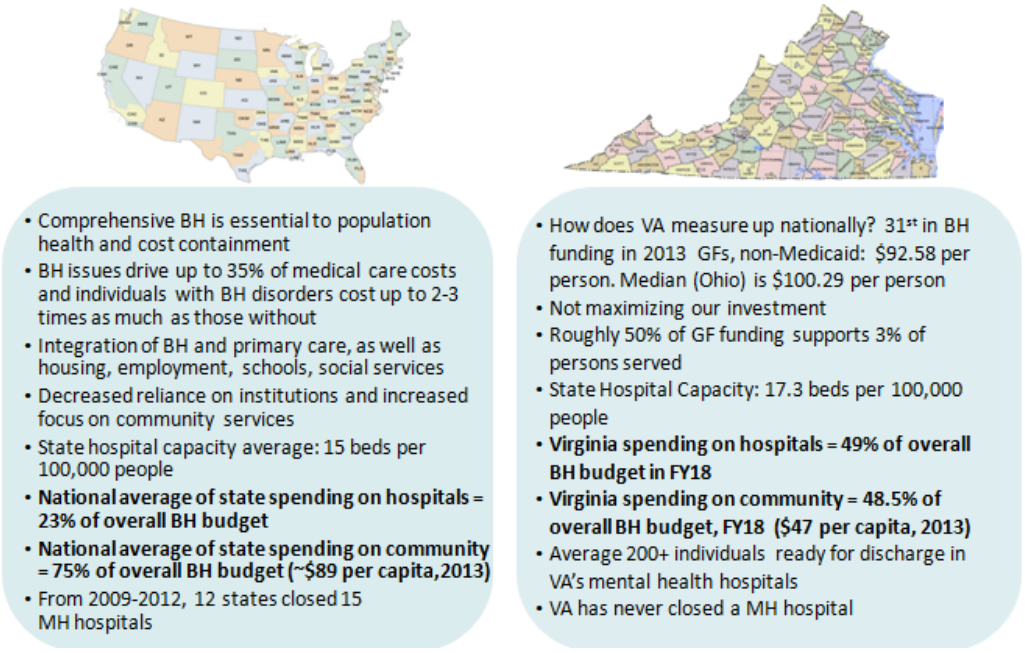
To help address this issue, the 2017 General Assembly required that the Office of the Secretary of Health and Human Resources develop an implementation plan for the financial realignment of Virginia's public behavioral health system. The following pages offer further detail on a plan that would realign the financial structure of Virginia's behavioral health system. *Financial realignment would work alongside STEP-VA to build the comprehensive community services needed to ensure that state hospital care is used only when clinically necessary and is available and effective when it is utilized.* The plan's ultimate goal is cost efficient care in the most integrated settings possible to increase critically needed community capacity, reduce and manage significantly increasing censuses at state hospitals, and ensure consistent fiscal standards of practice throughout the Commonwealth.

Financial Realignment Efforts Nationwide

Virginia's emergency system is uniquely challenged by the last resort law added in 2014 (§*37.2-809*) which requires an admission to the state hospital if no alternative psychiatric bed is found,

and by one of the shortest emergency custody order (ECO) periods in the nation. The importance of this singularity cannot be overemphasized. While Virginia's laws on ECOs require that the emergency evaluator search for other placements besides a state hospital, the eight-hour timeframe often limits the availability of other options. Also, the challenge in Virginia includes the reality that up to 45 percent of individuals seen by CSBs lack health insurance of any kind and are supported solely with general fund dollars. High numbers of individuals with no coverage, Virginia's lower level of funding for community services, and Virginia's unique laws severely compromise the ability to transition to a behavioral health managed care organization as some other states have done. In fact, as shown below in
Figure 3 below, Virginia's public behavioral health system lags behind the majority of other states.

Figure 3. The Behavioral Health (BH) Landscape: National vs. Virginia



In July 2017, the Behavioral Health Policy Collaborative (BHPC) was selected by DBHDS to provide expert input and review as part of the General Assembly required financial realignment plan development. Specifically, BHPC was tasked with researching and analyzing a collection of other states' efforts to realign the financial structure of their behavioral health systems.

Approach

BHPC explored how eight specific states are working to rebalance their mental health systems using financial incentives or disincentives, such as allocating state psychiatric hospital funds to county or other local behavioral health authorities to "buy beds," using risk- or performance-based contracts, applying managed care principles or approaches, setting annual inpatient targets where counties/localities assume risk for exceeding targets, and other strategies. BHPC did not intend to convey that these eight states are the only states where such activities have occurred.

Key Themes and Findings

Following BHPC's key informant interviews, data was coded and categorized, resulting in the

following themes. More detail about BHPC's analysis of other states' efforts to realign the financial structure of their behavioral health systems is found in Appendix A.

Theme 1: *Significant upfront investments in community-based services are necessary to rebalance systems away from psychiatric hospital-based care.*

The most prominent theme that emerged from BHPC's key informant interviews was the critical importance of making significant financial investments into community-based services to prevent unnecessary hospitalizations and transitioning individuals to appropriate services in the community after discharge. Key informants warned that efforts to decrease hospital utilization would be unsuccessful without such an investment. Investments made to ensure robust community services in Pennsylvania, Maryland, New Jersey and Washington included housing-related resources and supports, evidence-based services such as assertive community treatment (ACT) teams, mobile crisis services, short-term care facilities, permanent supportive housing, specialty facilities and community-based programs/housing for individuals with complex medical comorbidities. See Appendix A for details.

Theme 2: *The financial transition of state rebalancing efforts often includes preserving some allocation for state psychiatric hospitals while increasing the investment in community-based services, taking multiple years to see cost savings.*

In the beginning of rebalancing efforts, states must be prepared to take on the initial expense associated with the expansion of community-based service capacity, while slowly reducing funding to state psychiatric hospitals. Upfront costs of expanding community-based services can cost systems more than their previous investments, but are needed to eventually garner cost savings, as state psychiatric hospitals close or downsize. Appendix A summarizes efforts in Ohio, Pennsylvania, North Carolina, Maryland, New Jersey, Missouri and Minnesota to implement phased, multi-year funding strategies that slowly reduce investments in state psychiatric hospitals while increasing investments in community-based services to ensure community services are sufficient to meet the needs of individuals exiting psychiatric hospitals. Also noted is that instead of taking a per-bed approach to psychiatric hospital closures, states optimize both per-bed and operational cost savings by closing units within psychiatric hospitals or the entire hospital .

Theme 3: *Application of managed care principles is critical to divert both insured and uninsured populations from unnecessary hospitalization.*

Most states surveyed indicated that managed care principles both support the gate-keeping of psychiatric hospital beds, as well as diversion into more appropriate community-based services. In a few states, managed care entities are tasked with managing both Medicaid and grant dollars (federal, state, and local) that are utilized to purchase psychiatric hospital beds and community services. Appendix A includes examples of the application of managed care principles in North Carolina, Pennsylvania, Washington, Ohio and Maryland.

Theme 4: *Some states have allocated funds directly to counties/localities to purchase psychiatric hospital beds, driven by a state-developed, per-bed formula*.

In Ohio, Michigan and California, funds are allocated directly to counties or regions for the purchase of state psychiatric hospital beds. These counties have the option of using the funds for

state psychiatric hospital beds or alternatives to hospitalizations.

Summary of Other States' Efforts

Across a diverse set of states, efforts to rebalance behavioral health systems away from inappropriate reliance on psychiatric hospital-based care are marked with investments in community-based services and a financial transition strategy that protects and retains at least some state psychiatric hospital allocations while gradually increasing community-based service capacity to meet increased demands and increased consumer clinical complexities. BHPC's research indicates that the approaches and experiences with behavioral health system rebalancing and financing in Pennsylvania, Ohio, and California each offer elements that appear to align closest to Virginia's current thinking given that these states provide direct allocations to counties/localities to purchase psychiatric hospital beds. Some states utilize behavioral health managed care organizations (BHMCOs) or other MCOs to manage inpatient psychiatric hospitalizations and community services, while others provide allocations directly to localities to purchase psychiatric beds based on a pre-determined formula with varying applications of financial risk-bearing.

A Brief History of Virginia's Previous Financial Realignment Activities

DBHDS has considered or developed various proposals over the past 25 years to realign or restructure the financing of behavioral health or developmental services by shifting state funds from state facilities to community services. Examples of these efforts are included below:

Region 4 and Central State Hospital (CSH) Pilot Project – In 1999, DBHDS proposed using some of the state hospital funds freed up in a budget cut to finance an increase in community services that would decrease the demand for state hospital beds on an ongoing basis, thus shifting some state hospital resources to community services. Initially, this effort involved state funds reallocated from CSH to the seven CSBs in Region 4 (Central Virginia), the service area for CSH. The CSBs and CSH managed these funds on a regional basis to purchase local inpatient psychiatric hospital bed days. The project enabled the admissions unit at CSH to be closed. Also, this project became the basis for the Local Inpatient Purchase of Services (LIPOS) initiative that expanded statewide in subsequent years. LIPOS contracts with private hospitals to provide acute, short-term mental health psychiatric inpatient services instead of admitting these individuals to inpatient treatment in state hospitals.

System Reinvestment Project – A subsequent financial realignment initiative that grew out of the LIPOS initiative was the system reinvestment project. From 2004 through2011, DBHDS implemented a number of reinvestment projects, typically based in state hospital downsizing that became permanent. These projects shifted state hospital funds to communities to develop community capacity, including private inpatient bed purchase and accomplish unit closures. For example:

- In Region 1, $1.4 million from Western State Hospital was transferred to the CSBs to develop community capacity and close one hospital unit.
- In Region 5 (eastern Virginia), the initial wave of reinvestment efforts involved purchasing acute care services in local community hospitals and resulted in the closure of

the admissions unit at Eastern State Hospital (ESH). Two crisis stabilization programs were also developed using some of the reinvestment funds matched with additional funds from DBHDS. These efforts enabled ESH to be used for those who needed longer term care and was a factor in enabling the construction of a new but smaller ESH. ESH's capacity was reduced from 385 beds to two 150-bed units.

Northern Virginia Mental Health Institute (NVMHI) Community Psychiatric Bed Purchases – The 2011 Appropriation Act mandated cuts in state general fund dollars totaling 11 percent for DBHDS. In addition to cuts in administrative functions, NVMHI decided to close an admissions unit, reducing bed capacity from 129 to 110. In response to concerns from local providers and stakeholders about the impact of these planned reductions, DBHDS assembled a team of DBHDS and CSB staff to review the situation. The team concluded that while some improved efficiencies in operations and staffing could be found, the beds that had been planned for closure needed to be restored to the greatest extent possible and to do this, additional funding was necessary. Region 2 (Northern Virginia area) CSBs began to utilize state general fund dollars that had been granted for LIPOS purposes to maintain bed capacity at NVMHI after it was determined that adequate acute care beds could not be obtained from private hospitals in the region to make up for the loss of NVMHI's beds. As a result, the reduction from 129 to 110 beds was never implemented. The region supported the operation of 13 acute admissions beds at NVMHI, thus holding the bed capacity at 123. State funds were restored at the 2013 General Assembly session.

Reinvestment and transformation efforts have been implemented several times over the past two decades, with targeted reductions and diversion plans. These efforts served to strengthen regional collaboration to build on community capacity. However, while such efforts helped address a specific challenge, the inconsistency of funding such projects has led to variability across the Commonwealth. The "backstop" for all of these projects relative to state hospital usage was that the beds were closed and the hospitals did not go over census, an option no longer available today.

CSB Complexities and Challenges

CSB Complexities – CSBs are a network of 40 separate organizations with significant variations among multiple complex characteristics. Many of these characteristics are inter-related; for example, array of services and total budget size or geographical and population size and population density. Some of these complexities could affect the ability of particular CSBs to implement the changes associated with financial realignment. It is important to note that the enabling legislation for the CSBs (Chapters 5 and 6 of Title 37.2 of the *Code* of Virginia) created a structure that values and supports local linkages and autonomy so that each CSB responds to the needs and reflects the values and priorities of the local populations and governments it serves. Below are illustrations of the significant variations that exist among the CSBs. (More details on CSB complexities and challenges can be found in Appendix B.)

- *Local Governmental Relationships* **–** Virginia's 40 CSBs have a range of relationships with their local governments that define the relative degrees of flexibility and autonomy each CSB may have in areas such as staffing patterns, salaries, facilities, and services.
- *Mix of Funding Sources* – Of the total funds allocated to CSBs in FY 2016, 35.4 percent

of mental health funds and 35.3 percent of substance use disorder funds are state general fund dollars. Each CSB braids a diverse mix and amount of funds including:
  - State general fund dollars, some of which are unrestricted while others are restricted for specific purposes;
  - Local matching funds that are almost all local government appropriations;
  - State match for Medicaid;
  - Federal grants, including federal block grant funds and other smaller targeted federal grants allocated by DBHDS;
  - Fees that are primarily but not exclusively from Medicaid; and
  - Other funds such as sheltered workshop fees.

- *Total Budget Size* – Total budget size may reflect the managerial capacity of a CSB to implement and manage realigned funding streams. CSB total budgets are categorized as small (up to $16 million at 12 CSBs), medium ($16-$35 million at 18 CSBs), large ($36-$100 million at nine CSBs), and very large (more than $100 million at one CSB).

- *Array of Services Provided* – Every CSB provides emergency services, the only service each CSB is required to provide. Every CSB provides mental health outpatient, medication management, and case management services and some (but not all) types of day support and residential services, but in varying degrees for various populations. Some CSBs provide employment services. Every CSB provides substance use disorder outpatient services and prevention and wellness services and some but not all types of residential services. Some CSBs provide substance use disorder case management services. Some CSBs also provide specialized initiatives such as Programs of Assertive Community Treatment (PACT), crisis receiving centers, and residential or ambulatory crisis stabilization units.[2]

- *Geographical Size* – The geographical areas that CSBs serve range from 15.3 square miles (Alexandria CSB) to 2,761.4 square miles (Crossroads CSB).

- *Population Size* – The size of the total population in a CSB service area ranges from 14,996 (Dickenson County Behavioral Health Services) to 1,174,670 (Fairfax-Falls Church CSB) people.

- *Administrative Capabilities* – Many small budget and some medium budget CSBs may not possess strong administrative capabilities, including sophisticated data analytical expertise, detailed cost accounting and accounts receivable management, and clinical and business process analysis and management.

- *Unique Accountability Requirements* – CSBs have numerous unique accountability requirements imposed by the *Code of Virginia* and DBHDS and sometimes by local governments.

CSB Challenges – CSBs are dealing with or will confront several significant challenges in the next two to four years that may affect their ability to implement financial realignment strategies successfully.

[2] CSB Core Services Taxonomy 7.3 defines core services categories and subcategories. This document is available on the DBHDS website at www.dbhds.virginia.gov in the performance contract resources section under the Office of Support Services.

- *Health Policy Changes* – Medicaid CCC Plus implementation, Medicaid reimbursement and shifts in payer mixes make other structural adjustment more difficult and complicated. Importantly, federal changes and possible reduction to Medicaid would cause enormous risk to CSBs.
- *Profile of Individuals Receiving Services from CSBs* – In FY 2016, over 67 percent of the adults who received mental health services in CSBs had a serious mental illness and almost 80 percent of the children had or were at risk of serious emotional disturbances. In FY 2016, approximately 45 percent of the individuals receiving mental health or substance use disorder services had no Medicaid or other health insurance coverage.
- *Inability to Recruit and Retain Staff* – Most CSBs experience considerable difficulties in recruiting and retaining all types of staff due to inadequate compensation or benefit packages and competition from other providers.
- *Continued Workforce Shortages in Critical Positions* – Competition from private sector providers that frequently offer better compensation and working conditions exacerbates CSBs' ability to recruit and retain critical clinical staff positions, such as psychiatrists, medical doctors, psychologists, nurses, social workers and other professionals.
- *Local Government Financial Frustrations with State Government* – Inflexibility, lack of authority, unfunded state mandates and state constraints on local government revenue generation are persistent themes complicating state and local government relationships.
- *Implementation of Same Day Access and Primary Care Screening* – The General Assembly enacted legislation in 2017 to mandate CSB provision of same day access to treatment (SDA) and primary care screening by 2019 as part of STEP-VA. This is an initiative all CSBs support, but it will be a significant challenge for CSBs, and will require the appropriation of additional state funds.
- *Implementation of the Department of Justice Settlement Agreement* – Although the settlement agreement is focused on the developmental disability population, carrying out its requirements takes a great deal of staffing, planning and funds for any one CSB.
- *Increasing Population and Demands* – Virginia's population is rising and the numbers of individuals requiring behavioral health services is increasing accordingly.
- *Ensure No Local Funds Are at Risk* – The intent of realignment is to more effectively manage state general fund dollars rather than local funds, but steps would be taken so that financial realignment would avoid impacting local funds.

State Hospital Usage and Challenges

The use of state hospital beds are impacted by several key interactive variables, including:

- the number and type of admissions,
- the clinical and medical needs of the individuals, and
- the length of stay for each individual.

The Number of Admissions and Discharges for State Hospitals

Following the implementation of last resort legislation in FY 2014, state hospitals have experienced a 58 percent increase in total admissions and a 224 percent increase in temporary detention order (TDO) admissions since FY 2013. Figures 4 and 5 below show the total admissions and the total TDO admissions for state hospitals from FY 2013 through FY 2017.

Figure 4. Total State Hospital Admissions FY13 - FY17

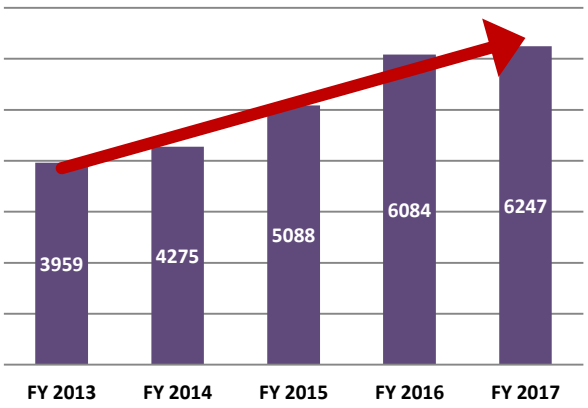
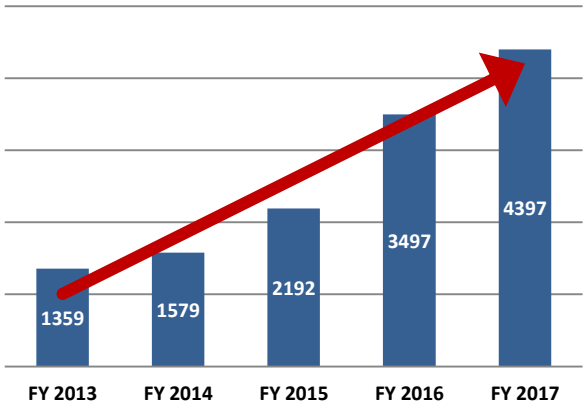


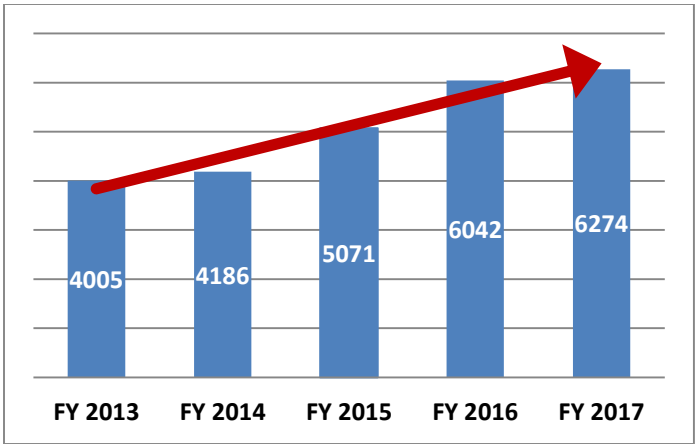
Figure 5. TDO State Hospital Admissions FY13 - FY17



There was also a 45 percent increase in the total number of forensic admissions from FY 2013 to FY 2017, growing from 930 admissions in FY 2013 to 1,343 admissions in FY 2017. In FY 2017, forensic admissions comprised 31 percent of all state hospital admissions.

Discharge trends from FY 2013 to FY 2017 generally reflected the trends for total state hospital admissions. Figure 6 below shows the state hospitals had a 57 percent growth for discharges, increasing from 4,005 in FY 2013 to 6,274 in FY 2017. This rate contributed to the growth of the average daily census, rising from 86 percent in FY 2013 to 93 percent in FY 2017.

Figure 6. Total State Hospital Discharges FY 2013 – FY 2017



The Clinical and Medical Needs of Individuals Admitted to State Hospitals

As previously noted, state hospital bed use is also impacted by the clinical and other general medical needs of the individuals they serve. The top four diagnostic categories of admissions to adult and geriatric state hospitals are: (1) schizophrenia; (2) mood disorders including bipolar

disorders, major depression, and dysthymic disorders; (3) psychotic disorders; and (4) substance use disorders and substance use related diagnoses. These diagnostic categories consistently comprised 83 percent to 90 percent of all admissions. Figures 7 and 8 below show diagnostic categories of admission at state hospitals in FY 2013 and FY 2016.

Figure 7. Diagnostic Categories of Admission, FY 2013

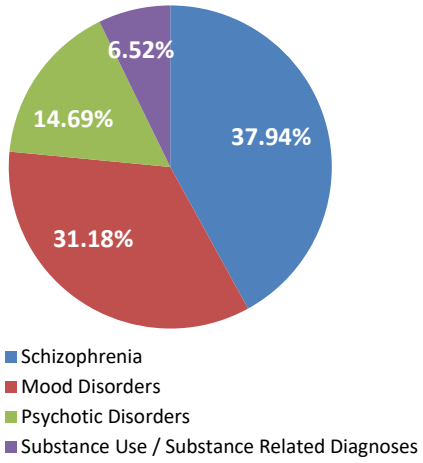
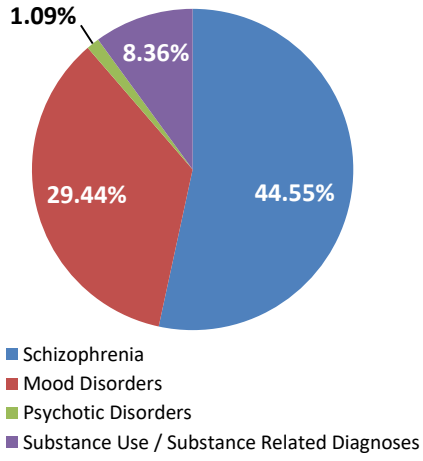


Figure 8. Diagnostic Categories of Admission, FY 2016



However, when looking at absolute numbers of admissions by diagnostic category, the number of individuals admitted with substance use disorders increased by 109 percent, growing from 213 admissions in FY 2013 to 445 admissions in FY 2016. In addition, the growing comorbid medical conditions of the individuals served by state hospitals is reflected in the 88 percent increase in uncompensated costs for medical care for individuals in state hospitals, which grew from $3,162,824 in FY 2013 to $5,940,729 in FY 2016. Figure 9 below shows the medical hospitalization costs for FY 2013 – FY 2016, reflecting the increase in admissions of individuals with medical conditions such as diabetes, chronic obstructive pulmonary disease and other conditions the state psychiatric hospitals are not medically equipped to treat.

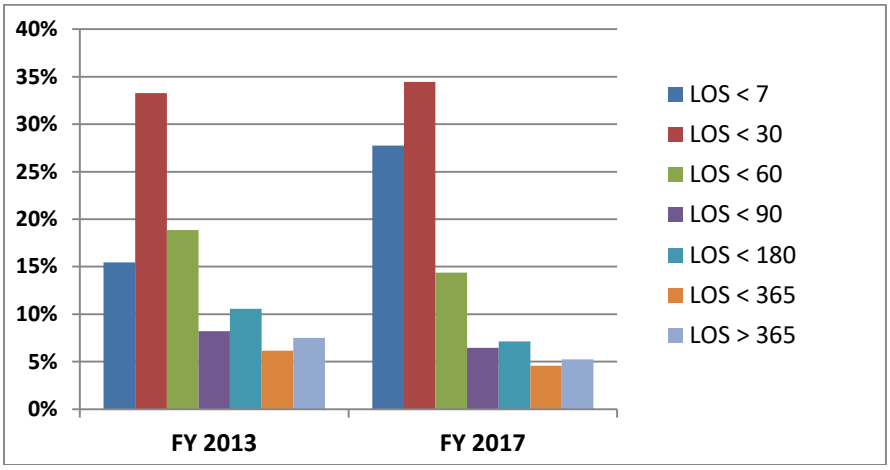
Figure 9. Medical Hospitalization Costs

	2013	2014	2015	2016
Special Hospitalization 9 MH Facilities Expenditures	$3,162,824	$3,358,190	$4,114,363	$5,940,729

Length of Stay

The length of time an individual spends in adult or geriatric state hospitals significantly impacts state hospital bed use. The length of time can be measured in several different ways. Historically, DBHDS has used the average length of stay (ALOS) at the time of discharge. An alternative method of measuring length of stay is the percentage of individuals discharged in succeeding intervals of time following admission, as shown below in Figure 10.

Figure 10. LOS in State Hospitals by Time Intervals – FY 2013 and FY 2017



The most notable change is the increase in the percentage of individuals discharged within seven days. In FY 2013, 15 percent of all individuals were discharged within seven days of admission. By FY 2017, this percentage had almost doubled, growing to 28 percent of all admissions. The percentage of individuals discharged within 30 days increased from 48 percent in FY 2013 to almost 63 percent in FY 2017 further reflecting an increased "efficiency" related to hospital utilization.

State Hospital Census Trend Challenges

From FY 2013 to FY 2017, the average daily census, or percent of beds filled, of the state hospitals on the first day of the month grew from 87 percent to 93 percent, with the highest daily census being five percent above the average daily census.
Figure 11 below shows the state hospital census on the first day of each month since FY 2012.

Figure 11. State Hospital Census on the 1st Day of Each Month, FY 2013 – FY 2017

	Catawba	Central State	Eastern State	N. VA	Piedmont Geriatric	S. VA	SW VA	Western State	Total Average
FY 2013	78%	75%	88%	96%	89%	79%	94%	90%	**86%**
FY 2014	86%	66%	88%	97%	90%	93%	92%	86%	**87%**
FY 2015	93%	79%	93%	93%	95%	84%	89%	94%	**90%**
FY 2016	90%	78%	93%	91%	98%	77%	88%	91%	**88%**
FY 2017	94%	86%	100%	86%	97%	90%	94%	95%	**93%**

Key: 55-69% | 70-84% | 85-99% | 100%+

Should this rate of increase for average daily census continue, the projected state hospital census in FY 2020 would be 99 percent with a projected high monthly average of 104 percent of its operational capacity. Best practices show that occupancy rates over 85 percent are considered less safe for patients and staff. In addition to significant safety concerns, sustaining such high occupancy rates compounds the workload for staff and has led to increases in turnover rates and overtime among critical staff. These increasing census trends have continued notwithstanding the sustained annual investment of $15,550,622 in community-based crisis stabilization programs, $10,875,231 in funds to purchase private hospital beds (LIPOS) and $21,153,441 in discharge

assistance funds (DAP) for individuals who are clinically ready for discharge.

Figure 12 below shows LIPOS, DAP, and Crisis Stabilization Funds from FY 2013 to FY 2017.

Figure 12. LIPOS, DAP, and Crisis Stabilization Funds by Fiscal Year

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
LIPOS	$8,020,484	$8,406,116	$8,450,121	$10,925,231	$10,871,436
DAP	$18,931,929	$20,483,667	$20,764,605	$21,153,441	$24,359,736
Crisis Stabilization	$15,529,606	$15,621,835	$15,486,800	$15,570,622	$15,570,622
Total	$42,482,019	$44,511,618	$44,701,526	$47,649,294	$50,801,794

Despite efforts to build these critical community services, the census at state hospitals is projected to continue rising at two percent annual growth for the foreseeable future. Even with the addition of 56 beds at Western State Hospital, such growth will cause the state hospitals to overflow by FY 2023 unless this course is not deflected. Further, the cost of providing the DAP, LIPOS and housing supports needed to facilitate safe and sustainable discharges must continue to rise significantly if Virginia is to maintain just the current rate of increase in state hospital utilization.

Figure 13 below shows the increasing cost of doing business as usual in Virginia state hospitals. The DAP, LIPOS and PSH projections are based on the average increases over the past three fiscal years. These services are expected to need to be continuously expanded in future years to meet demand. In addition, the chart below reflects the cost to build and staff a 56-bed expansion at Western State Hospital. However, the chart clearly shows Virginia is on a course to need even more state hospital beds, which would be costly to build and to staff and would detract from Virginia's ability to build community services capacity. The chart below does not include the cost to add these additional beds. Even with these expanded services, it is not enough to avoid the rapidly increasing state hospital census unless actions are taken to change this trajectory.

Figure 13. Cost of Doing "Business as Usual" in Virginia State Hospitals

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024*
Business as Usual	Maintain Current 1418 Beds			Add 56 Beds at Western State Hospital (WSH)		1474 Beds	
Census*	1347	1375	1404	1432	1460	1489	1516**
Utilization	95%	97%	99%	97%	99%	101%	**103%**
Staffing Cost		$5.8M	$6.2M	$6.2M	$6.2M	$6.2M	$6.2M
Discharge Assistance Planning (DAP)/Local Inpatient Purchase of Services (LIPOS) Cost		$4.9M	$9.8M	$14.7M	$19.6M	$24.5M	$29.4M
Staffing for 56-Bed WSH		$1.4M	$6.2M	$8.3M	$8.3M	$8.3M	$8.3M
Permanent Supportive Housing (PSH) Cost		$3M	$6M	$9M	$12M	$15M	$18M

* Census projections are based on the 2% per year growth experienced since "last resort" legislation went into effect in FY 2014: FY 2014 = 87% utilization; FY 2017 = 93% utilization.

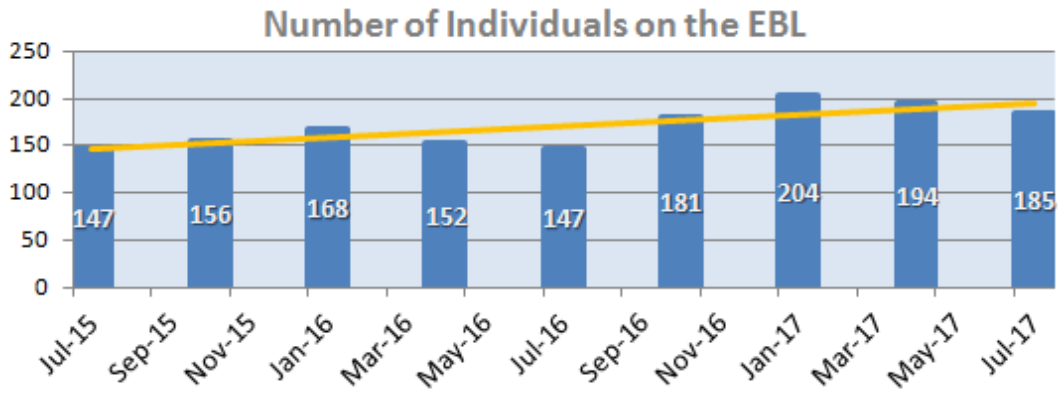
** FY 2024: Demand decreases IF outpatient services, permanent supportive housing and crisis services for STEP-VA are all fully implemented.

State Hospital Extraordinary Barriers to Discharge List

The national research conducted as part of this project on other states' experiences shows that successful investments in community-based services are necessary prerequisites to rebalance systems away from inpatient psychiatric hospital-based care and more toward community-based care. The most important factor in state hospital census pressures in Virginia is the fact that at any point in time between 12 to 14 percent of the individuals in state hospitals are clinically stable enough to leave the hospital and live in the community, but are unable to be discharged because the housing, services, and/or supports they need in the community either do not exist or are not available to them.

Individuals are placed on the extraordinary barriers to discharge list (EBL) after being clinically ready for discharge for more than 14 days. In August 2017, there were 179 individuals in state hospitals who were clinically ready for discharge for more than 14 days but appropriate community services were not available for a safe discharge. *This represented 13 percent of the total statewide census*.
Figure 14 below shows the individuals on the EBL since FY 2016.

Figure 14. Individuals with Barriers to Discharge Since FY 2016



In FY 2016, the average number of individuals on the EBL was 153 per month. In FY 2017, the average number of individuals on the EBL was 186 per month. These numbers include the constant transition of individuals discharged into the community as well as the ongoing addition of new individuals who are waiting for the availability of needed housing, services, and supports.

As a matter of demonstrating the right of individuals to live in the least restrictive settings (communities versus institutions) and a commitment to their recovery, individuals should not remain hospitalized beyond clinical necessity. Federal law, the U.S. Supreme Court and the vast majority of system experts and stakeholders agree that a person should not stay in a state hospital longer than necessary for inpatient treatment to resolve the risks requiring involuntary commitment. Whether it is a matter of restored liberty or simply opening a new chapter of their lives, it is clear that real life is lived in the community, not stuck in the state hospital.

Reducing the Extraordinary Barriers to Discharge List

It is very important to note that the EBL is not a static list. During FY 2017 there were 643 individuals added to the EBL and 595 individuals discharged at some point during the year. Even if everyone was taken off the EBL list on a single day, it would eventually grow again. As a result, it cannot be permanently eliminated. In fact, based on data from FY 2017, the EBL would grow to be around 176 by June 30, 2018 if all the individuals on the current EBL would have been discharged on June 30, 2017. Yet, there are specific community housing and support services that are shown to facilitate safe discharges from state hospitals. The following sections provide the background for the housing, services, and support needs of individuals in state hospitals as well as those who could be diverted from admission to state hospitals.

Needed Services

In February 2017, DBHDS conducted a point in time survey on the community support needs of the individuals in state hospitals who were clinically ready for discharge. In addition, DBHDS separately requested that the CSBs identify the strategies and resources for reducing state hospital utilization. The responses of the survey and the CSB request were very similar and consistent with the research and analysis conducted by the national experts. Of note, one particular program, permanent supportive housing (PSH), has shown significant positive outcomes for adults with serious mental illness. Multiple research studies have found that PSH is particularly effective in improving participants' housing stability and reducing their emergency department and inpatient hospital utilization. More information about this survey and PSH can be found in Appendix E.

While it is important to have a full continuum of crisis response services for avoiding or reducing state hospital bed use, the foundational component is a sustained investment in a full array of residential and housing options along with the needed services and supports. This will ensure that each community has the necessary resources to support successful community living, to manage and resolve crisis as they arise, and to ensure the needed community housing and services are available at the time of discharge from state hospitals. Services include:

A full continuum of housing options would, at a minimum, include:

- Necessary in-home supports for individuals living independently,
- Permanent supportive housing,
- Assisted living facilities,
- Intensively supervised living homes, and
- If appropriate for the individual, nursing homes with robust ancillary psychiatric, clinical, and behavioral management services along with the necessary resources and opportunities to transition into a more integrated community settings.

In addition to these basic housing options, individuals would need, at a minimum, the following core services and supports:

- Discharge planning,
- Case management,
- Tenancy supports,
- Psychosocial rehabilitation,
- Medication management,
- Outpatient services,
- Program of Assertive Community Treatment (PACT) services,

- Access to 24/7 on-site medical assistance (i.e. nursing care), and
- Supported employment/peer support.

A comprehensive system of crisis stabilization services in each region would, at a minimum, include:

- Onsite emergency evaluation services at key community locations,
- 23-hour ambulatory crisis stabilization services,
- Residential crisis stabilization to include medically supervised withdrawal, and
- Expanded access to local inpatient psychiatric care (i.e. general community hospitals with psychiatric units, private psychiatric hospitals).

DBHDS and the CSBs have experience developing the continuum of housing options that individuals on the EBL need in order to be discharged into more integrated community settings. The following initiatives are the most recent examples:

- In FY 2016, Region 5 contracted with a private provider to operate two, 8-bed transitional supervised living homes to provide intensive residential supervision for individuals on the EBL. These individuals' discharges were complicated by the lack of willing providers due to behavioral issues, complex service needs, criminal justice involvement, or specialized service and support needs. The 16 beds are being funded through the use of $1.2 million in discharge assistance funds.

- In 2017, DBHDS partnered with Western Tidewater CSB to purchase and renovate a 100-bed assisted living facility (ALF). The ALF will serve 40 geriatric individuals and 20 adults currently at Eastern State Hospital and provide five crisis respite beds for individuals living in the community. This program includes robust ancillary psychiatric, nursing, clinical, behavioral, and case-management supports, options for psychosocial programming, and services and resources to support transitioning to more integrated community settings, including permanent supported housing. This project is being funded through a combination of $500,000 in discharge assistance funds, $880,000 in geropsychiatric team services, and an estimated $713,000 in auxiliary grant funds. A similar project is being developed with Region Ten CSB in Nelson County.

Time Frame for Building the Services and Supports to Reduce the EBL

The estimated time frame for building housing, services and supports to reduce the EBL will vary significantly based upon the type of service and support to be developed and the need to acquire or renovate buildings. The categories below in Figure 15 provide examples of the estimated time frames that would be needed to build various categories of services, supports, and crisis response from the notice of the award of the funds until services are available to the individuals. CSBs may have longer time frames for building services and supports.

Figure 15. Timeline for Building Services and Supports Necessary to Reduce the EBL

Category Of Activity	Build-Out Timeline
Contract for existing services	3 months
Hire additional staff to build-out existing services	3 months
Start a new program in an existing office/treatment space	3 to 6 months

Acquire real estate and start a new service or program	6 to 18 months

Building the Housing, Services, and Supports to Reduce the EBL

As previously noted, in an effort to calculate the cost for building the needed community-based crisis response, housing, service and support needs, DBHDS took into consideration the average annual cost of maintaining an individual in the community using discharge assistance funds, the estimated cost for serving the individuals in the February 2017 point in time survey, and the CSBs' estimates of the costs associated with building the community-based resources they identified as necessary to reduce state hospital bed use, and experiences with the development of community infrastructure.

The cost of housing, services, and supports varies based on the community, the type of housing, and the needed services and supports. PSH costs approximately $15,000 per unit per year for housing and approximately $7,500 per year for services and supports per person. ALFs and intensively supervised living homes vary widely in costs based on location, services and supports, ranging from a low of $42,000 per bed per year to a high of $77,125 per bed per year for the most intensively supervised programs in Northern Virginia. In addition to the costs of housing, supports, and services, there are one-time start-up costs associated with the purchase, renovation, and start-up expenditures applicable to both housing and services.

As noted earlier, BHPC identified that a transition period is essential to build the array of community housing and support services needed to facilitate safe hospitals discharges before fully implementing financial realignment. As a result, the DBHDS plan begins with an integration plan for the investment of community-based residential and PSH services to facilitate the prompt discharge of individuals who are clinically ready to leave state hospitals. DBHDS included $10.7 million in FY 2019 and $8.4 million in FY 2020 and ongoing in its budget request for these services. These plans include specific funding for PSH to facilitate individuals transitioning from new supervised living homes and ALFs into integrated placements. In a separate budget item, DBHDS requested $2 million in FY 2019 and $2 million in FY 2020 and ongoing for four transitional supervised living homes specifically for the individuals who have been found Not Guilty by Reason of Insanity (NGRI) and are ready for state hospital discharge, since developing appropriate, safe community services for these individuals is very challenging. These two elements together constitute the community integration plan for start-up and continual support.

Projected EBL Discharges

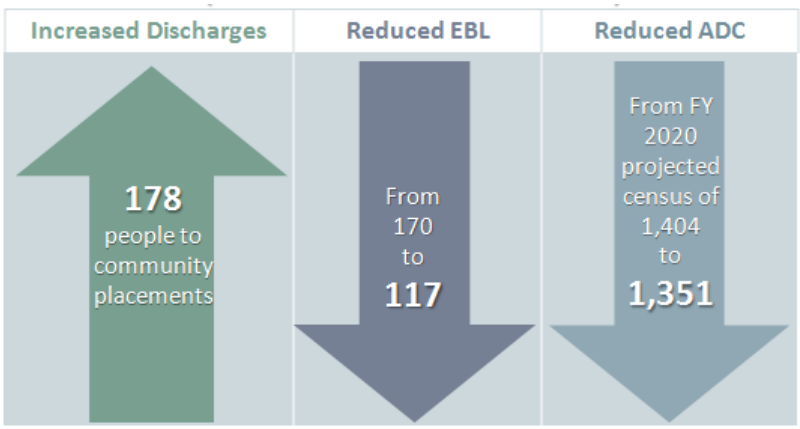
***FY 2019: Start-up for the Community Integration Plan* –** In FY 2019, the projected average daily census (ADC) in the state hospitals is 1,375. An ADC "unit" is equivalent to 365 bed days and approximately four individual discharges. Also in FY 2019, the EBL is projected to average 170 individuals, assuming there will be 575 individual added to the EBL each year. In addition, there is currently $3 million in discharge assistance plan (DAP) funding; with annual increases, these funds would result in approximately 50 discharges per year. The following discharges shown below in Figure 16 will be enabled through the plan above along with DAP:

Figure 16. FY 2019 State Hospital Discharges Projected Resulting from Community Integration Plan

Service	FY 2019 Discharges
Supervised Living Homes	62
Assisted Living Facilities	42
NGRI Homes	24
DAP	50
Total	**178**

FY 2020: Community Integration Plan Begins to Deliver Results – Without accelerated discharge efforts, in FY 2020, the ADC in the state hospitals is projected to be 1,404. DBHDS projects that as a result of the community integration plan efforts in FY 2019 as detailed above, the following reductions shown in Figure 17 will be seen to the EBL and the statewide state hospital census[3]:

Figure 17. Projected FY 2020 Statewide State Hospital EBL and ADC Reduction (Based on FY 2019 Efforts)



As the community integration plan continues in FY 2020, the following discharges are projected as shown below in Figure 18:

Figure 18. FY 2020 Discharges Projected from Community Integration Plan

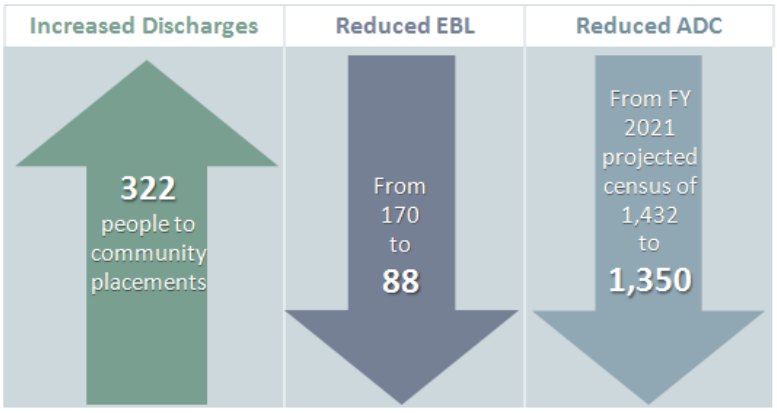
Service	FY 2020 Discharges
Supervised Living Homes	62
Assisted Living Facilities	8
NGRI Homes	24
DAP	50
Total	**144**

FY 2021: Community Integration Plan Results Accumulate – Without accelerated discharge efforts, in FY 2021, the ADC in the state hospitals is projected to be 1,432. The discharges above result in an additional reduction of 29 to both the EBL and the census. Since the community integration plan efforts began in FY 2019, the following reductions as shown in Figure 19 are anticipated to the EBL and the statewide state hospital census by FY 2021[4]:

[3] Discharging 178 of the 575 people expected to be added to the EBL results in a 31 percent reduction of the EBL. This 31 percent reduction of the 170 person EBL in turn equates to a reduction to the average daily census of 53.

[4] Discharging 144 of the 575 people expected to be added to the EBL results in a 25 percent reduction of the EBL. This 25 percent reduction of the 117 person EBL in turn equates to a reduction to the average daily census of 29.

Figure 19. FY 2021 Statewide State Hospital EBL and ADC Reduction (Based on FY 2019 and FY 2020 Efforts)



The community integration plan results in the discharge of 322 people from the EBL during FY 2019 and FY 2020 with a reduction to the ADC of 82. Starting in FY 2021, the ongoing cost of the community integration plan is $16.4 million plus an additional $270,000 each year for PSH attached to these actions. On average, this equates to $50,932 per person, far less than the average annual $231,000 per person cost of a state hospital bed.

EBL Reduction Strategy Summary

Consequent to Virginia's last resort legislation, eight-hour ECO period, and obligations to the forensic population, Virginia cannot fully control the admissions to its state hospitals. However, with appropriate resources and concentrated effort, it can dramatically reduce the number of individuals who remain in state hospitals 14 days beyond being determined clinically ready for discharge. Given that the EBL is not static, but features constant additions, the list cannot be fully eliminated. DBHDS' goal would be to dramatically reduce the EBL and ensure that no one remain on the list more than 60-90 days.

Services needed to facilitate safe discharges, such as housing, staff supervision, medication monitoring, crisis services, and other services and supports, could be developed within 12 months of initiation (though there may be exceptions). In addition to these services, DBHDS would work with the state hospitals and CSBs to develop statewide utilization review processes, clinical, legal, and risk criteria for continued stay, and discharge protocols. Tracking and monitoring mechanisms would also be developed including monthly reports related to the ADC, bed utilization per 100,000 population, EBL numbers, transition to PSH, other reports as indicated. Such strategies will allow DBHDS to focus not only on people on the EBL, but also on other discharge-ready individuals. Notably, the implementation of STEP-VA services will work in concert with the state hospital discharge services: STEP-VA infuses the services individuals need to better manage symptoms, negotiate employment, manage leisure time, develop and maintain relationships, and negotiate other real life problems associated with daily living. In doing so, individuals will be more able to avoid crises leading to ED visits, psychiatric or medical hospitalizations, and interactions with the criminal justice system.

Importantly, these census management and discharge strategies are foundational for financial realignment and make financial realignment significantly less challenging to

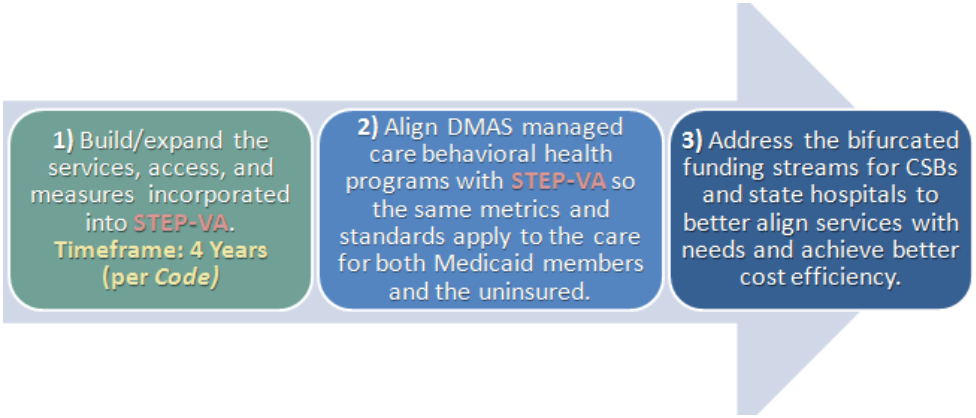
implement. Individuals being discharged from state hospitals must have an appropriate community placement with housing and support services to ensure a safe, successful and long-term discharge to the community. In most Virginia localities, such services are inadequate and must be developed. Through STEP-VA and by expanding the community housing capacity needed to target discharge-ready individuals, Virginia's imbalanced system will steadily evolve toward one with stronger community services and more integrated housing and supports for individuals. This shift permits the successful implementation of the significant changes called for in financial realignment, leading to better use of limited state general fund dollars and far better outcomes for individuals. The next section describes the financial realignment plan.

Financial Realignment Plan

Since March 2017, DBHDS has been working on developing the financial realignment concept to meet Virginia's specific needs and determining the cost for implementation. This development of the plan has included the involvement of CSBs, state hospitals, state agency partners, stakeholders, the General Assembly's Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century, and national consultants. Practical questions considered have included: How much "upfront" money is required for CSBs/regions to establish the necessary placements and services needed to allow individuals who are otherwise hospitalized to be treated and supported in the community? How much ongoing money is required to sustain the effort as individuals enter the system? How much money may be available from current state hospital budgets for this endeavor? How will CSBs/regions know what services and supports to develop and what utilization review practices may be necessary? How much funding is necessary to reflect the annual increases in service demand expected based on current trends? How can state hospitals make the transition to having more of their annual budget be based on bed utilization versus an annual appropriation? What are the state hospitals' fixed versus flexible costs? How is financial realignment confined to the efficient use of state general funds while assuring local funds are not involved? This is a significant operational change for both communities and state hospitals.

It is essential to understand that addressing the current and future demand for state hospital services cannot be fully accomplished by implementing STEP-VA. STEP-VA provides a standard array of clinical services with defined parameters for access and standards of quality. It does not provide housing for individuals, nor the supervised housing and placement support that is required for some individuals. Virginia must continue to build STEP-VA services by FY 2021, as required now by Virginia *Code*, to provide access to quality community services throughout the Commonwealth. Four to five years from now, when STEP-VA services such as same day access, outpatient services and additional acute services are all substantially implemented, there will be a reduction in demand for crisis services, including emergency department visits and hospitalizations. Still, housing and housing supports for individuals who would otherwise be in state hospitals will be necessary, but at considerably less cost than adding and staffing state hospital beds. The same is true for the alignment of behavioral health services, standards, and metrics between DBHDS and Medicaid so that there is efficiency for providers and consistency for individuals receiving state support for their care. Figure 20 below illustrates the steps needed to fully transform Virginia's public behavioral health system

Figure 20. Three Essential Steps to Transition Virginia's Public Behavioral Health Safety Net Services

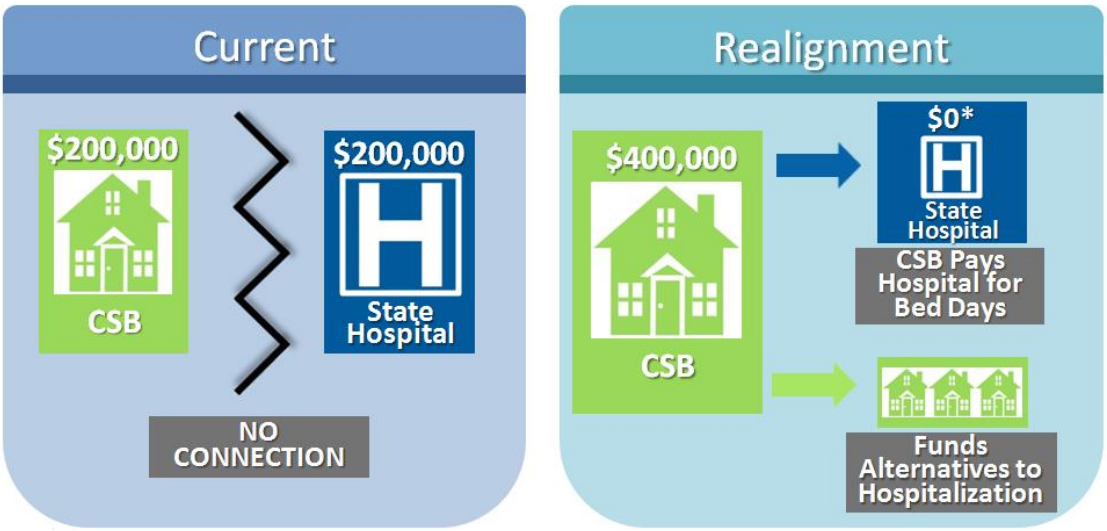


Financial Realignment General Concept

First, the basic premise of financial realignment for the Commonwealth's behavioral health system starts with pooling general fund dollars allocated to state hospitals for CSBs. These state hospital funds would be non-fixed hospital costs of treating civil individuals and NGRI individuals who are ready for release. CSBs would then use the money to develop and maintain community placements and housing supports and/or purchase state hospital services.

Once the financial transition to this model is completed, a portion of state hospital budgets would be based on usage rather than simply an annual appropriation. Financial realignment would address Virginia's current challenge where funds for needed community supports are tied up in state hospitals, resulting in costly hospital services being provided for individuals who no longer require this level of care. It also addresses the current reality that neither CSBs nor state hospitals have a financial incentive to avoid hospitalization in the first place or to decrease length of stay. The basic concept of financial realignment is shown below in Figure 21. Importantly, this is a concept example and these are not real dollars used.

Figure 21. Basic Financial Realignment Concept



These are **not real dollars in this concept example. The $0 would reflect only a determined amount of non-fixed hospital expenses, not the hospitals' entire budgets.*

Financial Realignment Implementation Steps

The community integration plan discussed in the previous section on EBL reduction serves as the preparation for the financial realignment plan. The community integration plan steps in FY 2019 pave the way for financial realignment of the Commonwealth's public behavioral health system and make its implementation significantly less challenging. Also in FY 2019, DBHDS will begin a standard utilization review process to ensure that individuals no longer meeting state hospital continued stay criteria for clinical acuity and risk are promptly identified for appropriate discharge.

Once the community placement and support services are built and in place, in FY 2020, DBHDS will make final determinations on the target state hospital bed reduction for each CSB along with other procedural decisions. These decisions will be made with CSB and state hospital involvement. DBHDS has developed a preliminary methodology and estimates for these targets.

Importantly, there will need to be an additional start-up and building phase for community housing and support services for financial realignment that will be necessary to meet CSBs state hospital bed reduction targets. At DBHDS' request in 2017, CSBs submitted plans for the services they believe will be necessary to reach these targets; however, DBHDS understands that the needs may change once the effects of the community integration plan are measured that will start in FY 2019 and other community services required by STEP-VA. As a result, these additional housing and support services identified by CSBs to reach the targets for financial realignment will not be fully built until FY 2021. Also, the end of FY 2021 marks the goal of reducing the state hospital average daily census (ADC) by 80 "units." An ADC unit is equivalent to 365 bed days and approximately four individual discharges. A reduction of 80 units plus the discharges achieved through the community integration plan reverses Virginia's state hospital census challenge and allows the state hospitals to operate closer to the 85 percent level of utilization that is safer for patients and staff alike.

In FY 2022, the CSB payment for state hospital beds above the predetermined utilization targets established for each CSB begin. State hospital bed usage above the monthly target will result in the CSB being billed for the additional beds days, and usage below the target will result in a refund the CSBs can use to build more community services. This approach balances the imperative to prudently manage the use of state hospital beds with their availability for those in need. These processes are described in detail in Figure 22:

Figure 22. Steps for Financial Realignment Start-Up and Implementation

STEP ONE – FINANCIAL REALIGNMENT PREPARATION

Year	Steps
FY 2019	Implementation of alternatives to continued state hospital placement. **The steps below describe the community integration plan found in the previous section on EBL reduction as preparation for financial realignment:** 1. DBHDS procures two 25-bed assisted living facilities (ALFs) in Regions 2 and 3 as well as four 8-bed supervised living homes in Regions 1,2,3, and 4. These will be supported by regional discharge support teams in all regions. 2. Each regional team will have access to $268,640 in permanent supportive housing (PSH) funds and be charged with, among other duties, ensuring that individuals in the supervised living homes and ALFs who are able to transition to PSH do so. 3. These actions would result in an 18 percent decrease in the EBL during this year (104 discharges

	out of an estimated 575 additions to the EBL). 4. The total cost of these actions is $10,728,200, which does not include $500,000 for four positions in the DBHDS central office to oversee and ensure the success of these projects. 5. In addition, new discharge assistance plan (DAP) funds of $3 million should accomplish a further decrease in the EBL of another 8.7 percent (50 discharges out of an estimated 575 additions to the EBL). 6. Since the 170-person EBL accounts for 12.4 percent of the 1,375 projected average census in FY 2019 there should be a decrease in the ADC of 45 during FY 2019 due to these actions. 7. A separate $2 million initiative to fund four smaller transitional homes for NGRI individuals would result in another 24 individuals being discharged from the EBL and an additional reduction in the ADC of eight during FY 2019 and in ongoing years. Note: the transition from these homes to other housing is projected to be slower than for the supervised living homes above due to the limitations related to being found NGRI (nine months versus six). 8. The FY 2019 reductions are projected as 53 from the EBL and the ADC by the end of FY 2019. 9. *Standardized Utilization Review* processes are developed and implemented in each of the state hospitals that include standardized continued stay criteria based on clinical acuity and risk. These processes will include standardized notification protocols for CSBs and DBHDS regarding individuals who no longer meet clinical and/or legal criteria for continued hospital stay. 10. Standardized monthly utilization reports are developed to include ADC, bed days used, bed use per 100,000, number on EBL, number transitioning into PSH, and other utilization metrics deemed necessary to monitor utilization and prepare for defined bed utilization targets and financial realignment.
FY 2020	1. The annualized cost of the actions above is $10.4 million plus $500,000 for oversight positions, resulting in an ADC reduction of 29 during FY 2020. The decrease relative to FY 2019 is due to the fact that just 20 percent of the individuals discharged to one of the two ALFs will be able to make the transition to other housing each year. 2. Complete implementation of standardized reporting/reports related to utilization. 3. **Finalize bed utilization targets and funding distribution for financial realignment for presentation during the 2020 General Assembly session.** Utilization targets will be based on the utilization of state hospitals per 100,000 population, ADC, access to private hospitalization, regional/geographic factors, and judicial practices as well as other factors deemed relevant at that time. 4. DBHDS review and approval of community capacity options developed by CSBs or Regions based on cost, likelihood of success, alignment with data from utilization review processes related to individuals ready for discharge and community support needs, etc. 5. Finalize reimbursement/refund procedures based on bed utilization. 6. Determination and presentation to the General Assembly of any *Code* or regulatory changes required for financial realignment including provisions to preclude local funds from being used to support state hospital care.

STEP TWO – FINANCIAL REALIGNMENT IMPLEMENTATION

Year	Steps
FY 2021	1. Based on approved plans for decreasing bed utilization (found in step number four in year FY 2020 above), CSBs and/or Regions begin developing additional new community capacity to decrease the average hospital ADC by an additional 80 during the last quarter of FY 2021. The approved one-time start-up costs may include: • Acquiring of property by lease or purchase, or reservation of space within existing apartments, supervised living homes, assisted living facilities, nursing homes, or other placements as indicated and approved; • Hiring and training of staff required to provide supervision or wrap-around supports necessary to allow individuals to live safely in the community; • Increasing capacity in existing or new crisis stabilization facilities or creating new crisis support capacity that will avoid hospitalization; • Developing new contractual provisions with private psychiatric units to support

	hospitalization when indicated; and • Addressing any other infrastructure items, including information technology/data requirements necessary to fully operationalize financial realignment. 2. Hospital discharges (or diversions) may begin at any point during FY 2021 but must be implemented to achieve an ADC reduction of 80 by the end of FY 2021. Ongoing funding to support this new capacity will be prorated to cover the final quarter of FY 2021, but it is expected that some support will begin sooner and some later so that the quarter of support will be sufficient. 3. The funding for the quarter will reflect the projected increased demand that will be operative during FY 2021 and will have accrued during FY 2019 and FY 2020. 4. Standardized utilization review and monthly report processes will continue through FY 2021 and adjustments made if indicated to distribution of the bed utilization targets. These adjustments will need to reinforce CSBs or regions that have already made progress toward meeting the defined targets rather than additionally compensate those who may have not done so.
FY 2022	1. Payment for bed utilization above target is implemented. 2. Bed utilization targets established for each CSB. These targets will be converted to a monthly utilization target for each CSB. 3. Bed utilization above the monthly target will result in the CSB being billed for the days utilized above the target. Bed utilization below the monthly target will result in a "refund" from the state hospital. These payments to CSBs will be due according to standard reimbursement procedures, typically within 30 days. 4. The cost to the CSB will be determined based upon the non-fixed costs of hospital care. Using FY 2018 numbers this cost would be $329/day or about 52 percent of the total cost of operating an inpatient bed. This number may be different in FY 2022 and will need to be adjusted based on current costs at that time. 5. With the full implementation of financial realignment the inpatient census during FY 2022 should be 1,300 versus 1,460 under the "business as usual" projection based on current trends. With an increased expenditure of $2 million each fiscal year the goal would be to maintain the ADC at that level or below, allowing the Commonwealth to make alternative decisions related to the size and number of state hospitals it operates should it choose to do so.

In order to accomplish financial realignment in this timeframe, CSBs may join together to provide some placements and supports for cost efficiency. It may be that one CSB develops a service and charges other CSBs for its use. Most of these options will be less costly than buying a hospital bed. In addition, CSBs (or DBHDS) may, and should when possible, contract with private providers of behavioral health services to administer community services.

In order to create the financial dynamic demonstrated above, the following steps should be taken. Discussion on costs for the items below is included in the financial analysis section of this report on page 34.

Census Targets

1. **Applicable Population for Determination of Census Targets** – The individuals involved will be civil individuals and individuals found NGRI who have achieved 48-hour pass levels. Individuals who are NGRI must successfully advance through a specific set of privilege increases overseen by a panel of clinicians and experts before they can reach a high enough level to be granted permission for a 48-hour pass.
2. **Bed Day Determination** – A "bed day" is when one patient occupies a state hospital bed and stays overnight in the hospital. The number of bed days per CSB is calculated based on how many of their clients are in the state hospital per day over a given period of time.

The number of bed days for which payments/refunds apply will be determined by the number of days above or below the target bed day utilization for civil and applicable NGRIs. This number will be determined based on the CSB bed utilization per 100,000 population, the state hospital average daily census (ADC), the availability of private hospital options, local/regional variables including geography and judicial practices. The goal is meaningful census targets that can be achieved based on these factors with due attention to reinforcing CSBs that already have achieved lower bed utilization. See Appendix F for an example of how bed reduction targets may be calculated for each CSB. The annual bed days will be parsed into monthly bed days so that payments and refunds can occur in a more timely way. Given that the census will still ebb and flow there will be months of higher demand, perhaps requiring bed purchase, and others of less demand leading to refunds, CSBs may choose how to spend the refund amount. Additional discussion on this issue is found in the next section of this report on financial analysis.

Funding and Services

3. **Determine Needed Community Services** – DBHDS conducted a point in time survey in February 2017 on support needs for individuals on the EBL and also surveyed CSB executive directors on community housing and support services needed to facilitate discharges. More information can be found in the previous section of this report on EBL reduction and in Appendix E. Results of these surveys directly led to the development of the community integration plan also discussed in the previous section. Additionally, more and possibly different services will be needed for financial realignment. It is important for CSBs to assess the needs of their clients who are likely to need state hospital care, and those at risk of needing such care. CSBs need to determine the services that will facilitate discharges as well as keep those at risk out of the state hospitals. Within each CSB some supports will not be feasible, but may become so by partnering with other CSBs or the region as a whole. DBHDS will request plans from the CSBs for what services would be required to meet the census reduction targets during FY 2020. Plans would be assessed based on cost, likelihood of success in meeting the reduction targets, impact of overall local capacity to sustain the reductions over time, and the time required to develop the capacity and implement the plan.
4. **Start-up Funding** – Funding must be provided to develop the placements and services into which state hospital individuals can be discharged. Start-up funding is necessary for the community integration plan to reduce the EBL as a critical precursor to financial realignment, and additional start-up funds will be required to implement financial realignment. In both cases, funding is based on what community services are needed. In addition, activities such as conducting procurements for services from private partners, hiring and training staff, and developing policies and procedures all require time and incur cost. Using the plans mentioned in number 3 above to meet census reduction targets, DBHDS currently *estimates* approximately $5 million during FY 2021 will be needed statewide and allocated through awards to individual CSBs or regions.
5. **Determine Cost for Needed Services** – Once this assessment has been translated into specific development needs, it becomes possible to develop costs, including ongoing funding, for those interventions and determine their timeframe for availability. Once it is known what may be available from state hospitals and under what circumstances, it is possible to begin determining the amount of new general funds that may be needed and to what extent Medicaid support may offset some of those costs. Importantly, the

development of new community capacity must recognize that the EBL is not static; supports cannot be developed for just the people currently stuck in the hospital, but also those who will get stuck over the course of the year.

6. **Determine Hospital Fixed and Variable Costs –** From the hospital's perspective, the need is to determine what costs are fixed, which are flexible, and under what circumstances they become flexible. Hospitals cannot save money unless a unit or building can be closed; thus, bed reductions at less than that level do not generate any significant savings. This means, among other things, that the smaller hospitals cannot achieve any savings to be used for improved community services. An internal group of state hospital staff and central office staff reviewed the fixed and variable costs at the state hospitals. Their analysis concludes that 52 percent of the hospital costs are variable for the initial unit of operation. More discussion on fixed and variable state hospital costs is included in the next section of this report on financial analysis.
7. **Determine Hospital Cash Flow Requirements –** Hospitals must determine the manner in which surges of higher census can be handled and how to work with staff from a unit that might close if simply filling vacancies elsewhere in the hospital is not possible. Hospitals also need to understand how to monitor their spending in relation to current and projected utilization, and how to manage their "cash flow" as reimbursements from CSBs will be 30 days from point of billing. Caution will be needed to assure that hospitals do not move prematurely to accomplish lower spending at the expense of necessary staffing. Given that some funds that have historically been state general funds dollars would now come from CSBs as special funds, there are some additional provisions needed to assure appropriate cash flow.

Management

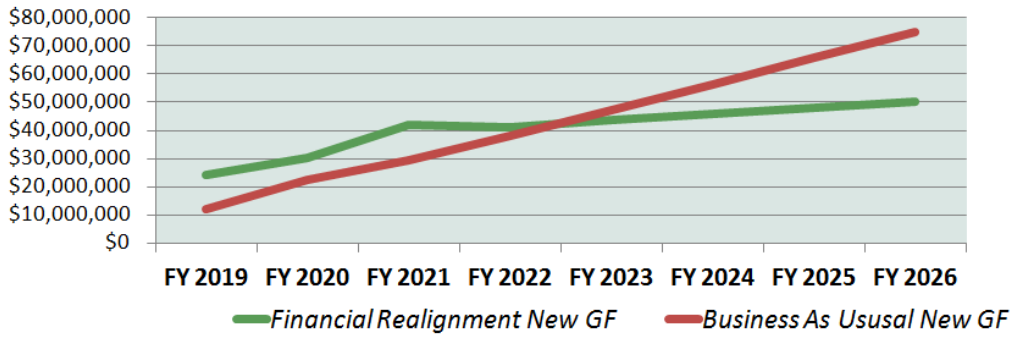
8. **Risk Pool** – As with any managed care enterprise, a risk pool of funds is a necessity to address overutilization not anticipated in the allocation. In the beginning the risk pool would be developed and managed through CSB's unexpended balances and special revenues. Special revenues are collected from various service fees and charges for medical, personal care and other services (e.g. Medicaid). The risk pool and other practice prohibitions against the use of local funds for state hospital bed purchase should provide reassurance to local governments that the state does not have any intention of utilizing any local funds. DBHDS plans to add language to the CSB performance contract to emphasize that local funds will not be used towards financial realignment.
9. **Central Office Oversight and Monitoring** – CSBs and state hospitals will require ongoing technical assistance from the DBHDS central office to ensure the success of the bed purchasing plan and to help manage risk. Central office will also need to play a central role in the enhancing and adhering to the utilization review, discharge processes and in monitoring the applicable monthly reports to ensure positive outcomes and accountability. While some existing central office staff would be retrained to help manage this new function, supplementary staff would include two reimbursement positions (additional discussion concerning reimbursement staff can be found in the financial analysis section of this report), a statewide discharge planning expert, and a community services position specializing in discharge services.
10. **STEP-VA** – Financial realignment would work in concert with the required clinical services being built through STEP-VA. As noted previously, STEP-VA is a standardized set of clinical services with parameters for access and common performance measures. It is not designed to provide housing or supervised housing. Once it is substantially

developed in terms of same day access, outpatient services and the crisis service continuum, it will reduce the demand for psychiatric and medical hospitalization and produce additional options for the Commonwealth.

As noted above and described in the review of similar efforts in other states, **it is essential that community development take place prior to implementation of the financial realignment**. At a practical level, this means providing funds during the fiscal year prior to implementation for developing the necessary community capacity. In doing so, bed utilization can decrease prior to CSBs becoming financially responsible for the purchase of state hospital beds. If implementation of bed purchase starts prematurely then CSBs may not have sufficient funds to simultaneously support both expanding community services and buying state hospital beds.

Implementing financial realignment across all 40 CSBs and properly sustaining it over time would reduce state hospital utilization closer to the best practice rate of 85 percent (with the goal to be below 90 percent), where safety levels are better for patients and staff alike. Figure 23 below compares the cost of continuing current financial operations in Virginia's state hospitals with the cost of financial realignment. Although the short-term investment for financial realignment is greater because of the need to expand the community services needed to facilitate safe and sustainable discharges from state hospitals, in the long run it would lead to a better use of limited state general fund dollars and far better outcomes for individuals.

Figure 23. Cost of Financial Realignment vs. Doing "Business as Usual" in Virginia State Hospitals



	FY19	FY20	FY21	FY22	FY23	FY24	FY25	FY26
Business as Usual GF	$12.0M	$22.2M	$29.2M	$38.3M	$47.3M	$56.4M	$65.7M	$74.8M
Realignment GF	$24.2M	$30.4M	$41.8M	$41.2M	$43.5M	$45.8M	$48.0M	$50.3M

By implementing financial realignment, the substantial "business as usual" costs (*see Figure 13. Cost of Doing "Business as Usual" in Virginia State Hospitals*) required for operating an ever increasing number of state hospital beds and significant capital costs related to upgrading, renovating, and replacing state hospitals can be avoided or at least minimized, allowing Virginia to focus its resources on the level of care most needed for the individuals it serves.

DBHDS Budget Analysis for Financial Realignment

Potential Resources Available in the System

The following information provides potential cost information for certain aspects of financial realignment as they would be operationalized. It is important to note that this document provides possibilities, rather than certainties. In order to craft a plan that will function effectively, further integration will be required among all components of the plan.

State Behavioral Health Hospitals – Virginia currently operates and budgets for nine state behavioral health hospitals, with base operating plan costs in excess of $353.8 million, of which nearly $293.5 million represents state general fund or (83 percent) of the base operating plan for these hospitals. The remaining $55.7 million are special funds generated primarily through Medicaid and Medicare reimbursement which account for 86 percent of the special fund revenues. State hospital general fund dollars represent nearly 38 percent of the nearly $772.6 million for the DBHDS system budget for FY 2018. This general fund amount is only slightly more than the $336.9 million Virginia allocates to CSBs for behavioral health services. Figure 24 below provides details on the hospitals' general fund appropriations and base operating plan for FY 2018.

Figure 24. FY 2018 State Hospital General Fund Appropriations and Initial Base Operating Plan

	FY 2018 GF Appropriation	FY 2018 NGF Appropriation	FY 2018 Base Operating Plan
Central State	$63,886,054	$380,063	$64,278,117
Eastern State	$68,620,257	$2,357,166	$70,977,423
SWVMHI	$32,360,705	$6,488,164	$38,848,869
Western State	$51,882,545	$6,363,140	$58,245,685
CCCA	$9,921,263	$3,614,326	$13,635,589
Catawba Hospital	$14,297,435	$10,335,302	$24,632,737
NVMHI	$28,639,650	$3,026,310	$31,665,960
Piedmont Geriatric	$8,967,073	$21,226,378	$30,193,451
SVMHI	$14,928,391	$1,789,217	$16,717,608
TOTAL	**$293,503,373**	**$55,580,066**	**$353,791,855**

Four Largest State Hospitals (CSH, ESH, SWVMH, WSH)	**GF Appropriation**	**% of Total GF Appropriation**
	$216,749,561	**74%**

It is noteworthy that the four largest hospitals, Central State, Eastern State, Southwestern Virginia Mental Health Institute, and Western State represent nearly three quarters of state general fund appropriation for behavioral health hospitals.

Additionally, it is important to recognize that, for the purposes of financial realignment, the majority of these general fund resources would not be available for reallocation to the community. Statutory requirements remain for serving individuals transferred from jails and support for most of the NGRI population must remain with the hospitals. Moreover, fixed costs related to maintaining buildings, information technology and phone support, utilities, grounds, equipment, and administration comprise approximately 48 percent of the total cost of state hospital operation and are unavailable for realignment funding. Lastly, financial transformation would focus on the adult population, as the state-operated Commonwealth Center for Children

and Adolescents provides coverage and placemen of last resort for children throughout Virginia and would not be conducive to a financial realignment back to communities.

Discharge Assistance and Local Inpatient Purchase of Beds – With oversight from the DBHDS Central Office, state hospitals and CSBs, utilizes funding for local inpatient purchase of beds (LIPOS) and discharge assistance program (DAP) to help manage census at the front door of the state hospitals and to facilitate integration back to the community at the backdoor. Virginia currently budgets $41.3 million general fund each year for this effort.

Complexities of State Hospital Resources

The complexity of utilizing state hospital resources begins with the fact that state hospitals operate differently from one another. Each state hospital varies in physical structure, number of buildings, patient population, number of beds, labor costs, and the nature of the regions they serve. Statewide, 82 percent of the state hospital budgets are related to personnel. While DBHDS has made significant efforts during the past two years to better align state hospital budgets, decades of historical differences in funding levels have not been completely addressed.

Variable Versus Fixed Costs

DBHDS analyzed what resources would be available if the state hospitals experienced a reduction in census and a corresponding reduction in the number of beds operated to determine if state hospital general fund support would be available for reallocation to community-based activities. Several academic studies have attempted to articulate fixed versus variable costs in hospitals. A study published in the *Journal of the American Medical Association* concluded that 82 percent of hospital costs are fixed. This study has been cited many times throughout other publications. A 2015 *Health Finance Journa*l article questioned the methodology of the above study. This study looked at Medicare cost report data from 1996-2010 and stated that 45-48 percent of hospital costs could be considered "overhead" or fixed. The authors concluded, "Our assessment suggests that roughly 50 percent of hospital costs are less responsive to changes in patient volume."

An internal group of state hospital staff and central office staff reviewed the fixed and variable costs at the state hospitals. The analysis concludes that 52 percent of the hospital costs are variable for the unit of operation available for closure. DBHDS worked with independent contractor Public Financial Management, Inc (PFM) in order to validate the internal group's findings. PFM's review of the hospital operations plans and analysis of fixed to variable cost ratios resulted in a range of 45.6 percent to 52.5 percent and was consistent with the internal group's conclusion of 52 percent for variable costs. State hospital variable costs include: nursing staff, housekeeping staff, physicians, clerical staff, pharmacy staff, pharmaceuticals, food and other non-personnel items.

As the census and beds are reduced, the savings would materialize ongoing only if the hospital at least takes offline an entire unit, which varies by hospital from 18 to 25 beds. This conclusion is supported by this statement from the *New England Journal of Medicine* published in 2011: "Because of the rigid cost structures, incremental reductions in resource use are unlikely to generate cost savings for either a health care setting or the health care system. The most

meaningful way to achieve savings is to focus on overall reductions in utilization rates for health care services and to **eliminate the associated unnecessary capacity**."

Reduction in State Hospital Operating Capacity

Figure 25 below reflects adjusted budget to display offsets or increases for shared services at multi-agency campuses:

Figure 25. State Hospital Adjusted Budgets

Hospital	Adjusted Budget	# of Beds	Cost Per Bed	# of Units
Central State	$65,162,824	277	$235,245	13
Eastern State	$70,977,423	302	$235,025	15
SWVMHI	$38,848,869	179	$217,033	10
Western State	$57,118,566	246	$232,189	9
CCCA	$14,690,857	48	$306,060	4
Catawba Hospital	$24,632,737	110	$223,934	4
NVMHI	$31,665,960	134	$236,313	6
Piedmont Geriatric	$28,093,451	123	$228,402	4
SVMHI	$16,717,608	72	$232,189	3

Each state hospital operates units consisting of a set number of beds based on the layout of the physical plant, adapted as best as possible to the current patient population and services provided. As the census reduces, the ability to reduce expenditures to any consequential degree is not possible until a full unit is taken offline and is not staffed. This reduction in staff and ancillary costs once a unit is closed are the funds that may be transferred from the hospitals.

An analysis conducted with staff at the hospitals and central office concluded that the average savings per bed at the state hospitals would be $120,000 per bed or 52 percent of the cost per bed (average is approximately $230,000 a bed for all state hospitals). If a state hospital is able to reduce their average census by 20 **and** take a 20-bed unit offline this would result in potential annual savings of $2.4 million. This projected savings could be transferred from the hospital to the community less any workforce transition costs (severance, leave payout, healthcare) for the layoff of positions, expecting that most positions savings are the result of attrition and turnover.

The current analysis projects that not all state hospitals are budgeted or structured to have the same flexibility due to size of the hospital. For example, if Western State achieved a 10 percent reduction in their annual census that would result in 28 beds being able to be taken offline (a full unit). Conversely, the same 10 percent at SVMHI would only result in seven beds being able to be taken off line. This would not allow SVMHI to achieve any type of unit reduction due to the size of the hospital and economies of scale a larger hospital is able to achieve. As such, the smaller hospitals will be excluded from the transfer of funds to the community. It is anticipated that the census will be reduced at all hospitals to a safe level; however, the smaller hospitals' ability to transfer funds is hampered by their size.

Risks, Challenges, and Mitigation Methods

Currently, state hospitals operate with an annual budget and the variability associated with special fund collections (i.e. Medicaid and Medicare billings) is pooled centrally to absorb

uncertainty. This allows for state hospitals to ensure resources being available to them throughout the entire fiscal year. Having CSBs purchase beds would introduce a new dynamic to the cash flow and operations of the hospitals. Hospitals would need to navigate both increases and decreases of the census along with the cash flows from the CSB payments. New procedures would be required to meet with this newly introduced risk to operations and cash flow.

- *Strategies and Tools for Staffing in New Environment* – Hospitals would need to be able to adjust staffing up or down depending on the census with more consideration of cost than they do at present. In the meantime, given the current high staff vacancy levels, such adjustments can be made using more or less overtime. However, if admissions suddenly increase after a unit had been taken offline, the hospitals would need to quickly hire individuals to meet this demand. Locum Tenens (contractual) physician and contract nursing staff could be utilized, but are much more expensive than regular employees and that state hospitals already experience difficulties in terms of availability and the time it may take to find available nurses and physicians. Assessing at what census level a unit can actually be taken offline and staff distributed to fill other vacancies will be important when that point is reached.

- *Strategies and Tools for Funding in the New Environment* – Given that only a small portion of the hospital's annual budget is being shifted, operational cash flow will not be significantly affected until nearing the end of the fiscal year. As the year ends, adjustments between state general fund dollars and special funds can require active management generally. If hospital days are being used and require staffing expenses when reimbursement may only come in during the next fiscal year this complexity is increased. Alternatively, if the hospital had to refund the money for unused days to CSBs in the final quarter of the fiscal year when staffing adjustments are less able to impact expenses, cash flow issues could develop. The ability to move money within the DBHDS system may be necessary to ensure prompt payments and other requirements are met at the end of the fiscal year.

  In addition, it would be prudent for the state hospitals to have the ability to retain unspent balances to address future financial risks. To accomplish this, the elimination or expansion of the $25 million special fund cap for DBHDS would be warranted. This would allow for the hospitals to create a financial risk pool to weather fluctuations year to year in census and revenue, which is vital for the feasibility of this initiative. Furthermore, flexibility to move funding, to include general fund dollars, between fiscal years and within the DBHDS system, across the agencies of central office, CSBs, and state hospitals would help to address any unexpected events during the initial roll out of financial realignment. In addition, this flexibility would provide protection from surges in admissions or discharges that disrupt operating plans once realignment is in place, and in those circumstances where DBHDS and CSBs identify opportunities to maximize the use of existing resources to meet the intent of realignment.

- *Reimbursement Considerations* – The Commonwealth would need to make changes to the Appropriation Act to allow for the cash to be carried forward into future fiscal years. Further investigation is needed to ascertain whether or not *Code* changes or regulation changes would be required to allow the hospitals to bill CSBs for the care of the individual receiving treatment. Currently, Section 37.2-715 of the *Code* of Virginia, "*The*

income and estate of an individual receiving services ***shall be liable for the expenses of his care****, treatment or training, and maintenance in a state facility. Any person responsible for holding, managing, or controlling the income and estate of the individual receiving services shall apply the income and estate toward the expenses of the individual's care, treatment or training, and maintenance*." Individuals receiving care are the ones responsible for the payment to the state hospitals. In reality, the vast majority of indigent individuals and families are, with exceptions, unable to pay for their state hospital care.

Additionally, the *Code* of Virginia (§ 37.2-717) states, "*The Department shall investigate and determine which individuals receiving services or parents, guardians, conservators, trustees, or other persons legally responsible for individuals receiving services are financially able to pay the expenses of the care, treatment or training, and maintenance, and the Department shall notify these individuals or their parents, guardians, conservators, trustees, or other legal responsible persons of the expenses of care, treatment or training, and maintenance and, in general, of the provisions of this article."* This is a very labor intensive process which has to be acted upon for each admission to the state hospitals. The implementation of this financial realignment plan adds another element of investigation, complexity and monitoring across state hospitals which has never been done before. How to best integrate these *Code* requirements with the new responsibility for payment passed to CSBs (for beds above the reduction target) is yet to be determined.

Regardless of how the *Code* issues are resolved, additional DBHDS reimbursement staff would be required to carry about the above responsibilities and changes. Revenue and finance staff would need to be able to project, track and reconcile census and revenue. To undertake this realignment, modifications to the hospital billing system will be required. The recognition of payment to and from the state hospitals and the CSBs, as well as the transfer of funds will all need to be investigated and the identified changes made. Individual CSBs are ultimately responsible for these hospital bed payments above the target and not the regions. It is expected that state hospitals will be billing CSBs outside of their region as there has been increasingly more individuals sent across catchment areas for treatment in state hospitals. There are currently seven reimbursement staff in central office and others working the hospitals statewide. Two new reimbursement positions would need to be added in the beginning phase of financial realignment. Given the magnitude of this effort and the accountability required, an additional two reimbursement positions may need to be added in central office before full realignment is implemented in FY 2021, with the potential need for other reimbursement positions added in the hospitals or on a regional basis.

- *Accounting of Bed Days* – The proposed model involves establishing and managing a target number of bed days per CSB. Any bed days utilized above that target would result in the CSB being charged for each additional day. All CSB bed days would be counted in their total bed day target whether the individual had insurance or not. Some individuals receiving treatment from the hospital will have health insurance and the hospital will receive reimbursement from the third party payer. DBHDS hospitals would need to refund any of that revenue back to the CSB if the CSB paid for that individual's bed days. This will create revenue risk at both the CSB and the hospital and cash flow and refunds

would need to be closely monitored. It is anticipated that CSBs would be billed or reimbursed on a monthly basis through the year followed by a potential CSB cost settlement process which will occur at the end of the fiscal year based upon bed utilization and other performance factors. For this process to work it will be of the utmost importance that the billing and tracking of bed days in the hospitals be transparent and easy to understand for the CSBs. Investment in a billing and financial system that can provide this capability and transparency would be an important step in ensuring that this can occur smoothly. Currently it is anticipated that DBHDS' Avatar billing system could be modified to accommodate this capability.

- *Collection Process for CSBs Payments* – Virginia would require CSBs to pay for any bed utilization above their bed target. If the CSB is unable to pay, the state would withhold an equal payment from the CSBs state general fund disbursement. These payments occur 24 times a year.

- *Start-up Funding* – As noted previously in this report, there is required setup time for building new or expanding existing community housing and support services. This start-up also requires funding to pay for the hiring of staff, infrastructure costs and other items needed for service development. As such, DBHDS would require additional state general fund dollars as bridge funding, a more flexible funding source that would allow DBHDS to develop new capacity while maintaining state hospital capacity at existing levels. These funds could be offset by funds in the DBHDS trust fund or from special fund balances. However, any reduction in current special fund balances would increase the risk to the state hospitals as they weather the reduction in general fund dollars proposed as units are taken offline. Furthermore, the majority of the funds associated with the trust funds has or will come from the sale of state training center property. As a result, many view these funds as needed for the U.S. Department of Justice settlement agreement although not exclusively earmarked for such purposes. Virginia *Code* states, *"Moneys in the Fund shall be used for mental health, developmental, or substance abuse services and to facilitate transition of individuals with intellectual disability from state training centers to community-based services."*

Incentive Plans

Item 284.E.2 required that the financial realignment plan include discussion on financial incentives for CSBs to serve individuals in the community rather than in state hospitals. Financial realignment is not envisioned to be a system of penalties or incentives, but a necessary reallocation of resources from one service type to another, and a recasting of the decision making matrix of individuals requiring treatment at the state hospitals. This enables financial consideration and the maximization of current resources to play a more salient role in the decision making of the DBHDS system.

Effective incentive plans require joint agreement of the relevant parties on both the performance elements and the financial incentives or penalties, which tend to be small (0.5-3 percent). Experiences in other states, such as Alaska, have demonstrated they can be effective in changing behavior. However, such a plan for census management would require the same level of capacity development and cost in the community, but feature far less in terms of the actual

financial dynamics. Financial realignment includes the opportunity to exceed reductions targets and, in so doing, preserving sufficient resources to truly add additional capacity rather than a small amount of money in a bonus payment. Although DBHDS has decided not to go the incentives and disincentives route, as this would not develop the kinds of infrastructure necessary to accomplish performance targets or system change, some of the material from DBHDS's Performance-Based Contracting Report, submitted to the money committees and the Secretaries of Finance and Health and Human Resources in 2016, may be of some use. The complete report is available at http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD4332016/$file/RD433.pdf (The most relevant sections of the report are contained in appendices E and F found in this link.).

With additional state resources provided from the state hospitals along with new general fund support, CSBs would have the option of using all or a portion of this funding to provide greater capacity and services within the community in lieu of utilizing state beds. These packages and menus of services and programs are outlined in this report.

State Employee Transition Plans

Item 284.E.2 required that the financial realignment plan include state hospital employee transition plans. The workforce of DBHDS has been struggling for years with vacancies and turnover of key critical direct care staff, including front-line workers, nursing, clinical, and medical staff. With financial realignment, each hospital would need to identify staffing needs based on anticipated bed utilization. If utilization is anticipated to be such that an entire unit can be taken offline and be unstaffed, virtually all staff from that unit would be deployed into vacant positions elsewhere in the hospital. Key professional staff would be a priority to retain. It is anticipated that, given existing vacancies, attrition rates, and essential system needs in the state hospitals that any layoffs of clinical staff would be few, if any.

The current vacancy rate for state hospital direct service associates (DSAs) systemwide is approximately 16 percent and the vacancy rate is currently approximately 20 percent for licensed practical nurses (LPN) and 22 percent for registered nurses (RNs). Due to the high turnover and vacancy rates, employees that are impacted by downsizing can be absorbed in current vacancies within each facility. For instance, the average number of filled DSA, LPN, and RN positions per unit within larger state hospitals (ESH, WSH, CSH, SWVMHI) is approximately 33. If one unit within each of those hospitals closed, approximately 50 vacancies in all other units would still exist to be filled. In the event that multiple units are closed, staff would be given the opportunity to be considered for vacancies at other state hospitals. If no other options exist, staff would be laid off in accordance with DHRM Policy 1.30, *Layoff*.

In DBHDS' experience with Virginia's plan to close four of the five state-operated training centers for individuals with intellectual disability, many of the impacted staff filled critical vacancies within the hospital and attrition has minimized the impact on staffing. In a transitional workforce where staffing reductions or additions are based on the utilization of state hospital beds, the development of a temporary workforce pool may be necessary. This would include establishing a wage pool of the staff positions needed to supplement the workforce during high and low state hospital bed census. Wage employees receive pay for hours worked rather than a fixed salary and intended to cover peak workloads and short-term needs. Wage employees are limited to working 1,500 hours per agency per year, which is calculated as the 365-day period

from May 1 through April 30 each year. Virginia Department of Human Resource Management policy does not allow flexibility to request exceptions to the 1,500 hour per year rule.

Another option is contracting with private firms to hire workers to fill additional roles that are needed for ongoing recruitment due to increased bed capacity. Although a more costly approach, DBHDS would not be providing employment benefits in this case and would have the ability to staff according to fluctuating employment levels. Covered employees (salaried employees in classified positions, eligible for benefits, etc.) may not be an option since there is no guarantee that they will meet the criteria outlined in DHRM Policy 2.20, *Types of Employment*, and meet the hours of work required per week, per year (i.e. quasi-full-time employees, part-time salaried employees, etc.).

Partnerships with the CSBs and private providers would be developed to identify critical functions and positions that will be needed in the community to provide services. Sharing of staff between the hospital and the CSB whereby staff would float between the two entities could be developed. Community workforce initiatives to be implemented, such as transitional training for hospital staff into community based services (certifications), outplacement services (career assessment with employment availability), establishing career centers with the CSBs, and job fairs hosted for the CSBs would support the workforce impacted.

Legislation and Budget Language Requirements

Item 284.E.2 required that the financial realignment plan include discussion on the legislation and Appropriation Act language needed to achieve financial realignment. Enabling legislation, authorization through Appropriations acts, and/or state human resource policy amendments may be required, including:

- Appropriation Act language
    1. Authorizing the DBHDS Commissioner to move funds between agencies 720, 790, and 792 as needed to support the plan with DBHDS providing quarterly reports of transfers to Governor, House Appropriations and Senate Finance Committees;
    2. Providing for the mandatory re-appropriation of June 30 state hospital general fund balances;
    3. Authorizing the hospitals to bill and accept payments from the community services boards for the cost of services provided;
    4. Permitting an exception to certain DHRM policies to give DBHDS facilities more employment flexibility to address workforce fluctuations; and
    5. Establishing caps on special hospitalization costs per patient.
- Legislation allowing DBHDS operated hospitals to become an authority.

Assessing Performance Indicators and Outcomes Measures

Item 284.E.2 required that the financial realignment plan include discussion on matrices to assess performance outcomes.

Statewide Quality and Performance – DBHDS and the CSBs, along with other relevant

stakeholders, will need to develop robust systemwide quality and performance metrics to ensure individuals receive the right level of care, at the right time, in the right place. As part of behavioral health system transformation, DBHDS will request funding for Service Process Quality Management (SPQM) an off-the-shelf analytical tool. This tool will help CSBs collect information about services to better strategize for the future, manage operations, develop continuous improvement strategies, and demonstrate outcomes to public and private payers. Successful implementation of STEP-VA services will require an analytical tool to monitor key behavioral health care outcomes and costs to achieve those outcomes for the individuals served. The tool will need to provide a way to consistently measure the quality, effectiveness, and efficiency of the services provided by STEP-VA.

CSB Performance – The essential measure for CSB performance is whether the CSB met the ADC/bed day reduction target. Additional measures would include bed utilization per 100,000 population, numbers of individuals on the EBL, individuals discharged to supervised living homes and assisted living facilities who then transition into permanent supportive housing, and hospital readmission rates. Within 30 days of receiving the bill Other performance measures ancillary to realignment include those related to STEP-VA such as measures for same day access, numbers of individuals served, percentage of individuals served by crisis services, numbers engaged in substance use disorder treatment, and outcome measures. These measures will provide a more encompassing assessment of CSB performance.

State Hospital Performance – For state hospitals, the performance measures would include the number of uncompensated bed days for the target population, which equate to days in the state hospital after the CSB identified immediately available placement. Other measures include length of stay for individuals admitted from jail, fidelity of the utilization review processes, and meeting human resource targets in the event of a unit being taken offline. Other current measures would continue such as tracking and measuring the ADC, admissions, discharges, vacancies, turnover, medical hospitalizations, staff overtime, seclusion/restraint, and aggressive events.

Stakeholder Involvement

DBHDS worked with multiple groups throughout the development of the financial realignment plan. Most importantly, DBHDS has involved the CSBs since March 2017 to gather data, seek input and address concerns. Meetings or communications with CSB executive director leadership were held routinely, on an almost weekly basis, throughout this process.

In addition, DBHDS held two meetings to share the plans and collect feedback from a stakeholder group involving representatives of individuals receiving services and family members, local governments, private providers and other stakeholders. Membership of this group can be found in Appendix G.

DBHDS has also engaged an expert panel of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century regarding this topic on a regular basis. It also retained national experts to review the plan and provide input during its development. The consultants provided information relative to what other states have attempted, provided expert advice as documented in the Financial Realignment in Other States section of this report, and reviewed pertinent work products as they have been developed.

Conclusion

The 2017 General Assembly required that plans be developed surrounding reducing the EBL and realigning the public behavioral health system. Implementing financial realignment across all 40 CSBs and properly sustaining it over time would reduce state hospital utilization closer to the best practice rate of 85 percent, where safety levels are better for patients and staff alike. Financial realignment across all CSBs would also reduce the number of individuals no longer needing a hospital level of care and decrease the amount of time individuals await discharge on the EBL. It also helps build the community system and helps shift the balance of state spending in the direction of what is seen in other states. Most importantly, it would allow individuals to be served at a level more consistent with their needs and experience a full life in the community.

One of the most compelling outcomes of financial realignment is the opportunity for stronger management of state hospital bed utilization by building and sustaining community capacity to support hospital discharges and incorporating a financial reason for CSBs and state hospitals to work together to safely transition individuals to those new or expanded services. In the long run, it would mean that the number of beds available in state hospitals would be determined by need rather than history and "best guesses." In doing so the substantial costs required for operating an ever increasing number of state hospital beds and significant capital costs related to upgrading, renovating, and replacing state hospitals can be avoided or at least minimized, allowing the Commonwealth to focus its resources on the level of care most needed for the individuals it serves.

Notably, the implementation of STEP-VA services will work in concert with the state hospital discharge services. STEP-VA infuses the critical community services individuals need to more effectively manage symptoms and avoid crises, hospitalizations, and interactions with the criminal justice system. Through implementing STEP-VA, starting the financial realignment process by building the community services needed to target state hospital discharge-ready individuals, Virginia's imbalanced system finally begins to favor stronger community services. This shift permits the successful implementation of the significant changes called for in the financial realignment plan, leading to more people being served, better use of limited state general fund dollars, and far more positive outcomes for individuals served by the system and their families.

Appendices

Appendix A: BHPC Analysis of Other States' Financial Realignment Efforts

In July of 2017, the Behavioral Health Policy Collaborative (BHPC) was selected by DBHDS to provide expert input and review as part of the General Assembly required financial realignment plan development. Specifically, BHPC was tasked with researching and analyzing a collection of other states' efforts to realign the financial structure of their behavioral health systems.

Approach

For the first phase of this engagement, BHPC conducted key informant interviews with representatives from state mental health authorities (SMHAs), managed care organizations (MCOs), national and state behavioral health provider associations, and national organization representatives to identify state approaches in rebalancing behavioral health systems away from institutional/state hospital-based care to community-based services. The interviews were designed to explore how eight specific states are working to rebalance their mental health systems using financial incentives or disincentives, such as allocating state psychiatric hospital funds to county or other local behavioral health authorities to "buy beds," using risk- or performance-based contracts, applying managed care principles or approaches, setting annual inpatient targets where counties/localities assume risk for exceeding targets, and other strategies. The eight states that were focused on were selected based on BHPC team members' knowledge of systems rebalancing efforts in those states and an awareness of the limited time to conduct this phase of the project. BHPC did not intend to convey that these are the only states where such activities have occurred.

Key Themes and Findings

Following BHPC's key informant interviews, data was coded and categorized, resulting in the following themes.

Theme 1: *Significant upfront investments in community-based services are necessary to rebalance systems away from psychiatric hospital-based care.*

The most prominent theme that emerged from BHPC's key informant interviews was the critical importance of making significant financial investment into community-based services to prevent unnecessary hospitalizations and transitioning individuals to appropriate services in the community post-discharge. Key informants warned that efforts to restrict access to or close psychiatric hospitals altogether would be unsuccessful without such an investment.

Service capacity investments should include housing-related resources and supports, and the development of evidence-based services such as assertive community treatment (ACT) teams, and mobile crisis services, short-term care facilities, and specialty facilities and community-based programs/housing for individuals with complex medical comorbidities.

- **Pennsylvania** provides funding to counties to cover robust community-based services for individuals being discharged from state hospitals, based on county targets aligned with regional hospital closure goals. Additionally, while unsuccessful, Pennsylvania advocated to utilize a percentage of revenue from the sale of state psychiatric hospital buildings and land for investment in a housing trust for people leaving hospitalization.
- **Maryland's** Administrative Services Organization – through a strong relationship with core service agencies (CSAs) that fund crisis beds and other acute services – not only authorizes and pays claims for state psychiatric hospital services, but also uses their connection with CSAs to

leverage residential beds as a step-down service from the state hospital, as people transition into community-based care.

- During 2005 – 2016, **New Jersey** invested $104 million in community-based services as part of an overall strategy to improve the system of care. Guided by its "Home to Recovery" Plan and Olmstead Agreement, significant investments were made in permanent supportive housing, ACT and other diversionary services that resulted in a direct impact on state hospital census and showed that individuals discharged from state and local hospitals could live successfully in community with the appropriate supports, challenging beliefs from some providers, policymakers, and family members that these vulnerable individuals could not live independently. The state also created a $200 million Special Needs Housing Trust Fund for the development of lease-based supportive housing to create a multi-year pipeline of housing for people with mental illness and other disabilities.
- In **Washington**, the Public Consulting Group recommended that Washington develop a supportive housing benefit and select a central coordinating entity for strategic housing investments in parallel to investments in community-based services. Public Consulting Group also recommended the establishment of smaller residential programs for individuals with complex medical comorbidities, decreasing Washington's reliance on state psychiatric hospitals and nursing homes for people with serious mental illness who have complex medical needs.

Theme 2: *The financial transition of state rebalancing efforts often includes preserving some allocation for state psychiatric hospitals while increasing the investment in community-based services, taking multiple years to see cost savings.*

In the beginning of rebalancing efforts, states must be prepared to take on the initial expense associated with the expansion of community-based service capacity, while slowly reducing funding to state psychiatric hospitals. Upfront costs of expanding community-based services can cost systems more than their previous investments, but are needed to eventually garner cost savings, as state psychiatric hospitals close or downsize.

For this reason, three informants noted that phased, multi-year funding strategies that slowly titrate down investments in state psychiatric hospitals while increasing investments in community-based services will ensure community services are sufficient to meet the needs of individuals exiting psychiatric hospitals. Informants also cited that instead of taking a per-bed approach to psychiatric hospital closures, states should close entire psychiatric hospitals or entire units within psychiatric hospitals to optimize both per-bed and operational cost savings.

- **Pennsylvania** did not provide the entire state psychiatric hospital allocation to counties to purchase beds so that the state could have resources to transition psychiatric hospital staff into community-based jobs and cover psychiatric hospital fixed costs. During a transition period, the state held back a percentage of the allocation for hospitals, to cover fixed costs of the hospital, carefully integrate hospital staff into community-based jobs, and support needed bed capacity during the transition.
- In **New Jersey's** planning for state psychiatric hospital closure they found that while the closure of a state psychiatric hospital generally takes several years from the date of announcement (requiring discharge planning and bridge funding for programs), they could decrease census and consolidate operations within each hospital and across the state hospital system to partially offset bridge funding costs for community services during the phase down. Reductions in census in each of the hospitals, because of increased community capacity, improved discharge planning and diverted admissions, allowed for unit consolidations and staffing efficiencies.
- One key informant indicated that in states that shifted state hospital allocations to counties to purchase beds, judges have continued to overly rely on state hospitals for civil and forensic evaluations and placements, often taking up psychiatric hospital beds for days when it is not necessary to conduct competency assessments on an inpatient basis. As such, financial transition

plans that escalate funding to counties should carefully consider how to also allocate/hold-back funds to cover basic psychiatric hospital costs (i.e. personnel, administrative, infrastructure), and assist counties with strategies to educate and collaborate with judges to divert individuals into less-costly and more clinically-appropriate community-based care. Attempts to encourage diversion among judges have had mixed results in both **Ohio** and **Maryland**.

- As a strategy toward hospital downsizing, a national expert indicated that several states (including **Missouri** and **North Carolina**) utilize general hospitals for individuals who can benefit from shorter hospital stays, allowing systems to close acute care units in state psychiatric hospitals, bill Medicaid for these services, serve individuals closer to their homes, provide better linkage to community-based care, and reserve state beds for higher-need individuals who require longer-term care, including those who may need to transition from the community hospital to the state psychiatric hospital for extended care.
- **Minnesota** closed several of its state psychiatric hospitals and instead opened local, under 16-bed facilities, in part to avoid the IMD designation and enable Medicaid billing. However, CMS, displeased with this approach, delayed certification for many of these new facilities and several have since closed.

Theme 3: *Application of managed care principles is critical to divert both insured and uninsured populations from unnecessary hospitalization.*

Most key informants indicated that managed care principles both support the gate-keeping of psychiatric hospital beds, as well as diversion into more appropriate community-based services. In a few states, managed care entities are tasked with managing both Medicaid and grant dollars (federal, state, and local) that are utilized to purchase psychiatric hospital beds. Examples of the application of managed care principles include:

- In **North Carolina**, a Local Management Entity that operates at-risk for hospitalization admissions prefers to place individuals needing psychiatric care in community hospitals over state psychiatric hospitals, citing that community hospitals are more likely to provide same-day admissions, utilize evidence-based clinical models, provide better transitions to community-based care, and provide better customer service for clients and payers.
- In **Pennsylvania**, Behavioral Health Managed Care Organization (BHMCO) capitation rates are adjusted to include the management of clients leaving psychiatric hospitalization, and a direct allocation is granted to counties to build infrastructure and provide community-based care to meet county targets for community transitions from hospitals.
- In **Washington**, the Public Consulting Group recommended that the state develop a state psychiatric hospital managed care risk model, which will include MCO contract and provider participation requirements, performance metrics, shared risk arrangements, and capacity building for MCOs to contract with hospitals.
- In **Ohio**, Medicaid MCOs currently have responsibility for all inpatient hospitalizations, including psychiatric admissions in private hospitals, and in July 2017, the MCOs will also be expected to manage inpatient psychiatric hospitalizations for their Medicaid enrollees when they are admitted to an IMD, including the state hospitals.
- In **Maryland**, hospital admissions - general and private psychiatric - are handled through the ASO, authorizing services and paying claims. Both the ASO and many of the Emergency Departments have close relationships with the CSAs (which have crisis beds) and if people are appropriate for crisis rather than acute care, or need step-down services, they are frequently diverted. There is an expectation that the ASO will control hospital admissions and there are penalties written into its contract, but no real consequences.

Theme 4: *Some states have allocated funds directly to counties/localities to purchase psychiatric hospital beds, driven by a state-developed, per-bed formula.*

In at least three states included in our research, states allocate funds directly to counties or regions for the purchase of state psychiatric hospital beds. These counties have the option of using the funds for state psychiatric hospital beds or alternatives to hospitalizations. Some key informants noted the importance for states to have a plan if counties/regions exceed their allocation, with special attention to not incentivizing poorly-performing counties who request more monies and dis-incentivizing counties who effectively managing funds.

- In **Ohio**, funds are allocated to local/regional Boards to purchase state psychiatric hospital beds. States set a per-diem price for a state psychiatric hospital bed, informed by a formula based on that region's historical hospital data, population, and poverty rates.
- In **Michigan**, the state provides funding to Community Mental Health Service Providers (CMHSPs) to either purchase state psychiatric hospital services or alternatives within their catchment areas.
- In **California**, the state terminated direct funds to state psychiatric hospitals in the 1990's, providing a formula-based allocation to counties. Some counties engaged in risk-based contracts with providers to put them at financial risk for psychiatric hospitalizations for those they serve, but this practice has ended.

Areas for Further Inquiry

In conversations with Virginia DBHDS leadership about the structure of the Commonwealth's behavioral health system and the potential interest in engaging counties in the purchase of psychiatric hospital beds, BHPC's research indicates that the approaches and experiences with behavioral health system rebalancing and financing in Pennsylvania, Ohio, and California each offer elements that appear to align closest to Virginia's current thinking given that these states provide direct allocations to counties/localities to purchase psychiatric hospital beds.

While this report provides a summary of high-level themes we concluded as a result of our review of selected states' approaches to system rebalancing, our work also identified several areas/topics that merit further inquiry and consideration to be helpful to DBHDS as it develops and refines its approach. These topics include, for example:

- Processes used by states to ensure psychiatric hospital diversions are clinically-appropriate.
- Design, methodology, and specifics of formulas that determine allocations counties for purchase of hospital beds.
- Timeframes for rebalancing efforts, including financial transition plans.
- Specific funding amounts for investments in community-based services (i.e. bridge/transition funding, other funding that buttresses rebalancing efforts).
- The application and interplay of state and federal parity laws, and their impact on managed care and administrative processes.
- Specific quality and performance metrics used to measure system performance amid rebalancing efforts.
- Data-informed assessments of successful (vs. unsuccessful) rebalancing efforts among states.
- Successful stakeholder engagement and communications strategies.

Summary of Other States' Efforts

Across a diverse set of states, efforts to rebalance behavioral health systems away from inappropriate reliance on psychiatric hospital-based care are marked with investments in community-based services and a financial transition strategy that protects and retains at least some state psychiatric hospital allocations while gradually increasing community-based service capacity to meet increased demands and increased consumer clinical complexities. Some states utilize BHMCOs or other MCOs to manage inpatient psychiatric hospitalizations, while others provide allocations directly to counties/localities to purchase

psychiatric beds based on a pre-determined formula with varying applications of financial risk-bearing.

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Key Informant Interviews

Interview questions were administered through telephone conversations, apart from Washington where information was mined from a report, and New Jersey where limited information was collected from email exchanges with informants. Representatives from Arizona were contacted but did not respond within the short timeframe provided for the research. The following questions were asked of the state-level key informants with these questions adapted for the interviews of national-level experts:

- Can you provide an overview of the general structure of your state's behavioral health system (ASOs, MCOs/BHMCOs, all-payer systems, Medicaid expansion, etc.)?
- Can you share your state's approach to system rebalancing, with special attention to financial incentives and risk-sharing approaches that divert uninsured populations in your state away from unnecessary psychiatric hospitalization?
- For insured populations – Medicaid or otherwise – is your state's approach different? Why or why not?
- Was this approach authorized through legislation, litigation/settlement, agency/executive action, or other means?
- Is your state's approach successful at achieving its aims? Any flaws?
- Where can I go to find additional resources/detail about your state's approach?
- Do you have any other comments or best practices to share?

Following is a list of the key informants, along with the organizations and states they represent, ending with the national-level experts' names and organizations.

BHPC Key Informant Interviews by State, Informant Name, and Job Title/Agency		
State	**Key Informant**	**Job Title/Agency**
California	Rusty Selix Paul Curtis	Public Policy and Advocacy Director, California Council of Community Behavioral Health Agencies Executive Director, California Council of Community Behavioral Health Agencies
Pennsylvania	Joan Erney	Chief Operating Officer, Community Behavioral Health; Former Deputy Secretary, Pennsylvania Office of Mental Health and Substance Abuse Services
Maryland	Timothy Santoni	Vice President, Health Management Consultants; Former Deputy Director, Maryland Mental Health Administration
Michigan	Robert Sheehan	Chief Executive Officer, Michigan Association of Community Health Boards
New Jersey	Kevin Martone	Executive Director, Technical Assistance Collaborative; Former Deputy Commissioner, New Jersey Department of Human Services
North Carolina	David Swann	Consultant, MTM Services; Former Chief Executive Officer, Crossroads Behavioral Health Local Management Entity
Ohio	Teresa Lampl	Associate Director, Ohio Council of Behavioral Health and Family Services

		Providers
Washington	Public Consulting Group Report, titled, "Final Alternative Options and Recommendations Report: Washington Mental Health System Assessment"	Not applicable
National-level Interviews	**Key Informant**	**Job Title/Agency**
National	Brian Hepburn, MD	Executive Director, National Association of State Mental Health Program Directors
National	Ted Lutterman	Senior Director of Government & Commercial Research, NASMHPD Research Institute, Inc.

Sources

In addition, the following sources were used in BHPC's research and analysis in its review of selected states' efforts to structure and finance mental health systems rebalancing:

Human Services Research Institute, Technical Assistance Collaborative; Public Policy Forum (2014). Analysis of Adult Bed Capacity: For Milwaukee County Behavioral Health System.

Lutterman, T. Virginia's State Mental Health System - How it Compares Nationally and Trends in State Mental Health Systems. Presentation to Virginia General Assembly: September 9, 2014. NASMHPD Research Institute, Inc.

NASMHPD Research Institute, Inc. (2017). State Profiles: 2015 Information on Controlling Admissions to State Psychiatric Hospitals.

New Jersey Department of Human Services Division of Mental Health and Addiction Services (2010). Plan for Closure of Senator Garrett W. Hagedorn Psychiatric Hospital.

Ohio Department of Mental Health (2010). A Report of Ohio's Acute Mental Health Care.

Pennsylvania Office of Mental Health and Substance Abuse Services (2017). Adult/Older Adult Community Integration.

Public Consulting Group (2016). Final Alternative Options and Recommendations Report: Washington Mental Health System Assessment.

Public Sector Consultants Inc (2015). Community Mental Health in Michigan: Evidence and Innovation.

Appendix B: Community Services Board (CSB) Complexities and Challenges

CSB Complexities – Community services boards, including the one behavioral health authority (BHA), herein referred to as CSBs, are a network of 40 separate complex organizations with significant variations in the following characteristics:

- local government relationships
- mix of funding sources
- total budget size
- array of services provided
- geographical size
- population size
- administrative capabilities
- unique accountability requirements

Variations in these complex characteristics and the challenges CSBs now face will affect the successful implementation of a realignment of public behavioral health services funding from state hospital budgets to CSBs. Many of these characteristics are inter-related for example, array of services and total budget size or geographical and population size and population density. Some of these complexities could affect the ability of particular CSBs to implement the changes associated with financial realignment. It is important to note that the enabling legislation (Chapters 5 and 6 of Title 37.2 of the Code of Virginia) created a structure that values and supports local linkages and autonomy so that each CSB responds to the needs and reflects the values and priorities of the local populations and governments it serves.

- *Local Governmental Relationships* – While 133 cities or counties in Virginia established the 40 CSBs, CSBs have a range of relationships with their local governments. There are three types of CSBs defined in § 37.2-100 of the Code of Virginia. Each type has a different kind of relationship with its local government(s); these relationships define the relative degrees of flexibility and autonomy each CSB may have in areas such as staffing patterns, salaries, facilities, and services. Even within a type, there are idiosyncratic variations in the nature of a particular CSB's relationship with its local government(s). In turn, this affects each CSB's ability to innovate and implement new organizational and operational models or approaches or even new services. While these relationships and variations do not affect the consistency of the CSB mission, they do affect the implementation of state mandates.
    - There are 27 operating CSBs. While cities and counties establish these CSBs, they are not agencies of those local governments. Operating CSBs function independently of local governments; generally there is little local government ownership of or investment in operating CSBs.
    - There are 10 administrative policy CSBs. Most of these CSBs function as actual departments of the local government or governments that established them; a few function as quasi-local government departments. Uniformly, there is a high degree of local government ownership of and investment in administrative policy CSBs.
    - There are two policy-advisory CSBs to local government departments (Portsmouth and Loudoun County). These CSBs have little authority and function only as advisory boards to their local government departments. There is great variability in local government ownership of these CSBs; one has a very high degree of local government investment, while the other has minimal local government investment.
    - There is one BHA; it most closely resembles an operating CSB, but it has several additional powers and duties. The BHA functions independently of the local government that established it, and there is relatively little local government

investment in the BHA.

In addition, the number of cities or counties that CSBs serve affects local government relationships.

Localities Served	Number of CSBs	Localities Served	Number of CSBs
One City or County	11	Six Cities or Counties	3
Two Cities or Counties	7	Seven Cities or Counties	1
Three Cities or Counties	5	Nine Cities or Counties	1
Four Cities or Counties	6	Ten Cities or Counties	1
Five Cities or Counties	5	Total for 40 CSBs	133

- *Mix of Funding Sources* – Of the $650 million of total FY 2016 funds supporting community mental health services, only 35.4 percent are state general funds ($230 million). Of the $145 million of total funds supporting community substance use disorder services, only 35.3 percent are state general funds ($51 million). Local government appropriations represent a significant portion of many CSBs' budgets, particularly for administrative policy CSBs. For example, 89 percent of all local matching funds ($116.5 million out of $131 million) for mental health services came from 11 CSBs in FY 2016. Statewide, local governments appropriate 20 percent of total funds supporting mental health services and 22 percent of total funds supporting substance use disorder services. Generally, DBHDS does not fund 100 percent of the cost of any service or population. Instead, DBHDS participates in the total cost of all CSB services to all populations. Each CSB braids a diverse mix and amounts of the following funds:
  - State general funds, some of which are unrestricted while others are restricted for specific initiatives or purposes;
  - Local matching funds that are almost all local government appropriations;
  - Federal grants, including the $40 million substance use disorder and $10 million Mental health federal block grant funds and other smaller targeted federal grants allocated by DBHDS;
  - Fees that are primarily but not exclusively from Medicaid; and
  - Other funds such as sheltered workshop fees.

  The original expansion of Medicaid coverage for mental health services and for substance use disorder services is described in Appendix C. The proportion of Medicaid payments for mental health and substance use disorder services provided by CSBs has increased from FY 2014 to FY 2016. CSBs also often rely on in-kind contributions from their localities of services or space that may not appear in their budgets.

- *Total Budget Size* – The total budget from all funds of each CSB reflects its size and organizational complexity. CSB total budgets ranged from $3.3 million to $157 million in FY 2016. CSB total budgets are categorized as small (up to $16 million at 12 CSBs), medium ($16 - $35 million at 18 CSBs), large ($36 - $100 million at nine CSBs), and very large (>$100 million at one CSB). Total budget size may reflect the managerial capacity of a CSB to implement and manage realigned funding streams.

- *Array of Services Provided* – Every CSB provides emergency services. Every CSB provides mental health outpatient, medication management, and case management

services and some but not all types of day support and residential services. Some CSBs provide some type of employment services. Every CSB provides substance use disorder outpatient services and prevention and wellness services and some but not all types of residential services. Some CSBs provide substance use disorder case management services. Some CSBs also provide specialized initiatives such as Programs of Assertive Community Treatment (PACT), crisis receiving centers, and residential or ambulatory crisis stabilization units. Even for the services all CSBs provide, marked variations exist in the amounts provided. Variations in types and volumes of services CSBs provide will affect the ability of particular CSBs to implement the changes associated with financial realignment. More information on the types of services provided by CSBs can be found on the DBHDS website at www.dbhds.virginia.gov in the performance contract resources section under the Office of Support Services.

- *Geographical Size* – The geographical areas that CSBs serve range from 15.3 square miles (Alexandria CSB) to 2,761.4 (Crossroads CSB) square miles.

Area (Sq. Mi.)	No. of CSBs	Area (Sq. Mi.)	No. of CSBs
< 200	6	1,000-1,499	9
200 – 500	9	1,500-1,999	4
501-999	6	2,000+	6

- *Population Size* – The size of the total population in a CSB service area ranges from 14,996 (Dickenson County Behavioral Health Services) to 1,174,670 (Fairfax-Falls Church CSB) people. CSBs with large populations tend to have a greater variety and volume of services.

Population	No. of CSBs	Population	No. of CSBs
<100,000	10	300,000-<400,000	5
100,000-<200,000	14	400,000-<1,000,000	2
200,000-<300,000	8	1,000,000+	1

- *Administrative Capabilities* – Administrative capabilities vary tremendously by CSB. Many small budget and some medium budget CSBs may not possess strong administrative capabilities, including sophisticated data analytical expertise, detailed cost accounting and accounts receivable management, and clinical and business process analysis and management.

- *Unique Accountability Requirements* – Unlike other providers of behavioral health services, CSBs have numerous unique accountability requirements imposed by the Code of Virginia and DBHDS and sometimes by local governments. CSBs are required to provide emergency and case management services and will be required to provide same day access and primary care screening beginning in FY 2020. CSBs also have to provide extensive individual demographic and clinical data about people they serve to the DBHDS monthly and detailed funding and expenditure reports semi-annually. CSBs also are subject to numerous statutory mandates included in Appendix D.

CSB Challenges – CSBs are dealing with or will confront several significant challenges in the next two to four years that may affect their ability to implement financial realignment strategies successfully.

- *Health Policy Changes* – Medicaid CCC Plus Implementation, Medicaid reimbursement and shifts in payor mixes make other structural adjustment more difficult and complicated. As DMAS implements CCC Plus during FY 2018 and FY 2019, the shift of Medicaid mental health rehabilitation services from fee-for-service reimbursement, inadequate as that is, to a managed care payment mechanism will pose extraordinary challenges to the continued availability of those services. As MCOs carve their profits out of already inadequate Medicaid funding levels, CSBs may struggle to remain economically viable. Since Medicaid is the single largest source of funds for community behavioral health services (over 40 percent in FY 2016), this will limit the attention and commitment of CSBs to implementing financial restructuring because CSBs may view the MCO conversion as a threat to their continued existence. Also, any Medicaid requirements established by DMAS create de-facto standards and expectations for services provided to individuals without Medicaid coverage. Importantly, federal changes to Medicaid and possible reductions would cause enormous risk to CSBs.
- *Profile of Individuals Receiving Services from CSBs* – In FY 2016, over 67 percent of the adults CSBs served in mental health services had a serious mental illness and almost 80 percent of the children had or were at risk of serious emotional disturbances. Also, CSBs serve many individuals with no insurance coverage. In FY 2016, approximately 45 percent of the individuals receiving mental health or substance use disorder services had no Medicaid or other insurance coverage.
- *Inability to Recruit and Retain Staff* – Most CSBs, particularly operating CSBs or CSBs without significant local government support, experience considerable difficulties in recruiting and retaining all types of staff due to inadequate compensation or benefit packages and competition from other providers.
- *Increasing Personnel and Operating Costs Without Adequate State Government Financial Support* – Like the private sector and state government, CSBs experience increased personnel and operating costs every year. State funds support only a statewide average of 35 percent of CSB behavioral health budgets statewide. In some CSBs, the percentage is much less; for example, at the Fairfax-Falls Church CSB, it is 19.2 percent. Yet, state government has not provided even the state share of any increased operating costs in decades. When the state does provide any infrequent and inadequate salary increases, it appropriates only the state share of the increase. Thus, a three percent salary increase becomes at best on average a one percent increase and frequently even less, depending on the exact percentage of state funds allocated to a particular CSB. Thus, at the Fairfax-Falls Church CSB, it is 6/10 of one percent. This also ignores the fact that the largest state program funding behavioral health services is Medicaid, and it does not participate in the cost of the salary increase. Medicaid is the single largest source of funds for CSBs, yet historically, its payments do not cover the cost of the services it reimburses. There have been very few Medicaid rate increases, and they have never funded the real increases in personnel or operating costs. The shift to MCO payments will only exacerbate this situation. Except for most administrative policy CSBs, the amount of local government funding support is minimal and almost never accounts for personnel or operating cost increases.
- *Continued Workforce Shortages in Critical Positions* – Like DBHDS, CSBs continue to experience significant difficulties in recruiting and retaining critical staff positions, such as psychiatrists, medical doctors, psychologists, nurses, social workers, and other

professionals. Competition from private sector providers that frequently offer better compensation and working conditions exacerbates this situation. This situation even affects unlicensed positions such as group home staff who frequently can receive better pay with less stress in the retail and food service industries. Finally, the ongoing trend to require licensing or certification for more types of community services positions contributes to this situation.

- *Local Government Financial Frustrations with State Government* – Historically, local governments have been frustrated with the state government's unwillingness to provide more flexibility and authority for local governments to raise revenues while continuing to transfer financial responsibilities to local governments. Unfunded state mandates and state constraints on local government revenue generation are persistent themes complicating state and local government relationships. It is possible that local governments may view DBHDS' proposed behavioral health financial realignment as an effort by state government to transfer an historic state responsibility, the provision of state mental health inpatient services, to local governments without adequate financial resources.
- *Implementation of Same Day Access and Primary Care Screening* – The General Assembly enacted legislation in its 2017 session to mandate CSB provision of same day access (SDA) and primary care screening by 2019. This is an initiative all CSBs support, but it will be a significant challenge for CSBs, and will require the appropriation of significant additional state funds.
- *Implementation of the Department of Justice Settlement Agreement* – CSB requirements for building community capacity, case management, monitoring, and other components of the settlement agreement are quite onerous. Although the settlement agreement is focused on the developmental disability population, carrying out the agreement requirements takes a great deal of staffing, planning and funds for any one CSB.
- *Increasing Population and Demands* – Virginia's population is rising and the numbers of individuals requiring services is increasing accordingly. In addition, fighting Virginia's opioid epidemic has required expanded services, especially in expanded access to services through DMAS' Addiction and Recovery Treatment Services (ARTS) programs. Also, there is the possibility of new demands such as traumatic brain injury services.

Appendix C: Original Expansion of Medicaid Coverage for Behavioral Health Services

- In 1990, a billion dollar deficit resulted in state facility downsizing and reduced budgets in the community by $30 million. Fifteen million dollars of CSB state funds became Medicaid match dollars for a new set of services: MR Waiver services; Community Mental Health Rehabilitation Services; MH and MR Targeted Case Management Services, which were restricted to provision by CSBs. Individuals could receive these services only if CSBs gave their state fund dollars as match for Medicaid. During this time, CSBs converted CSB-allocated state fund dollars to Medicaid match for reimbursement so that Virginians could continue to receive services and, in many cases, so that CSBs could expand services.
- Through the 1990s, the General Assembly directed CSBs to maximize Medicaid and serve as many individuals as possible with all funding streams.
- During the 1990s, Virginia's policy for services and populations shifted from more generalized behavioral health disorders and developmental needs to a sharp focus on individuals with serious mental illness, especially those at risk of state hospitalization and severe intellectual disability. This led to a focus on priority populations**:** those individuals who would receive the most emphasis within CSBs, regardless of any reimbursement streams for them.
- Nine million dollars of state funds were removed from the appropriation for community substance use disorder services, and CSBs were directed to maximize additional Medicaid dollars. DBHDS set Medicaid targets for CSBs to meet with the targets increasing each year. In essence, the largest portion of the CSB system was forced to rely upon Medicaid reimbursement, despite Virginia's stringent Medicaid eligibility standards. In FY 2002, 2003 and 2005, large amounts of state funds were reduced from CSB appropriations and diverted to address DMAS deficits, and the mental health and developmental targeted case management rates were increased to allow CSBs to funnel funds into those programs previously supported with state general funds. Since CSBs are solely responsible for targeted case management, this preserved services for non-Medicaid eligible individuals and for services that are non-Medicaid reimbursable.
- Mid-1990s saw Medallion II implemented in many parts of Virginia through managed care organizations (MCOs). MCOs managed medical care and certain behavioral health services: psychiatry and medication management; outpatient therapy; inpatient services.

Source: VACSB (edited)

Appendix D: Statutory Mandates Applicable to CSBs but not to Other Providers

Core Mandates for CSBs in the Code of Virginia §37.2-500

The core of services shall include:

- Emergency services, and
- Case management services subject to the availability of funds appropriated for them

In order to ensure a comprehensive community system, the CSB shall function as the single point of entry into publicly funded mental health, developmental, and substance abuse services.

Additional Mandates for CSBs (Code of Virginia Titles 37.2 and 16.1)

Emergency Services for psychiatric crises (24/7 via phone or in-person) and pre-admission screening (24/7 in person)

- The pre-admission screening process for involuntary detention requires that:
    - The preadmission screening report be available for the special justice at the commitment hearing,
    - A recommendation to the magistrate regarding the need for a temporary detention order (TDO), and
    - A psychiatric bed be located if the magistrate issues a TDO

2014 Code changes add CSB responsibilities to this section including:

- Some level of responsibility for ensuring that everyone who is screened has been provided with a copy of their rights and description of the process,
- Notification of the state hospital when a preadmission screening evaluation has been conducted as a result of an emergency custody order (ECO),
- Identification of a state hospital to receive a TDO while continuing to work on locating a more appropriate bed and assuring paperwork changes are accurate if there is a change in TDO location, and
- Utilization of the psychiatric bed registry.

Further mandates in these Code titles include:

- Attendance at every commitment hearing, which follows every TDO that is executed;
- Preadmission screening for all state facility admissions;
- Discharge planning for individuals being discharged from state hospitals;
- Oversight of mandatory outpatient treatment (MOT) and concomitant reporting;
- Provision of MOT services if no other provider is available or willing to do so;
- Engagement with the Department regarding the annual Performance Contract, which stipulates requirements for receipt of state and federal block grant funds, populations to be served, data reporting, and other accountability and assurances; and
- Mental health screenings for juveniles placed in secure facilities.

Mandates Not Contained in Titles 37.2 and 16.1

- As designated by the Department's commissioner, CSBs shall implement conditional release plans for individuals adjudicated not guilty by reason of insanity (NGRI) and report to the court on adherence (§ 19.2-182.7).
- CSB staff shall participate on every Family Assessment and Planning Team (§ 2.2-5207).
- CSB staff shall participate on every Community Policy and Management Team (§ 2.2-5205).
- CSB executive directors shall sit on every Community Criminal Justice Board (§ 9.1-178).
- CSBs shall receive referrals from local threat assessment teams (§22.1-79.4).
- CSBs shall participate on local Part C interagency coordinating councils (§2.2-5305).
- CSBs shall develop MOUs for emergency services and referrals with community colleges (§ 23-219.1).
- CSBs shall conduct VICAP assessments (Appropriations Act).
- CSBs shall participate on CIT partnerships (Appropriations Act).
- CSBs shall comply with other requirements in the current Appropriations Act.

Source: VACSB (edited)

Appendix E: February 2017 Point in Time Survey of EBL Needs

In February 2017, a point in time survey was conducted on the community housing, services and supports needed by 228 individuals in state hospitals who were clinically ready for discharge. Of these individuals, 89 percent (202) had housing needs as shown below:

Estimated Type of Housing Need for Individuals on the EBL

Permanent Supportive Housing	14	7%
Assisted Living Facility	66	33%
Nursing Home	52	26%
Independent Living	31	15%
Supervised Living Homes	36	18%
Sponsor home	3	1%
Total Individuals With Housing Needs	**202**	**100%**

Of those 202 individuals with housing needs, 46 percent (93) were complicated by the lack of willing providers due to the individuals' history of behaviors, complex service needs, criminal justice involvement, or lengthy waiting list for those specialized service and support needs. Such barriers to accessing housing are shown below:

Barriers to Accessing Housing – February 2017 Point In Time Survey

No willing provider due to current or past behaviors	39
No willing provider due to legal charges	5
No willing provider due to medical needs	11
No willing provider due to sex offender status	2
Willing provider but no bed available (on waiting list)	21
Locating provider for IDD individual	15
Total Individuals With Barriers To Housing	**93**

Of the 228 individuals surveyed in state hospitals, 40 percent (91) had unfunded service and support needs, as shown below:

Unfunded Service and Support Needs February 2017 Point In Time Survey

Case management	22
Psychosocial rehab/day program	21
Psychiatry	4
Counseling	1
Medications	16
Extra supervision (1:1, daytime, ADL)	16
Mental health skill building	5
Program of Assertive Community Treatment (PACT)	6
Total Individuals With Unfunded Service And Support Needs	**91**

In addition, DBHDS examined the experiences of individuals using permanent supportive housing programs for adults with serious mental illness and found that the programs are clearly targeting individuals experiencing homelessness, incarceration, and frequent hospital utilization. Permanent supportive housing (PSH) has shows significant impacts for adults with serious mental illness. Multiple research studies have found that PSH is particularly effective in

improving participants' housing stability and reducing their emergency department and inpatient hospital utilization. In the six months prior to being housed (n=211) they were largely either homeless or institutionalized. In addition, of the individuals in the program, 15 percent were patients in one of Virginia's state hospitals in the year before they entered the PSH program. Early outcomes show promising impacts on housing stability and hospital utilization. At six months after moving into a PSH unit, 94 percent of the residents remain stably housed. In addition, those with a hospital stay six months before or after moving into a PSH unit, state hospital bed days were reduced by an average of 63 days and local hospital bed days were reduced an average of 6.9 days.

Appendix F: *EXAMPLE* CSB Hospital Targets for Financial Realignment

CSB	Bed Days Excluding all NGRI	ADC exclude NGRI	Total $ Exclude NGRI	ADC/100K exclude NGRI	Census target
Alleghany Highlands CSB	1903	5.2	$626,087	30.12	-1
Harrisonburg-Rockingham CSB	2092	5.7	$688,268	5.33	-1
Horizon Behavioral Health	9316	25.5	$3,064,964	12.27	-5
Northwestern Community Services	5263	14.4	$1,731,527	8.05	-2
Rappahannock Area CSB	6157	16.9	$2,025,653	6.40	-2
Rappahannock-Rapidan CSB	5313	14.6	$1,747,977	11.04	-2
Region Ten CSB	10060	27.6	$3,309,740	13.78	-5
Rockbridge Area	1675	4.6	$551,075	13.55	-1
Valley CSB	7531	20.6	$2,477,699	20.89	-5
Alexandria CSB	2815	7.7	$926,135	5.89	-1
Arlington County CSB	3448	9.4	$1,134,392	4.84	-1
Fairfax- Falls Church CSB	10699	29.3	$3,519,971	3.27	
Loudoun County	1211	3.3	$398,419	1.21	
Prince William County CSB	7111	19.5	$2,339,519	5.33	-2
Cumberland Mountain	5428	14.9	$1,785,812	19.67	-3
Dickenson County	806	2.2	$265,174	18.53	
Highlands Community Services	7521	20.6	$2,474,409	35.88	-6
Mount Rogers CSB	8200	22.5	$2,697,800	23.64	-6
New River Valley	6774	18.6	$2,228,646	12.24	-3
Planning District One	7502	20.6	$2,468,158	28.14	-6
Blue Ridge Behavioral Healthcare	14546	39.9	$4,785,634	19.60	-8
Danville-Pittsylvania	8262	22.6	$2,718,198	27.30	-6
Piedmont Community Services	5058	13.9	$1,664,082	12.32	-3
Southside CSB	1533	4.2	$504,357	6.22	
Chesterfield CSB	2798	7.7	$920,542	3.03	
Crossroads CSB	53	0.1	$17,437	0.17	
District 19 CSB	1439	3.9	$473,431	2.89	
Goochland-Powhatan	295	0.8	$97,055	1.96	
Hanover County CSB	669	1.8	$220,101	2.25	
Henrico Area	3257	8.9	$1,071,553	3.31	
Richmond	4797	13.1	$1,578,213	7.24	-2
Chesapeake	1693	4.6	$556,997	2.54	
Colonial Behavioral Health	1628	4.5	$535,612	3.33	
Eastern Shore CSB	648	1.8	$213,192	4.92	
Hampton-Newport News CSB	6985	19.1	$2,298,065	7.71	-3
Middle Peninsula-Northern Neck	250	0.7	$82,250	0.60	
Norfolk CSB	4536	12.4	$1,492,344	6.29	-2
Portsmouth	345	0.9	$113,505	1.29	
Virginia Beach CSB	6622	18.1	$2,178,638	5.16	-2
Western Tidewater CSB	4384	12.0	$1,442,336	10.06	-2
Total	**180623**				**80**

Appendix G: Stakeholder Group Membership

Financial Transformation Stakeholder Group

Requirements:

1. Community services boards

2. Individuals receiving services and their families

3. Local governments

4. Private providers

5. Other stakeholders

Name	GROUP
Janet Areson	Virginia Municipal League
Katie Boyle	Virginia Association of Counties
Michael Carlin	Virginia Association for Community-Based Providers
Molly Cheek	Virginia Network of Private Providers
Bruce Cruser	Mental Health America - Virginia
Bill Elwood	Virginia Coalition of Private Provider Associations
Jennifer Faison	Virginia Association of Community Services Boards
Jennifer Fidura	Virginia Network of Private Providers
Lee Higginbotham	Hospital Corporation of America
Scott Johnson	Association of Community Based Service Providers
Deirdre Johnson	Virginia Organization of Consumers Asserting Leadership
Alison Land	Virginia Hospital & Healthcare Association
Margaret Nimmo Holland	Voices for Virginia's Children
Tim Palus	Hospital Corporation of America
Rhonda Thissen	National Alliance of Mental Illness - Virginia
Michael Triggs	Virginia Coalition of Private Provider Associations
Jennifer Wicker	Virginia Hospital & Healthcare Association
Marjorie Yates	Substance Abuse and Addiction Recovery Alliance