

HJR 16: State-Operated Institutions

The Use of Small Mental Health Treatment Facilities

Prepared by Sue O'Connell, Research Analyst
for the Children, Families, Health, and Human Services Interim Committee
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Background

During the House Joint Resolution 16 study of state-operated institutions, several stakeholders have suggested the use of 16-bed mental health facilities as a way to better meet the treatment needs of mentally ill individuals and to draw in federal Medicaid funds to pay a portion of the treatment costs.

State law currently allows for involuntary commitment to 16-bed facilities. However, the facilities have never been created in Montana despite attempts to fund services in those settings.

This paper summarizes past efforts to allow for and fund treatment at 16-bed facilities in Montana and also summarizes approaches taken in other states that operate or fund small facilities.

2003: Authorization for Small Facilities

The 2003 Legislature approved Senate Bill 348, which was introduced by Sen. Bob Keenan at the request of the Department of Public Health and Human Services (DPHHS). SB 348 established a framework for the use of "behavioral health inpatient facilities," or BHIFs.

Among other things, the bill:

- defined a BHIF as a licensed facility of 16 or fewer beds that could be either a freestanding licensed hospital or a distinct part of another licensed hospital;
- allowed DPHHS to contract with BHIFs to provide services to individuals who were involuntarily committed for mental health treatment or held for an evaluation in advance of a commitment proceeding;
- allowed a judge to commit a person to a BHIF, rather than the Montana State Hospital, for up to 90 days; and
- allowed a county to transfer an inmate suffering from a mental disorder to a BHIF.

At the same time, the Legislature appropriated about \$1.8 million for contracting with one BHIF to provide services during the 2005 biennium. About \$1.33 million of that amount came from the general fund, while \$467,000 was appropriated from state alcohol tax revenues.

The budget proposed by then-Gov. Judy Martz had sought additional funds to contract for up to three BHIFs and to reduce the overall population of the State Hospital.

A Legislative Fiscal Division analysis of that budget request raised several items for legislative consideration. The analysis noted that the proposal did not include start-up or construction costs, did not address whether the facilities could recruit or retain adequate staff, may have underestimated the average daily costs, and may have overestimated the percentage of

Medicaid-eligible individuals likely to be served in the BHIFs. In addition, the proposal did not address who would be responsible for the costs of indigent individuals who were committed to a BHIF but who were not covered by Medicaid, Medicare or private insurance.¹

"The assumption that a private entity would construct a new facility in the current unstable funding environment for mental health services might be questionable," the analysis noted.

2003: RFP Fails to Produce Proposals

The concerns raised in the budget analysis proved prophetic. In July 2003, the state issued a Request for Proposal for contracted BHIF services. It received no proposals from providers.

The RFP spelled out the criteria a successful bidder would need to meet in order to be awarded a contract. The criteria included:

- designing and operating a licensed hospital facility and program that accepted the same level of patient as served at Montana State Hospital;
- maintaining a full-time staffing pattern 24 hours a day;
- complying with all standards for psychiatric hospitals; and
- developing a system of care that also provided for treatment of the patients' physical health problems.

The state would not have paid for the costs of treating any patients who were admitted on a voluntary basis and would not have paid for any mental or physical health services provided to Medicare-eligible patients. The maximum daily reimbursement rate ranged from \$410 to \$530, depending on the insurance status of the patient and whether the patient was discharged to community services or to the State Hospital.

Although no providers submitted a formal proposal to provide BHIF services, Deaconess Billings Clinic did send a letter explaining why it decided against bidding on the project. The hospital said the RFP would expose any entity to "potentially huge losses." The hospital listed several concerns, primarily centering on the need to cover all medical costs for patients when payment sources for those costs would be nonexistent or inadequate.

2007: Refining the Idea

The Legislature revisited the topic in 2007, making changes in the language related to facility licensing and allowing DPHHS to adopt rules setting standards for licensure. The Legislature also appropriated \$3 million in general fund and \$3.2 million in federal funds for BHIFs. The appropriation was limited to paying for services and could not be used to construct buildings.

DPHHS subsequently adopted rules governing the facilities. However, little progress was made beyond that after the state encountered difficulties in obtaining a commitment from the Centers for Medicare and Medicaid Services (CMS) that Medicaid funds could be used to pay for services offered at BHIFs.²

¹ "Legislative Budget Analysis: 2005 Biennium," *Legislative Fiscal Division*, January 2003, Pp. B-186-187.

² Memo from Joyce DeCunzo, administrator of the DPHHS Addictive and Mental Disorders Division, to the 2007-2008 Children, Families, Health, and Human Services Interim Committee, June 2008.

Similar Facilities in Other States

As DPHHS and others were working on developing rules for BHIFs, they reviewed similar facilities in Minnesota, Arizona and Washington. During the HJR 16 study, advocates for the use of 16-bed facilities have again pointed to Minnesota as an example to emulate and also noted that Vermont has moved to the use of smaller, regional facilities.

Following is a brief summary of how small facilities in those four states are funded, operated and used.

- **Minnesota:** Since 2003, Minnesota has closed five of its state-run hospitals and moved patients into 16-bed "community behavioral health hospitals." The state has kept one of its institutions open; the 100-bed facility serves aggressive and clinically complex individuals. The state opened 10 community behavioral health hospitals over a five-year period, but has since closed one of the hospitals because of difficulties in retaining and recruiting psychiatrists. The state leases the hospital buildings and operates the facilities, which are all licensed as hospitals and certified by CMS. The transition from institutional to community-based hospitals was the result of a three-year planning process.

The state pays about \$1.5 million per year to lease each hospital; operating costs total about \$4.4 million per hospital per year.

- **Arizona:** Arizona has one state-run hospital with 112 beds to serve mentally ill individuals who are civilly committed. Patients are admitted to the state hospital only if they have not responded to treatment at inpatient facilities operated by one of the several Regional Behavioral Health Authorities (RHBAs). These authorities receive Medicaid funds from the state to arrange and pay for community-based mental health services from a variety of providers. Most individuals served by Arizona's publicly funded mental health system qualify for Medicaid. The RHBAs have established an inpatient system of care that includes psychiatric hospitals, which have anywhere from 60 to 100 beds, and psychiatric health facilities, which have 12 to 16 beds.

The psychiatric health facilities serve the least acute and medically complex patients; many of the facilities will only accept patients who have no significant physical health problems. While no limit exists on the length of stay for individuals at a psychiatric health facility, most patients stay anywhere from a few days to a few weeks. In rural areas, the facilities primarily stabilize patients or perform court-ordered evaluations. Under rules adopted in October, the facilities will be licensed as hospitals in the future.

- **Washington:** The state of Washington operates two state hospitals for the mentally ill. The hospitals generally accept only those patients who are in need of continued treatment after first receiving care in a community-based facility or hospital. In Washington, individuals are first committed to either the psychiatric unit of a hospital or to one of several Evaluation and Treatment Centers, where they can be treated for up to 72 hours. The order for treatment may be extended for 14 days if necessary. A patient in need of further involuntary treatment is then usually committed to one of the state hospitals.

The Evaluation and Treatment Centers are free-standing, 16-bed facilities that generally do not offer a full range of medical care. Patients with complicated physical health needs are usually admitted to a hospital, rather than an Evaluation and Treatment Center. In 2009, Washington had nine Evaluation and Treatment Centers, and patients stayed an average of 11.2 days. Washington recently awarded \$4.8 million in grants to four entities to build or renovate small facilities to provide additional short-term inpatient treatment beds. Demand for the beds is expected to increase following recent changes to the state's involuntary treatment laws.

- **Vermont:** Damage from Tropical Storm Irene in August 2011 forced the closure of the 54-bed Vermont State Hospital, the only state-run facility for people with mental illness. The 2012 Legislature subsequently approved a plan for a "dispersed" system of mental health care that relies on the construction of a new 25-bed state hospital and creation of treatment beds elsewhere in the state, as well as development of new intensive residential services. Planning for the changes actually began several years earlier, but the Legislature was forced in 2012 to determine how to replace capacity that was lost when the state hospital closed. The new state-run hospital will be supplemented with a 14-bed psychiatric unit at a southern Vermont hospital, a six-bed unit at a central Vermont hospital, and a seven-bed, state-run secure facility near the state capital of Montpelier. The state paid for renovating the psychiatric unit at one of the hospitals and built a unit at the other hospital, but the hospitals will provide psychiatric and medical treatment.

The 2012 legislative reforms also:

- prohibit certain providers from refusing to accept patients who meet eligibility criteria;
- require that the new 25-bed state hospital be reduced to 16 beds if CMS refuses to provide federal Medicaid funds for a 25-bed facility; and
- provide retirement incentives for Vermont State Hospital employees, because of the need for fewer state employees at the new, smaller state hospital.

Sources:

- Interviews with:
 - Tom Ruter, Director of Operation Support, State Operated Services, Minnesota Department of Human Services, Dec. 11, 2013.
 - Dr. Stephen Dingle, Medical Director, Division of Behavioral Health Services, Arizona Department of Health Services, Dec. 31, 2013.
 - Judy Rostenstreich, Senior Policy Advisor, Vermont Department of Mental Health, Dec. 17, 2013.
- *Acute Adult Inpatient Psychiatric Services*, brochure published by Minnesota Department of Human Services, State Operated Services.
- *Act No. 79, An Act Relating to Reforming Vermont's Mental Health System*, April 4, 2012.
- *An Introduction to Arizona's Public Behavioral Health System*, Division of Behavioral Health Services, Arizona Department of Health Services, January 2013.
- *Inpatient Psychiatric Capacity in Washington State: Assessing Future Needs and Impacts (Part One)*, Washington State Institute for Public Policy, July 2011.
- Dan Thesman, "Wash. State Awards Nearly \$5M to Increase Number of Short-Term Psychiatric Care Beds," *kapptv.com*, Dec. 31, 2013.