Psychiatric Hospital Beds in California: Reduced Numbers Create System Slow-Down and Potential Crisis

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A Report from the *California Institute for Mental Health*

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Acute Psychiatric Services in California

A Preliminary Evaluation with Recommendations for Future Assessment and Immediate Action Prepared for the California Institute for Mental Health

Executive Summary

In 1995, California consolidated the administration of its two mental health Medi-Cal systems into one system to be administered by the local county. The Department of Mental Health (DMH) and other stakeholders, including the California Mental Health Directors Association (CMHDA) developed a Health Care Financing Administration (HCFA) waiver plan that, it was hoped, would lead to lower expenditures on inpatient care and, therefore, more money to provide needed community based care. It was believed that local administration, with flexibility and integration into local systems of care would provide greater efficiency and effectiveness.

Among the factors leading to this conclusion was the belief that "cost-based" reimbursement for psychiatric hospitalization was most likely higher than "market based" reimbursement. In the following years, counties were very effective at negotiating lower rates for inpatient hospital days.

Under financial pressure due to reduced reimbursements from all sources, a saturation of the market, and increased regulatory pressure, there was a major consolidation of hospitals. There was also movement by some hospitals from non-profit to for profit entities. Many of these for profit hospitals also became publicly traded.

The administrators of these larger organizations were increasingly focused on "the bottom line." From a strictly financial standpoint,

psychiatric inpatient beds looked less attractive. First, reimbursements from counties and managed behavioral healthcare organizations had been consistently declining. Some hospitals, classified as "IMDs" continued to be barred from federal financial participation.[1] Second, the potential liabilities of these units continued increasing (e.g., HCFA audits of billing for Medicare), as did regulatory requirements (HCFA requirements concerning seclusion and restraint and county utilization review systems).

In addition, national and regional economic forces led to a critical shortage of qualified mental health staff for inpatient psychiatric units.

With very little community discussion or planning, many hospital inpatient units, and, indeed, entire psychiatric hospitals, were closed.

Fortunately, counties did reinvest inpatient hospital savings into community-based care, and generally perceive that this reinvestment did result in reductions in inpatient care for traditional community mental health clients, such as those with schizophrenia, bipolar disorder and severe recurrent depression.

Unfortunately, both in California and nationally, there were significant increases in the number of dually diagnosed clients (those with substance abuse), and patients behaviorally disordered due to organic dysfunction who required inpatient hospitalization because alternative services were not available. This shift in the inpatient population may have contributed to an increase in administrative days that further reduced hospital reimbursement.

As a result of these trends, there is now a shortage of inpatient psychiatric beds in California as well as a lack of adequate capacity of the existing mental health system to provide alternative

[1] Under the federal Medicaid program, facilities that are considered "Institutions for Mental Disease" or "IMDs" are currently prohibited from being reimbursed by Medicaid for patients between the ages of 22 and 64. IMDs are defined as licensed acute care facilities, nursing facilities or residential treatment programs with more than 16 beds that have 50 percent or more of their licensed beds designated for the treatment of persons with mental illness or substance abuse disorders. (Refer to page 12 for more information.)

care for those clients with more severe and urgent need for care. Significant licensing and regulatory barriers also contribute to the lack of alternative care capacity. In addition, the overall crisis in lack of affordable housing exacerbates the pressure on placement alternatives.

This shortage appears to be most severe and pervasive for children (ages 1 through 12) and adolescents (ages 13 to 18). Adult shortages vary from region to region. Los Angeles is the exception, with shortages only for sub-specialty care.

There is a general belief among mental health professionals that there are significant opportunities to develop additional community based alternatives to hospitalization. This includes crisis services with a residential component that might prevent hospitalization; community based facilities that could manage some patients currently being treated in skilled nursing facilities; and specialized programs for persons with organic brain syndromes.

This report suggests both short-term and long-term strategies for addressing the situation, as well as areas for further study. Short-term strategies include the following:

1. Develop and strengthen partnerships and regional initiatives at multiple levels:

    (a) Set up discussions with California hospitals through the California Healthcare Association (CHA) in order to identify steps that could be taken immediately and in the long run in order to improve the availability of hospital beds

    (b) Set up workgroup(s) with providers of alternative services, such as crisis residential (California Association of Social Rehabilitation Agencies), crisis stabilization (CHA) and special residential treatment programs (children and adolescents, geriatric patients), to identify barriers to expansion of services and to create a statewide action plan to address those barriers

2. Conduct a real-time inventory of beds to assess and monitor acute bed numbers and demand.

3. Conduct an assessment of the use of administrative day beds to determine the types of alternatives needed to resolve placement needs. Identify populations of patients in need of hospital alternative programs that do not currently exist (e.g., sub-acute psychiatric rehabilitation beds for behaviorally disordered adults with brain injuries). Determine state, regional and local responsibilities/solutions.

In addition to sustaining many of these short-term solutions on a long-term basis, the following long-term strategies are proposed:

1. Collaborate with DMH to identify regulatory and legal barriers to developing and implementing alternative programs and create a legislative agenda for change.

2. Open alternative placement programs. Consideration should be given to contracting with providers of existing programs.

3. Form partnerships with national organizations such as the National Association of State Mental Health Program Directors, the National Association of County Behavioral Health Directors, and the National Association of Psychiatric Health Systems, to develop a national legislative strategy to eliminate the Institute for Mental Disease (IMD) federal exclusion.

4. Work with DMH to clarify an appropriate audit mechanism for administrative day determinations that is compatible with standards of practice in psychiatric hospitals and consistent with Health Care Financing Administration (HCFA) regulations.

5. Strengthen the role of regional organizations of mental health plans in meeting the needs of acute psychiatric patients by developing special programs for community-based care.

6. Utilize partnerships to negotiate longer and more uniform contracts with hospitals.

7. Identify ways to reduce the administrative costs of operating hospitals by developing more standard and streamlined ways of accomplishing the goals of utilization review and ensure that the least restrictive and most effective treatment is provided to patients.

One of the clearest findings from this very preliminary analysis is that there needs to be more sustained attention to the analysis of existing data and prediction from that data of future needs in the system.

Since the implementation of the Freedom of Choice waiver in California, the Department of Mental Health has acquired better and better data about service utilization. Unfortunately, as is often the case in public systems, the resources to analyze this data have not kept up with the need to do so.

The costs of not addressing this problem will be measured not just in wasted Medicaid dollars, as individual providers respond to shortages by raising their rates, but also in human suffering due to lack of appropriate care. Some recommendations for further data analysis are identified at the end of this report.