North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Adam Sholar
Legislative Counsel
Director of Government Affairs

February 28, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 1026, Legislative Building
Raleigh, NC 27601

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 307A, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Mark Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Hise and Representatives Burr and Hollo:

Session Law 2013-360, Section 12F.2.(f) requires the NC Department of Health and Human Services to report on a uniform system for local inpatient psychiatric beds or bed days purchased during State Fiscal Year 2012-13, and other initiatives funded by State appropriations to reduce State psychiatric hospital use. Pursuant to the provisions of law, the Department is pleased to submit the attached report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

The attached report will show the initiative which was funded initially in 2008, Session Law 2008-107; expanded in 2009, Session Law 2009-451; and expanded again in 2013, Session Law 2013-360, has demonstrated success.

Please contact Dave Richard, Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, should you have any questions regarding this report. Mr. Richard can be contacted at (919) 733-7011.

Sincerely,

Adam Sholar

cc:

Matt McKillip	Denise Thomas	Susan Jacobs
Jim Slate	Patricia Porter	Theresa Matula
Dave Richard	Sarah Riser	Joyce Jones
Jim Jarrard	Kristi Huff	Rod Davis
Pam Kilpatrick	Brandon Greife	reports@ncleg.net

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SENT VIA ELECTRONICE MAIL

Mark Trogdon, Director
NC General Assembly
Fiscal Research Division
Room 619, Legislative Office Building
Raleigh, NC 27603-5925

Dear Mr. Trogdon:

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Report on
Funds for Local Inpatient Psychiatric Beds or Bed Days
Session Law 2013-360, Section 12F.2

Prepared for:

North Carolina General Assembly

Joint Legislative Oversight Committee on Health and Human Services

Fiscal Research Division

March 1, 2014

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Funds for Local Inpatient Psychiatric Beds or Bed Days
Session Law 2013-360, Section 12F.2

March 1, 2014

Session Law 2013-360, SECTION 12F.2.(f) states, *Reporting by Department. – By no later than March 1, 2014, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on all of the following:*
(1) A uniform system for beds or bed days purchased during the fiscal year ending June 30, 2013, from (i) funds appropriated in this act that are designated for this purpose in subsection (a) of this section, (ii) existing State appropriations, and (iii) local funds.
(2) Other Department initiatives funded by State appropriations to reduce State psychiatric hospital use.

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS or Division) of the North Carolina (NC) Department of Health and Human Services (DHHS or Department) has taken a number of steps to increase and fund local inpatient psychiatric beds or bed days not currently funded by or through Local Management Entity-Managed Care Organizations (LME-MCOs) and adding higher payments for the local inpatient psychiatric beds or bed days for individuals with higher acuity levels and more complex needs. In 2013, per directive of Session Law 2013-360, Section 12F.2.(a), *the Department shall develop and implement a two-tiered system of payment for purchasing these local inpatient psychiatric beds or bed days based on acuity level, with an enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels, as defined by the Department . . .* (Session Law 2013-360, Section 12F.2.(a).

The purpose of the funds for local inpatient psychiatric beds or bed days is to strengthen and expand community capacity to ensure individuals experiencing a crisis related to their mental illness, substance use disorder or developmental disability receive appropriate crisis services in the community. Historically, individuals in a crisis situation requiring short-term inpatient hospitalization have been served at the state's three psychiatric hospitals - Broughton Hospital in Morganton in Burke County, Central Regional Hospital in Butner in Granville County, and Cherry Hospital in Goldsboro in Wayne County. By serving an individual in the community, the hospital provides more appropriate care by keeping the individual connected to family, friends and community service providers and reserves the state hospital resource for individuals who require longer-term hospitalization or specialty services only state hospitals can provide.

The initiative funded initially in 2008, Session Law 2008-107; expanded in 2009, Session Law 2009-451; and expanded again in 2013, Session Law 2013-360 has demonstrated success. This initiative is commonly referred to as "three-way hospital contracts" because new community psychiatric inpatient beds are created and funded

through a contract among the community hospital, the LME-MCO responsible for the county in which the hospital is located, and the DMHDDSAS. The details on the use of those funds and the success of the initiative are outlined in this report. A summary by funding source, of the public, non-federal dollars used to purchase bed days in the community is also presented in this report.

I. *Beds/Bed Days Purchased from Existing State Appropriations*

In addition to funds specifically allocated for hospital inpatient bed/bed day purchased through three-way contracts, ninety-one percent (91%) of the LME-MCOs use a portion of their generic allocation of state funding to purchase hospital inpatient services. However, the majority of funds to strengthen these community efforts have come from legislative appropriations. In State Fiscal Year (SFY) 2012-13, ten (10) LMEs paid for services for more than 3,500 individuals in community hospitals at a cost of over $14 million.

Table I. Inpatient Bed Days Purchased with Local Management Entities-Managed Care Organization Allocations of State Appropriations SFY 2013

LME-MCO	State Funds Expended SFY 2012-2013	Number of In-Patient Bed Days Purchased	Persons Served
Alliance Behavioral Healthcare	$6,416,232	9,355	1,044
Cardinal Innovations Healthcare Solutions	$2,791,993	5,860	763
CenterPoint Human Services	$1,737,665	2,829	454
CoastalCare	$8,835	15	2
East Carolina Behavioral Health	$79,633	134	22
EastPointe	$372,269	783	141
MeckLINK Behavioral Healthcare	($60,041)	(119)	10
Partners Behavioral Health Management	$211,744	460	95
Sandhills Center for Mental Health/Developmental Disabilities/Substance Abuse Services	$2,003,926	3,791	883
Smoky Mountain Center	$658,104	1,095	174
Total	**$14,219,359**	**24,203**	**3,588**

Claims for services reported to-date through the DMHDDSAS Integrated Payment and Reporting System (IPRS) for SFY 2013 indicate the LME-MCOs are on track to expend similar amounts and more of their allocations for SFY 2014 for purchase of inpatient psychiatric bed days.

II. *Beds/Bed Days Purchased Using Funds Appropriated under:*

S.L. 2011-145, Section 10.8.(b)(under Session Law 2011-145, Section 10.12.(b) "Three Way Hospital Contracts") and Session Law 2013-360, Section 12F.2.(a), "the Department shall develop and implement a two-tiered system of payment for purchasing these local inpatient psychiatric beds or bed days based on acuity level, with an enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels, as defined by the Department."

In 2008, the NC DHHS convened a task force comprised of hospital administrators, psychiatrists, other clinicians and providers, LME leaders, and advocates to develop a comprehensive plan for community crisis services for individuals with mental health, developmental disabilities, and substance abuse service needs. The task force focused on the problem of the decreasing availability of community psychiatric inpatient beds. Between 2001 and 2006, 200 community psychiatric inpatient beds had been closed. During that same period, admissions to state psychiatric hospitals for inpatient care had steadily risen resulting in a length of stay of seven days or less representing more than fifty percent of all admissions in SFY 2006-2007. In catchment areas where LMEs used county funds and/or state appropriations to purchase indigent care in the community, those trends were not as severe. The task force identified the lack of funding for community psychiatric inpatient care for indigent people as one of the main obstacles to building a full crisis service continuum in the community and developed a plan to request funding for the purchase of this care. In 2008, the General Assembly appropriated $8,121,644 for community psychiatric inpatient care. Though the task force recommended some funding to stabilize the existing beds in community hospitals, the General Assembly limited the funding to new beds only.

All beds created through this initiative must also be available for involuntarily committed individuals who would otherwise qualify for admission to a state psychiatric hospital. Community hospitals may create new beds in several ways: 1) by increasing the number of beds actually in operation if their current license for psychiatric beds is greater than the number being operated; 2) by designating inpatient units for involuntarily committed persons if they had not previously held that designation; or 3) by increasing the number of licensed psychiatric inpatient beds in the hospital, either through a transfer of beds from a state hospital or a transfer of acute beds within the hospitals.

Participating hospitals were and are still paid a standard rate of $750 per occupied bed day. This rate is inclusive of all professional and ancillary charges (laboratory tests,

medications, physician's fees, etc.) and a week of medication upon the individual's discharge. The current rate at state psychiatric hospitals ranges from $931 to $1,203 per day.

The beds contracted through the three-way contracts serve as a regional resource. Although today the LME-MCO in whose catchment area the beds are located serves as the manager of the contract, the beds are available for any individual requiring inpatient hospitalization in the State of North Carolina. For this reason, DMHDDSAS worked to locate the beds strategically throughout the state and to target areas where there have historically been a high number of admissions for short-term lengths of stay in state hospitals. The LME-MCOs managing the contracts are responsible for participating in discharge planning designed to connect individuals to community-based services upon discharge from the hospital. There were 135 beds contracted in SFY 2012-2013 and 170 beds contracted for SFY 2013-2014. The 170 beds are located in ten LME-MCOs throughout the state.

The 135 beds contracted in 2012-2013 and the 170 beds contracted for 2013-2014 are due to the General Assembly's adding $9 million to the $29 million they had already allocated for this program. Of this funding, $2 million were used to purchase services through an enhanced rate (payment structure to hospitals) for serving more complex patients. Specifically, the General Assembly appropriated $38,121,644 for SFY 2013-2014 and $38,121,644 for SFY 2014-2015 to purchase additional local inpatient psychiatric beds or bed days not currently funded by or through LME-MCOs.

The three-way hospital contract strengthened the valuable partnerships among community hospitals and LME-MCOs and DHHS and the NC Hospital Association. People receive needed services in their home communities. Demand for short term (seven days or less) state hospital admission has been reduced, resulting in state hospitals devoting their resources to treating the more challenging and chronic individuals. These individuals are spending less time in hospital Emergency Departments (EDs) waiting for a bed to become available in a state psychiatric hospital, thereby, reduces the time that sheriff's deputies must remain with people in the ED. DMHDDSAS strongly recommends the General Assembly continue and expand its support for this financial sound and programmatically worthwhile program.

For the SFY 2013-2014 cycle, seven hospitals applied for new three-way bed contracts - three were approved and four were denied three-way bed contracts. The three hospitals that received initial funding for three-way beds were the University of North Carolina Hospital - WakeBrook (5), Good Hope Hospital (5), and Halifax Regional Medical Center (5). Seven hospitals requested expansion of their existing three-way bed contracts – two were approved to expand their three-way bed contracts and five hospitals were denied expansion of their existing contracted beds. The two hospitals that received additional funds to increase their three-way contracted beds and expand services were New Hanover Regional Medical Center (5) and Presbyterian Healthcare System (4). Based on historical utilization levels, funding levels were increased for Frye

Regional Medical Center, Forsyth Medical Center, and Catawba Valley Medical Center to 90%, 100%, and 100%, respectfully.

DMHDDSAS established a Three-Way Contract Work Group during the early stages of implementing the initiative. The work group is comprised of representatives from DMHDDSAS; Division of State Operated Healthcare Facilities; NC Hospital Association; LME-MCO management - a medical director, a care coordinator and finance staff; and representatives from individual hospitals. The Work Group met monthly and demonstrated to be very beneficial in the three-way inpatient contract efforts by helping to focus on the care needs of consumers and the financial obligations of hospitals as well as address quality management issues including outcome measures. The Work Group developed criteria for selecting new hospitals, expansion beds, and enhanced rate beds.

The Development of Enhance Rate Structure Plan by the Three-Way Contract Work Group includes the following:

- Clinical and patient specific criteria for qualifying for admission to an enhanced bed;
- Facility specific criteria to qualify to deliver this service;
- Selection process for the appropriate type of facility to render services; and
- Daily rate for the enhanced bed per the legislation and selected three pilot hospitals for program implementation based on the above criteria.

Acuity Indicators for Three Way Bed Enhanced Rates

To qualify for an enhanced rate, the following conditions must be met:

A. Patient must be involuntarily committed AND
B. Must meet one of the following 2 criteria
    i. Has 5 denials for acuity or are already in a facility that can adequately serve them
    ii. On state hospital wait list or ineligible for state hospital care
C. AND any of the following:
    i. History of actual assault on others or serious damage to property during this episode, i.e., this behavior led to their current assessment, OR the patient is typically assaultive when in a decompensated state.
    ii. Despite 1:1, patient continues to exhibit behaviors that would be immediately self-injurious.
    iii. Individual is currently restrained or has required restraints in the ED during this episode, and the patient has continued potential for agitation and forced medication – this excludes restraints by Law Enforcement.
    iv. Individual is pregnant and requires detoxification from substances. Level IV ASAM and 3rd trimester pregnancy in patients requiring detoxification services are particularly high priority.
    v. Individual requires treatment of unstable co-morbid medical conditions for example complex wounds, hemodialysis, chronically unstable diabetes, etc.
    vi. Aspiration risk requiring additional nursing monitoring.
    vii. Conditions resulting in need for assistance with transfers and/or ambulation or other ADLs.
    viii. Bed-ridden due to psychiatric condition.
    ix. MRSA positive with draining wound.

3 Way Contract Selection Criteria

Requirements (per Contract and Legislation)

1). IVC Designated Facility
2). New Capacity
- New Capacity Defined as creating new facility (brick and mortar build), re-designation of existing unit to become psychiatric inpatient unit, continuing use of existing unit that is in imminent threat of closure

3). Services paid to new contracted beds through 3 way contract are not to supplant existing services paid from state sources.
4). Maintain Liability Insurance of $1,000,000 per occurrence and $3,000,000 in aggregate
5). Licensure of facility must not be "suspended", "debarred" or otherwise deemed ineligible
6). Be willing to prioritize admissions based on medical necessity, not locus of residency (CASP facility)
7). Must not be designated as an IMD facility

Criteria for the expansion of beds at existing 3 Way Contracted Hospital

1). Must continue to meet all requirements for community hospital contractor outlined above
2). Demonstrate history of exceptional use of current allocated beds. This use must not be merely financial (as initial contracts are allocated at 75% of capacity). Additional beds must be requested if capacity on initial contract is currently or trending to be above 100% of initial contracted beds.
3). Demonstrated history of use cannot be solely determined by hospital census figures, but fully adjudicated claims. Trending presumption based on claims history can take into account future claims which come from a proportion of reported hospital census figures.
4).Currently have or will be able to bring psychiatric inpatient capacity on-line in short time frame (within 3 months)
5). Must consider if there are immediate plans for a new 3 way contract hospital in same catchment or short geographical distance from current hospital
6). Must have aggregate Average Length of Stay (ALOS) under 7 days
7). Preference given to hospitals where LME-MCO catchment has relatively high utilization of state facility psychiatric inpatient beds where ALOS < 7 days.

Criteria for Selection of New Hospital

1). Must meet all requirements for community hospital contractor outlined above
2). Hospital's application for 3 way contract beds must be supported by LME-MCO that will be authorizing 3 way contract services for hospital
3). Must be current network member of LME-MCO that will be authorizing services
4). Preference given to hospital that will increase accessibility of service. Items that will be considered for accessibility will be:
- Geographic distance from currently designated 3 way contract hospitals
- Catchment area has demonstrated in prior years that capacity in area has been underserved. (i.e., individuals with home county designations from that catchment are being served out of catchment by other 3 way contracted hospitals).

5). Preference will be given to hospitals that currently have or will be able to bring psychiatric inpatient capacity on-line in short time frame (within 3 months)
6). Preference will be given to hospitals that have ability to serve individuals underserved with 3 way contracts (i.e., willing to take SA consumers for ASAM Level 4 detoxification and/or those with psychiatric disorders with co-occurring IDD).
7). Preference will be given to hospitals where LME-MCO catchment has relatively high utilization of state facility psychiatric inpatient beds where ALOS < 7 days.

Criteria for Selection of a "Higher Tiered Rate" Inpatient Bed Hospital

1). Must be existing 3 way contracted hospital
2). Must have dedicated intensive support unit within a psychiatric inpatient service.
3). Must have adequate staff and staff training for acute care. This consists of evidence of:
- staff training plan\history showing training in prevention, crisis de-escalation and training of seclusion and restraint techniques.
- staffing plan must demonstrate adequacy of qualified staff and rapid access to staffing as needed for emergencies.

4). Acute unit must have special environmental features and procedures that demonstrate:
- dedicated seclusion area
- controlled access to unit and policy and procedure to reduce risk of elopement
- safety protocols in place and routine inspections of environment to eliminate dangerous materials that could be accessed by patients (safety team minutes, logs of inspections, etc.)

The chart below reflects the December 1, 2013 three-way contracts for inpatient beds by LME and the enhanced rate structure.

Table II. New Beds Created and Bed Days Purchased Through 3-Way Contract and Enhanced Rate Appropriations SFY 2013-2014*

LME-MCO	Number of Beds Under Contract SFY 2014	Current Contract Funding Amount	2013 Bed Days Purchased (Based on Date of Service)
Alliance Behavioral Healthcare	24	$4,024,450	1,869
Cardinal Innovations Healthcare Solutions	10	$1,743,218	1,727
CenterPoint Human Services	11	$3,011,250	3,185
CoastalCare	13	$3,202,875	3,368
East Carolina Behavioral Health	13 (2 of which are enhanced)	$3,558,800	2,472
EastPointe	16	$4,380,000	3,998
MeckLINK Behavioral Healthcare	11 (2 of which are enhanced)	$2,395,363	503
Partners Behavioral Healthcare	31 (2 of which are enhanced)	$7,815,613	7,771
Sandhiills Center for MH/DD/SAS	22	$4,089,137	3,729
Smoky Mountain Center	19	$3,900,939	1,647
Western Highlands	0 (now in Smoky's totals)	0 (now in Smoky's totals)	2,342
Grand Total	**170**	**$38,121,644**	**32,611**

*Through June 30, 2013 incurred by June 30, 2013, lagged claims under NC Tracks not included.

The funds for local inpatient psychiatric beds or bed days have been successful in expanding community capacity for short term stay inpatient services through the three-way bed contracts. Access has been improved and individuals needing challenging mental health and substance abuse services can be offered these services close to home for most people. As the initiative evolved, hospitals expressed concerns about the inadequacy of the $750 per day for more complex and challenging patients. The NC General Assembly requested DHHS to develop a plan for two-tiered rates, i.e., an

enhanced rate, and the criteria for both hospitals and patients to qualify for it. Due to the success of this program, more hospitals are requesting contracts and it became necessary to develop criteria for new hospital beds within an existing contract.

Three hospitals were approved for the pilot study on the enhanced rate structure that requires more acute patient care. Each hospital received two beds for the new enhanced rate structure. The enhanced rate is $900 per day. The contract was effective December 15, 2013, and hospitals in the pilot study are:

- Catawba Valley Hospital – 2 beds
- Presbyterian Hospital – 2 beds
- Vidant (Pitt) – 2 beds

The main purpose of the pilot study is to serve more acute and complex patients than the population served by the "regular" three-way bed contracts. Site visits will help evaluate the success of this focus.

Conclusions and Plans for the Future

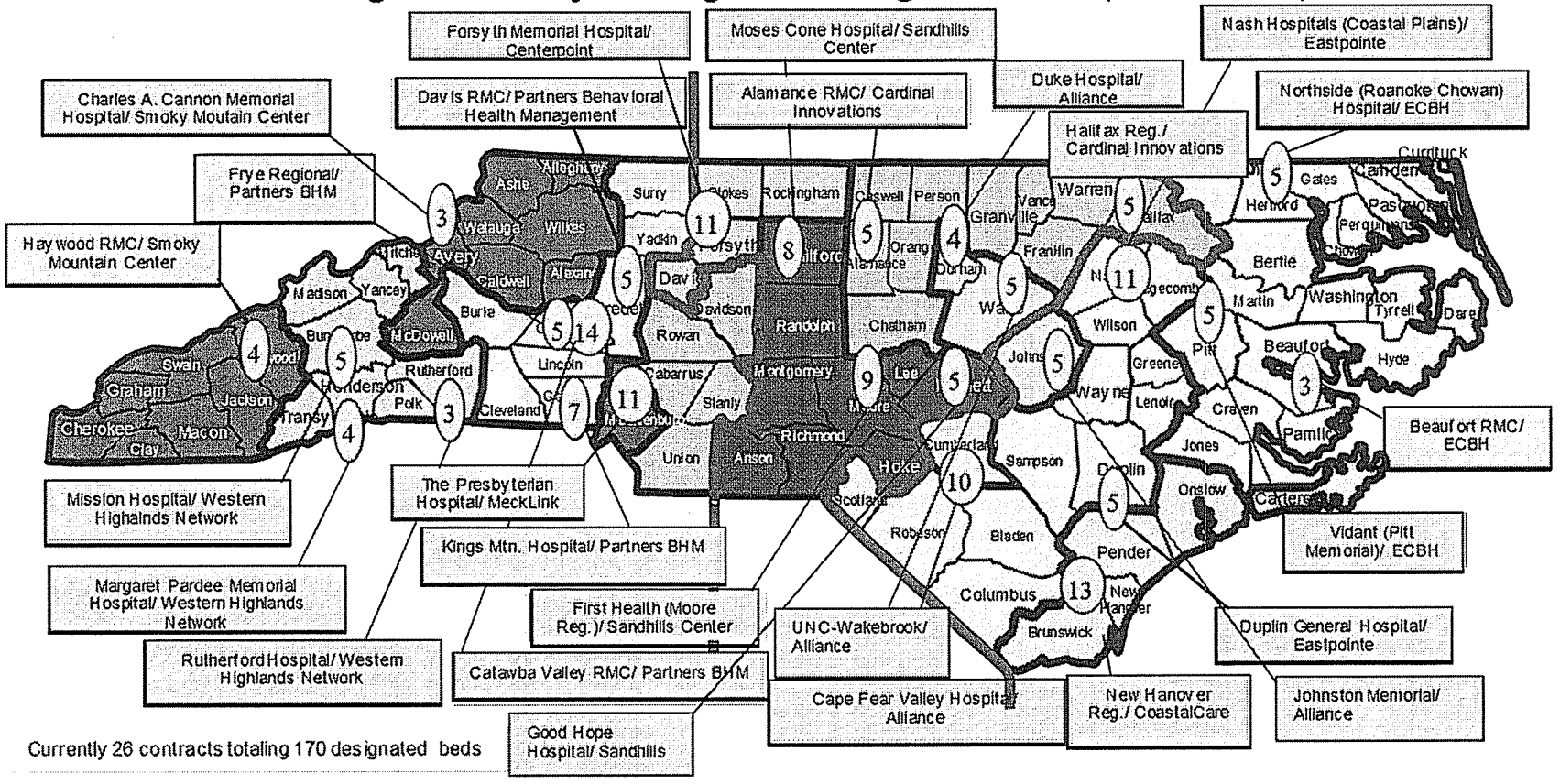
The pilot study beds with the enhanced rate structure were established to serve more acute and complex patients and not serve the same population as the original three-way bed contracts. Site visits with chart reviews will be done to determine the three pilot hospitals' (appropriate) use of the enhanced rate for more acute patient care as designed in the pilot study. The client criteria established by the three- way hospital group will guide the site visits/chart reviews. The site visits will help evaluate if the enhanced beds are serving their intended purpose. Hospitals with contracts could benefit from meeting with each other to address various issues, e.g., types and amount of discharge medications for indigent patients. Also, there remains an ongoing need to promote and standardize the selection process.

Today there are 26 contracted hospitals - 23 hospitals with the three-way contract and three hospitals with the enhanced rate contract – with 170 total beds under contract. The next step needed is to evaluate outcomes of these services to determine the impact on Emergency Department length of stay for behavioral health and individual/client clinical outcomes.

The Three-Way Contract Work Group members were especially pleased DMHDDSAS included hospitals, LME-MCOs, and other stakeholder representation from across the state early in the group's work and throughout the process. There was critical focus on both clinical and financial aspects of the contracts. The Work Group worked well together and successfully evolved to establish and agree upon selection criteria. The Work Group also aims to address the public communications on the program, impact of the three-way bed contracts on local hospital utilization rates and certificates of need as documented by the NC State Medical Facilities Plan from the Division of Health Service Regulation, possibility of hospitals adding acuity indicators on intake forms, and examining claim data from NC Tracks.

The Division remains committed to this program and will involve stakeholders through the Three-Way Contract Work Group to triage administrative and programmatic issues and ensure the future success and continued expansion of this program.

3-Way Contract Community Hospital Beds as of 11/1/13 and Proposed Local Management Entity - Managed Care Organizations (LME-MCOs) on 9/30/13



* Please note that contract totals for Vidant (Pitt), Catawba Valley Medical Center, and Presbyterian Hospitals contain 2 enhanced beds each

References:

Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services. (2011, November). *Emergency Department Length of Stay Action Plan.* Retrieved from: http://www.ncdhhs.gov/mhddsas/services/crisisservices/edlengthofstayplan.pdf

Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services. (2013, October). *Report on Local Community Hospital Payments and Review of Tiered Rate Structure for Future Community Hospital Payments, Recommendation #2 of Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health Report to 2013 NC General Assembly*. Retrieved from: http://www.ncdhhs.gov/mhddsas/statspublications/Reports/reports-generalassembly/recommendation2.pdf