State Hospital Bed-Day Allocation Methodology and Utilization Review Protocol for Fiscal Year 2022

As Required by
Health and Safety Code Section
533.0515(e)

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Table of Contents

Executive Summary

Texas Health and Safety Code, Section 533.0515(e), directs the Health and Human Services Commission (HHSC), in conjunction with the Joint Committee on Access and Forensic Services (JCAFS) to submit a legislative report regarding a bed-day allocation methodology and utilization review (UR) protocol. This report provides information on:

1. Activities to update the bed-day allocation methodology and UR protocol;
2. The outcomes of the implementation of the bed-day allocation methodology by region;
3. The actual value of a bed day for the two years preceding the report and the projected value for the five years following the report;
4. An evaluation of factors that impact the use of state-funded hospital beds by region;
5. The outcomes of the implementation of the bed-day UR protocol and its impact on the use of state-funded hospital beds; and
6. Any recommendations of HHSC or the JCAFS to enhance the effective and efficient allocation of state-funded hospital beds.

The bed-day allocation methodology and UR protocol were adopted in 2016. In 2020, the JCAFS recommended no changes to the bed-day allocation methodology. The JCAFS recommends no changes to the bed-day allocation methodology in 2022. Implementation of the 2022 bed-day methodology shifts additional bed days to areas with higher rates of poverty but does not result in a dramatic redistribution of beds.

Utilization review activities were conducted in 2021 and 2022. In fiscal year 2021, the JCAFS revisited UR Protocol findings from 2017, 2018, and 2019 and gathered qualitative and quantitative information from local mental health and behavioral health authorities (LMHA/LBHA) and superintendents of state hospitals regarding over or under utilization of state hospital beds, readmissions, and length of stay.

In 2022, the JCAFS began UR Protocol activities to analyze growth trends of patients who have been in the state hospital for more than 365 days, identify factors driving the number of people found incompetent to stand trial who are in the hospital for more than 180 days and recommend options for alternative

placements that may help to reduce the number of long-term state hospital patients.

Based on the results of the utilization review and stakeholder input, the JCAFS's recommendations are as follows:

1. Increase access to treatment in the community;
2. Increase access to private psychiatric beds in the community;
3. Use best practices for jail diversion;
4. Increase access to long-term inpatient hospital beds in the community;
5. Increase access to step-down facilities and long-term supportive housing;
6. Develop proposals for long-term residential facilities;
7. Provide stakeholders with a cost-benefit analysis of creating long-term permanent supportive housing options; and
8. Provide transition planning for individuals who have had long-term hospital stays.

1. Introduction

Texas Health and Safety Code, Section 533.0515(e), directs HHSC to submit a legislative report regarding a bed-day allocation methodology and UR protocol. Per statute, the report is published and distributed to the Governor, Lieutenant Governor, Speaker of the House of Representatives, Senate Finance Committee, Senate Health and Human Services Committee, House Appropriations Committee, House Public Health Committee, and House Human Services Committee. The report is due December 1 of every even-numbered year.

Additionally, the statute charges the JCAFS with developing and making recommendations to the HHSC Executive Commissioner and monitoring the implementation of updates to a bed-day allocation methodology and making recommendations for the implementation of a bed-day UR protocol including a peer review process.

2. Background

The JCAFS formed in 2015 by combining two statutorily-required advisory bodies, the state bed-day allocation advisory panel established pursuant to H.B. 3793, 83rd Legislature, Regular Session, 2013, and the forensic workgroup authorized by S.B. 1507, 84th Legislature, Regular Session, 2015. Prior to HHS Transformation in 2016, the Department of State Health Services combined the advisory panel and workgroup to form the JCAFS because of shared membership and similar charges. The forensic workgroup's authority expired in November 2019; however, the JCAFS will not be abolished as long as its enabling statutes remain in effect.

The JCAFS is statutorily charged with developing and making recommendations to the HHSC Executive Commissioner and monitoring the implementation of updates to a bed-day allocation methodology. The methodology allocates, to each designated region, a certain number of state-funded beds in state hospitals and other inpatient mental health facilities for voluntary, civil, and forensic patients. The JCAFS is further charged with making recommendations for the implementation of a bed-day UR protocol including a peer review process. The initial recommendations for an updated bed-day allocation methodology and UR protocol were submitted in February 2016, adopted by the Executive Commissioner in May 2016, and implemented in fiscal year 2017.

The bed-day allocation methodology uses a poverty-weighted population to allocate state-funded beds to local authorities rather than a standard per capita formulation. The UR protocol includes a flexible framework that allows the process to be tailored to the specific focus of review. The protocol is designed to understand and address the factors driving patterns of utilization instead of focusing exclusively on the number of bed days used by a local authority.

3. Summary of Activities

The JCAFS Access Subcommittee completed one cycle of utilization review in 2021. The review revisited UR Protocol findings from 2017, 2018, and 2019 and gathered qualitative and quantitative information from LMHAs/LBHAs and superintendents of state hospitals regarding over or under utilization of state hospital beds, readmissions, and length of stay. The utilization review activities for 2022 consisted of planning and preparing for JCAFS Access Subcommittee members to implement activities to understand barriers to discharge for people in the state hospital system for over 365 days.

The outcomes of utilization review activities are described in the Outcomes of Implementation – Utilization Review section of this report. Health and Safety Code, Section 533.0515(e), requires an evaluation of factors that impact utilization, including clinical acuity, prevalence of serious mental illness, and the availability of resources in a given region. The *Factors that Impact the Use of State-Funded Beds* section of this report provides an evaluation of these factors. The JCAFS recommendations regarding the bed-day allocation methodology and UR protocol are found in Appendix A.

4. Outcomes of Bed-Day Allocation Methodology

Implementing the 2022 bed-day allocation methodology, which was originally approved in 2016, shifts additional beds to areas with higher rates of poverty but does not result in a dramatic redistribution of beds. The impact by region is detailed below in Table 1.

The change in beds allocated to each region aligns with the expected outcomes.

Table 1. Change in Allocated Bed Days by Region (Fiscal Year 2016 Allocation)

Local Authority	Allocation with Prior Methodology	Allocated with Updated Methodology	Change in Bed Days	Percent Change in Bed Days
Anderson Cherokee Community Enrichment Services	3,782	3,643	-139	-3.68%
Andrews Center	13,536	13,654	118	.87%
Austin Travis County Integral Care	36,699	39,146	2,447	6.67%
Behavioral Health Center of Nueces County	11,381	12,503	1,122	9.86%
Betty Hardwick Center	5,780	5,908	128	2.21%
Bluebonnet Trails Community Center	29,187	30,113	926	3.17%
Border Region Behavioral Health Center	14,065	13,020	-1,045	-7.43%
Burke Center	13,176	12,801	-375	-2.85%
Camino Real Community Centers	7,704	7,933	229	2.97%
Center for Healthcare Services	61,757	68,894	7,137	11.56%
Center for Life Resources	3,334	3,128	-206	-6.18%
Central Counties Services	15,840	15,631	-209	-1.32%
Central Plains Center	3,256	2,826	-430	-13.21%
Coastal Plains Community Center	7,524	8,059	535	7.11%

Local Authority	Allocation with Prior Methodology	Allocated with Updated Methodology	Change in Bed Days	Percent Change in Bed Days
Community Healthcore	15,025	14,806	-219	-1.46%
Denton County MHMR Center	24,349	26,334	1,985	8.15%
Emergence Health Network	30,960	30,214	-746	-2.41%
Gulf Bend MHMR Center	5,601	6,209	608	10.86%
Gulf Coast Center	20,385	21,967	1,582	7.76%
Heart of Texas Region MHMR Center	11,902	12,082	180	1.51%
Helen Farabee Centers	9,797	9,845	48	.49%
Hill Country Mental Health and Developmental Disabilities Center	21,549	22,393	844	3.92%
Lakes Regional Community Center	5,448	5,270	-178	-3.27%
MHMR Authority of Brazos Valley	11,896	11,979	83	.7%
MHMR Services for the Concho Valley	E	4,451	413	10.23%
My Health My Resources Tarrant County	61,392	66,547	5,155	8.40%
North Texas Behavioral Health Systems and Life Path Systems	127,983	135,895	7,912	6.18%
Pecan Valley Centers for Behavioral and Developmental Health	13,862	13,550	-312	-2.25%
Permian Basin Community MHMR	10,419	13,105	2,686	25.78%
Spindletop Center	13,939	13,952	13	.09%
Starcare Specialty Healthcare	10,880	11,888	1,008	9.26%
Texana Center	28,724	30,993	2,269	7.9%
Texas Panhandle Center	13,266	13,329	63	.47%
Texoma Community Center	6,308	6,346	38	.60%

Local Authority	Allocation with Prior Methodology	Allocated with Updated Methodology	Change in Bed Days	Percent Change in Bed Days
The Harris Center for Mental Health and Intellectual and Developmental Disabilities	146,438	163,282	16,844	11.50%
Tri-County Behavioral Healthcare	22,781	24,074	1,293	5.68%
Tropical Texas Behavioral Health	52,410	48,475	-3,935	-7.51%
West Texas Center for MHMR	7,038	8,071	1,033	14.68%

5. Value of a Bed Day

Information on the actual value of a bed day for the state hospital system for the two years prior to this report, as well as projected values for the five years following the date of this report are provided in Tables 2 and 3 below. The values were generated using actual expenditures and historical information.

The HHSC state hospital system bed-day costs reflect the average daily expenditures of the state hospital system and HHSC administrative functions that support state hospital system operations, divided by the state hospital system average daily census. The values were calculated to reflect the true total cost to the state of Texas when compared to private providers and might differ from previous reports.

Table 2. Historical State Bed Day[1] Costs (Fiscal Years 2020 through Q3 2022)

Inpatient Services	2020	2021	2022
State Hospital System	$608	$771	$808[2]

Table 3. Projected Bed Day[3] Costs (Fiscal Years 2023 through 2027)

Inpatient Services	2023	2024	2025	2026	2027
State Hospital System	$816	$824	$832	$840	$848

[1] This value includes the total cost to HHSC and other costs to the state (i.e., benefit pay).
[2] State hospital system bed-day costs for fiscal year 2022 were calculated as of the third quarter. This is an estimate and is subject to change after the close of the fiscal year.
[3] Projected state hospital system bed-day costs for fiscal years 2023 through 2027 are based on fiscal year 2022 assumptions, which assume cost increases related to inpatient hospitalization of 1.5 percent while maintaining the same average daily census.

6. Factors that Impact Use of State-Funded Beds

The JCAFS identified the following factors that impact the use of state-funded beds. These recommendations may not reflect the position of HHSC.

Health and Safety Code, Section 533.0515, requires an evaluation of factors that impact utilization, including clinical acuity, prevalence of serious mental illness, and the availability of resources in each region as a part of the bed-day allocation methodology. During previous biennia, the JCAFS considered each of these factors in determining its recommendations, with the goal of having an equitable methodology based on consistent, reliable data that can be readily updated to reflect change over time.

However, key barriers that preclude the incorporation of a measurement in the allocation of beds include:

- The dynamic nature of clinical acuity;
- Limited data to measure acuity for local service areas;
- Limited data on the prevalence of serious mental illness for local service areas; and
- Lack of consensus on the method to assess the availability of local resources.

Additionally, the increasing proportion of state hospital beds allocated to forensic commitments complicates the assessment of the bed-day allocation methodology and the identification of ways to improve access to state hospital beds for local communities.

In considering an allocation methodology, one issue not specified in the statute is relevant poverty. Most persons receiving HHSC-funded mental health services have incomes at or below 200 percent of the federal poverty level (FPL), and most state hospital patients also fall into this category. Areas with a higher proportion of persons living in poverty are likely to have a higher demand for state-funded inpatient beds. The 2016 bed-day allocation methodology considers relevant poverty and allocates hospital beds based on a poverty-weighted population (i.e., double weight is given to populations with incomes at or below 200 percent FPL).

As a result, more beds are allocated to local service areas with higher rates of poverty.

These considerations inform the JCAFS's recommendation to maintain the bed-day allocation methodology adopted in 2016. Although there are barriers that complicate an accurate assessment and measurement of bed-day allocations, the JCAFS recommends maintaining the bed-day allocation methodology adopted in 2016.

Tables 4, 5, 6, and 7 on the following page contain an inventory of HHSC-funded mental health programs in each service area. These programs include Community Based Crisis Program (CBCP) projects, community mental health hospital beds (CMHH), purchased psychiatric beds (PPB), outpatient competency restoration (OCR) programs, and jail-based competency restoration (JBCR) programs. CMHHs are established through legislative appropriations, while local authorities purchase PPBs from private psychiatric hospitals.

HHSC-funded CBCP projects include:

- **Crisis respite units** - a place where people at low risk of harm to self or others can stay for as long as seven days. Professional staff are available to provide counseling and medication.
- **Crisis peer respite programs** - staffed by peer providers and provide community-based, non-clinical support to help people find new understanding and ways to move forward.
- **Crisis residential units** - provides short-term crisis services in a home-like environment for people who might harm themselves or others.
- **Extended observation units (EOUs)** - a place where people who are at high risk of harm to self or others are treated in a secure environment for up to 48 hours. Professional staff are available to provide counseling and medication services.
- **Crisis stabilization units (CSUs)** - designed to treat symptoms of mental illness for those who are at high risk of admission to a psychiatric hospital. Treatments such as counseling and medication are provided in a secure environment with a stay of up to 14 days.
- **Contracted psychiatric beds** - inpatient beds in community hospitals for people who need short term stabilization services.

- **Triage** - provides clinical assessment at the point of entry to crisis services to identify the level of service required.

Table 4. Fiscal Year 2022 HHSC-Funded CBCP Projects

Local Authority	Project Type	Funding
Andrews Center	Contracted Psychiatric Beds	$63,750
Austin Travis County Integral Care	Contracted Psychiatric Beds	$1,884,619
Austin Travis County Integral Care	Crisis Respite	$1,535,273
Behavioral Health Center of Nueces County	Crisis Respite	$300,684
Betty Hardwick Center	Contracted Psychiatric Beds	$1,179,159
Bluebonnet Trails Community Services	Extended Observation Unit	$1,291,926
Bluebonnet Trails Community Services	Crisis Respite	$563,816
Burke Center	Extended Observation Unit	$492,620
Burke Center	Crisis Residential	$1,461,684
Burke Center	Continuity of Care	$140,995
Camino Real Community Centers	Crisis Residential	$797,950
Camino Real Community Centers	Contracted Psychiatric Beds	$232,258

Local Authority	Project Type	Funding
Center for Health Care Services	Extended Observation Unit	$261,300
Center for Life Resources	Crisis Respite	$214,240
Central Plains Center	Crisis Respite	$43,538
Central Plains Center	Contracted Psychiatric Beds	$535,398
Central Plains Center	Mental Health Deputy	$86,593
Coastal Plains Community	Contracted Psychiatric Beds	$300,000
Community Healthcore	Extended Observation Unit and Crisis Residential	$2,096,976
Community Healthcore	Contracted Psychiatric Beds	$1,336,982
Community Healthcore	Triage	$305,592
Emergency Health Network	Contracted Psychiatric Beds	$599,500
Emergency Health Network	Crisis Residential	$447,077
Emergency Health Network	EOU	$416,668
Gulf Bend Center	Contracted Psychiatric Beds	$294,236

Local Authority	Project Type	Funding
Gulf Bend Center	Mental Health Deputy	$224,075
Gulf Bend Center	Continuity of Care Program	$65,862
Harris Center for Mental Health and Intellectual and Developmental	Peer Crisis Respite	$930,168
Heart of Texas Region MHMR Center	Crisis Respite	$1,233,406
Heart of Texas Region MHMR Center	Extended Observation Unit, Crisis Residential, and Triage	$2,190,043
Helen Farabee Centers	Contracted Psychiatric Beds	$599,885
Helen Farabee Centers	Crisis Respite	$373,443
Helen Farabee Centers	Inpatient Substance Use Treatment and Detox Program	$1,204,500
Hill Country Mental Health and Developmental Disabilities	Crisis Stabilization Unit	$75,147
Hill Country Mental Health and Developmental Disabilities	Contracted Psychiatric Beds	$48,000
Hill Country Mental Health and Developmental Disabilities	Mental Health Deputy	$54,458
LifePath Systems	Contracted Psychiatric Beds	$10,000
LifePath Systems	Extended Observation Unit	$263,161

Local Authority	Project Type	Funding
MHMR Authority of Brazos Valley	Contracted Psychiatric Beds	$304,968
MHMR Services for the Concho Valley	Contracted Psychiatric Beds	$1,319,964
MHMR Services for the Concho Valley	Crisis Respite	$234,296
MHMR Tarrant County	Crisis Respite	$1,318,357
MHMR Tarrant County	Crisis Residential	$2,150,494
MHMR Tarrant County	Adolescent Crisis Respite	$1,529,686
Pecan Valley Centers for Behavioral and Developmental Healthcare	Contracted Psychiatric Beds	$247,500
Pecan Valley Centers for Behavioral and Developmental Healthcare	Crisis Respite	$234,300
Permian Basin Community Centers	Contracted Psychiatric Beds	$1,570,593
Permian Basin Community Centers	Triage	$472,032
Spindletop Center	Crisis Respite	$265,100
Spindletop Center	Crisis Residential	$557,700
Spindletop Center	Extended Observation Unit	$607,453

Local Authority	Project Type	Funding
Spindletop Center	Contracted Psychiatric Beds	$651,585
Spindletop Center	Mental Health Deputy	$1,073,589
Texana Center	Substance Use Treatment (in a Crisis Residential Unit)	$186,023
Texana Center	Contracted Psychiatric Beds	$1,340,280
Texas Panhandle Centers for Behavioral and Developmental Health	Contracted Psychiatric Beds	$1,110,122
Texas Panhandle Centers for Behavioral and Developmental Health	Mental Health Docket	$332,255
Texas Panhandle Centers for Behavioral and Developmental Health	Continuity of Care	$194,526
Tri-County Behavioral Healthcare	Contracted Psychiatric Beds	$166,666
Tri-County Behavioral Healthcare	Crisis Stabilization Unit	$1,726,464
Tri-County Behavioral Healthcare	Crisis Intervention Response Team	$143,336
Tropical Texas Behavioral Health	Contracted Psychiatric Beds	$980,513
Tropical Texas Behavioral Health	Co-Occurring Psychiatric and Substance Use Disorders Rapid Crisis	$546,312
West Texas Center for MHMR	Contracted Psychiatric Beds	$351,024

Local Authority	Project Type	Funding
West Texas Center for MHMR	Crisis Respite	$789,248
West Texas Center for MHMR	Mental Health Deputy	$294,905

Table 5. Fiscal Year 2022 Community Mental Health Hospital and Private Psychiatric Beds

Local Authority	Type of Bed	# of Beds
Anderson Cherokee Community Enrichment Services	PPB Forensic	20.0
Anderson Cherokee Community Enrichment Services	PPB	3.2
Andrews	PPB	1.7
Austin Travis County Integral Care	PPB	12.5
Betty Hardwick Center	PPB	4.6
Bluebonnet Trails Community Services	PPB	6.2
Border Region	PPB	4.7
Burke Center	PPB	6.4
Camino Real Community Centers	PPB	3.3
Center for Health Care Services	PPB	30.9
Center for Life Resources	PPB	1.8
Central Counties Services	PPB	4.9
Coastal Plains Community Center	PPB	7.7
Community Healthcore	PPB	1.5
Concho Valley	PPB	1.5
Denton County MHMR Center	PPB	12.8
Emergence Health Network	PPB	4.0
Gulf Bend MHMR Center	PPB	3.9
Gulf Coast Center	PPB	2.6
Gulf Coast Center	CMHH	20.0

Local Authority	Type of Bed	# of Beds
Harris Center	PPB	27.5
Harris Center	CMHH	165.0
Heart of Texas Region MHMR Center	PPB	6.2
Hill Country Community MHMR Center	PPB	7.0
Lakes Regional Community Center	PPB	4.1
LifePath Systems	PPB	13.9
MHMR Authority of Brazos Valley	PPB	7.6
MHMR Services of Tarrant County	PPB	32.1
North Texas Behavioral Health Authority	PPB	33.7
Nueces	PPB	5.4
Pecan Valley Centers	PPB	5.6
PermiaCare	PPB	1.7
Spindletop Center	PPB	9.5
Starcare Specialty Health Systems	PPB	1.7
Starcare Specialty Health Systems	CMHH	30.0
Texas Panhandle	PPB	1.8
Texana Center	PPB	6.8
Texoma Community Center	PPB	4.8
Tri-County Behavioral Healthcare	PPB	8.9
Tropical Texas Behavioral Health	PPB	22.2
West Texas Center for MHMR	PPB	10.8

Table 6. Fiscal Year 2022 Outpatient Competency Restoration Programs and Target Number of People Served for Each Program

OCR Programs	Target
Andrews Center	32
Austin Travis County Integral Care	36
Behavioral Health Center of Nueces County	12
Bluebonnet Trails	13
Center for Healthcare Services	40
Center for Life Resources	9

OCR Programs	Target
Central Counties	15
Community Healthcore	3
Concho Valley	9
Emergence Health Network	41
Harris Center	60
Heart of Texas Region MHMR Center	15
LifePath	13
MHMR Services of Tarrant County	25
North Texas Behavioral Health Authority	75
Pecan Valley	13
StarCare Specialty Health Systems	16
Tri-County Behavioral Healthcare	15

Table 7. Fiscal Year 2022 Jail-Based Competency Restoration Programs and Target Number of People Served for Each Program

Jail-Based Competency Restoration Programs	Target
Behavioral Health Center of Nueces County	12
Harris Center	80
North Texas Behavioral Health Authority	60
PermiaCare	9
StarCare	50
Tarrant	100

Tables 4 - 7 above provide a partial representation of local resources. A wide range of services and supports are relevant to the need for inpatient care, and they are supported with local, state, and national funding sources, both public and private. These resources vary over time, compounding the challenges of compiling and maintaining a comprehensive and reliable inventory to use in an allocation methodology.

There is no consensus as to how the availability of resources should be considered in allocating bed days. From one perspective, it makes sense to allocate more bed days to areas with fewer resources. However, such an approach could serve as a

disincentive for local stakeholders to invest in services and initiatives to reduce the need for inpatient care, leading to greater reliance on state-funded programs.

7. Outcomes of Implementation – Utilization Review

The recommendations outlined in this section reflect the views of the JCAFS and may not reflect the position of HHSC.

The goal of the UR protocol is to bring key stakeholders together to analyze factors contributing to patterns of use and barriers to timely discharge; identify successful and new strategies to address local and regional challenges; and make recommendations to address systemic issues and resource needs to inform state policymakers.

The JCAFS Access subcommittee completed one cycle of utilization review in 2021. The review revisited findings from 2017, 2018, and 2019 UR Protocols and gathered qualitative and quantitative information from LMHAs and superintendents of state hospitals regarding over or under utilization, readmissions, and length of stay.

Summary findings include:

1. **Lack of control over bed-day utilization:** Although the Bed-Day Allocation Methodology allocates state-funded beds evenly, LMHAs/LBHAs expressed that they have no control over their bed-day utilization due to the growing number of forensic commitments in state-funded beds.
2. **Lack of access to civil and voluntary state hospital beds:** Due to the proportion of state hospital beds allocated to the forensic waitlist, LMHAs/LBHAs expressed concern that they have limited access to state hospital beds for people with civil commitments.
3. **Increasing need for community private psychiatric beds (PPB):** LMHAs/LBHAs expressed a need for increased funding to meet the growing needs for PPB beds due to a growing population and rising PPB costs.
4. **Need for long-term residential facilities:** The LMHAs/LBHAs and superintendents expressed concern for shortages in safe and stable housing that can meet the needs of people who experience long-term mental health issues and would be better served in a residential placement.
5. **Need for improved communication between LMHAs/LBHAs, jails, state hospitals and courts regarding individuals on the forensic clearinghouse waitlist:** LMHAs/LBHAs expressed experienced challenges in

communicating with jail staff, state hospital staff, and court representatives regarding diverting individuals charged with misdemeanor offenses off the waitlist, initiating compelled medications for people found incompetent to stand trial in jails, and releasing people from jail on personal recognizance bonds without notifying the LMHA/LBHA.

6. **Need for increased availability of transitional support services for long-term state hospital patients returning to the community:** The LMHAs/LBHAs and state hospital superintendents shared a need for increased availability of transitional and support services to help long-term residents access vital services such as reinstatement of benefits, transportation to aftercare appointments, and assistance with employment upon return to the community.
7. **Need for education of community members and stakeholders:** The LMHAs/LBHAs and superintendents identified education on the long-term cost benefits that would result from the improved access to long-term residential facilities as a priority.

In 2022, the JCAFS began UR Protocol activities to analyze growth trends of patients who have been in the state hospital for more than 365 days, identify factors driving the number of people found incompetent to stand trial who are in the hospital for more than 180 days and make recommendations on the options for more appropriate placement that may help to reduce the number of long-term state hospital patients.

In consultation with HHSC staff, the JCAFS has developed interview questions for state hospital administrators and clinicians pertaining to the 365-day population and plans to conduct interviews in fiscal year 2023. The JCAFS also plans to analyze data collected by State Hospital Central Administration using an assessment tool developed to capture the needed placement upon discharge, patient strengths that support community-based living, and legal, clinical, and social barriers to discharge.

The JCAFS was not able to discern the impact of the UR protocol on the use of state-funded hospital beds due to the complexity of factors that influence the care provided by state hospitals.

8. JCAFS Recommendations to Enhance the Effective and Efficient Allocation of State-Funded Hospital Beds

These recommendations reflect the views of the JCAFS and may not reflect the views of HHSC.

Like other states across the country, Texas faces a growing crisis in effectively serving Texans with mental illnesses that are involved with the criminal justice system. The number of persons found Incompetent to Stand Trial and added to HHSC's waitlist for inpatient competency restoration services continues to increase, with approximately 2,500 persons on the forensic waitlist as of September 2022 and 70 percent of state hospital beds in Texas currently utilized by the forensic population. A systematic approach to forensic and diversion services is needed to both reduce the number of persons entering the criminal justice system and more efficiently utilize resources for persons who need them. The JCAFS recommendations are as follows:

1. Increase access to treatment in the community.
    A. Allow LMHAs/LBHAs more flexibility to provide evidence-based services, including psychotherapy for broader diagnostic groups.
    B. Provide more training for clinicians to provide evidence-based psychotherapy for high acuity patients.
    C. Reassess state budget funding to address additional direct care positions.
    D. Increase the range of supportive and residential housing options.
    E. Explore expanded and tailored housing options. Allow access to short-term acute community beds for jail use.
2. Increase access to private psychiatric bed (PPB) funding to address the increased volume of high need individuals who are unable to access state mental health facilities.
3. Utilize best practices for jail-diversion.
    A. Utilize best practices for jail diversion such as pre-arrest diversion (mental health deputies, co-response models) programs, including the use of peers for co-response.

B. Expand availability of Outpatient Competency Restoration (OCR) and Jail-Based Competency Restoration (JBCR).

C. Expand peer support, clubhouses, and respite services for adults and youth, including peer respite services.

4. Increase access to long-term inpatient hospital beds in the community for people who have chronic mental illnesses refractory to treatment.
5. Increase access to step-down facilities for individuals who need care for longer than 7 days and long-term supportive housing options for people who have chronic mental illness.
6. Develop proposals for long-term residential facilities.

   A. Study outcome of current LMHA/LBHA programs that are conducting pilot programs for transitional/step-down supportive housing.

   B. Scale-up transitional LMHA programs that are working.

   C. Work with the Texas Council of Community Centers to develop proposals for the creation of long-term housing options.

7. Provide stakeholders with a cost-benefit analysis of creating long-term permanent supportive housing options. Educate the community regarding the positive impact that long-term supportive housing options would have on the lives of individuals living with chronic mental illness and on the lives of their family members, as well as members of society as a whole.
8. Provide transition planning for individuals who have had long-term hospital stays. LMHA and state hospital staff should work to ensure that these patients receive ongoing assistance with accessing the full array of services that they need.

9. Conclusion

In 2022, the JCAFS recommended no changes to the bed-day allocation methodology which was adopted in 2016.

Activities associated with the UR protocol included revisiting of utilization review studies completed in 2017, 2018, and 2019 to evaluate factors that impact bed-day utilization, readmission, and length of stay. The JCAFS also began activities to analyze growth trends of patients who have been in the state hospital for more than 365 days, identify factors driving the number of people found incompetent to stand trial who are in the hospital for more than 180 days and make recommendations on options for more appropriate placement that may help to reduce the number of long-term state hospital patients. The JCAFS recommendations for changes to the UR protocol can be found in Appendix A.

Based on the results of the utilization review in 2021 and 2022, as well as stakeholder input, the JCAFS recommends addressing Texas' growing crisis in effectively serving Texans with mental illnesses that are involved with the criminal justice system. HHSC will continue to work with the JCAFS to ensure the continuum of inpatient psychiatric services meets the needs of Texans.

List of Acronyms

Acronym	Full Name
CMHH	Community Mental Health Hospital
FPL	Federal Poverty Level
HHS	Health and Human Services
HHSC	Health and Human Services Commission
JCAFS	Joint Committee on Access and Forensic Services
LBHA	Local Behavioral Health Authority
LMHA	Local Mental Health Authority
OCR	Outpatient Competency Restoration
JBCR	Jail-Based Competency Restoration
PPB	Private Psychiatric Bed

Appendix A. JCAFS Recommendations for Updated Bed Day Allocation Methodology and Utilization Review Protocol

2022 recommendations from the JCAFS to the Executive Commissioner regarding an updated Bed Day Allocation Methodology and Utilization Review (UR) Protocol

Recommendations for an Updated Bed-Day Allocation Methodology

In developing a bed-day allocation methodology, Health and Safety Code, Section 533.0515, requires an evaluation of factors that impact utilization, including clinical acuity, prevalence of serious mental illness, and the availability of resources in a given region. As described in Section 6, the JCAFS considered each of these factors and barriers in their application in making its recommendations.

The JCAFS's three recommendations in 2022 related to the allocation of beds are unchanged from the previous recommendations made in 2016, 2018, and 2020. They include:

1. Continue to allocate beds based on the poverty-weighted population within each local service area;
2. Retain the current exclusions for bed days in maximum security units and the Waco Center for Youth; and
3. Do not impose any sanction, penalty, or fine for utilization above allocated bed days.

The current methodology allocates bed days based on the poverty-weighted population in each local service area. A poverty-weighted population gives double weight to populations with incomes at or below 200 percent of the FPL:

$$\textit{Poverty-weighted Population} = \textit{Total Population} + \textit{Population} \leq 200\%\ \textit{FPL}$$

The committee based its recommendation to use the poverty-weighted population on the following:

- The overwhelming majority of persons receiving HHSC-funded mental health services have incomes at or below 200 percent FPL.
- Beginning in the 2016-2017 General Appropriations Act, House Bill 1, 84th Legislature, Regular Session, 2015, the Legislature used the poverty weighted population as the basis for comparing per capita funding among local mental health and behavioral health authorities and appropriating funds to those below the statewide level of per capita funding. Using the same metric for allocating funding and hospital beds allows for a consistent approach to resource allocation.
- The proposal to move to the poverty-weighted population in the 84th Legislative Session was supported by a broad group of stakeholders.

With respect to sanctions or penalties, the JCAFS recommended the state not impose sanctions, penalties, or fines on local mental health and behavioral health authorities that use more than the allocated number of hospital bed days. Rather, the bed-day allocation methodology should continue to be used as a metric for analyzing bed-day utilization.

Recommendations for Utilization Review Protocol

The goal of the UR protocol is to bring key stakeholders together to identify factors that contribute to patterns of inpatient utilization and barriers to timely discharge, successful and new strategies to address local and regional challenges, and systemic issues and resource needs to inform state policymakers.

The UR protocol adopted by the JCAFS in 2018 established a flexible framework that allowed the model to evolve. The JCAFS 2022 recommendations related to utilization review adhere to the flexible framework utilized in 2018 with additional responsibilities assigned to the recently established JCAFS Data subcommittee, as follows:

1. Continue collection of data for the JCAFS data dashboard as the primary tool for reporting and analyzing state hospital utilization.
2. Assign responsibility for identifying and monitoring data points related to the forensic waitlist and hospital utilization to the JCAFS Data subcommittee.
3. Assign responsibility for utilization review activities to the JCAFS Access subcommittee.

4. The 2022 UR protocol will include:
    A. A review of statewide and local data;
    B. teleconferences with local mental health and behavioral health authorities and state hospitals; and
    C. surveys of local mental health and behavioral health authorities and state hospitals.
5. Conduct follow-up to assess the results of the UR protocol.
6. Compile successful and promising strategies identified during utilization review activities for use as a statewide resource.