North Carolina Department of Health and Human Services

Pat McCrory
Governor

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

October 1, 2013

The Honorable Louis Pate, Chair
Appropriations Subcommittee on
Health and Human Services
Room 1028, Legislative Building
Raleigh, NC 27601-2808

The Honorable Ralph Hise, Chair
Appropriations Subcommittee on
Health and Human Services
Room 1026, Legislative Building
Raleigh, NC 27601-2808

Dear Senators Hise and Pate:

The Subcommittee on Mental Health provided recommendations to the Joint Legislative Oversight Committee on Health and Human Services in the Report to the 2013 General Assembly. Attached is the Report on Local Community Hospital Payments and Review of Tiered Rate Structure for Future Community Hospital Payments, as required by Recommendation 2 in the Report to the 2013 General Assembly. This report is due to the Joint Legislative Oversight Committee on Health and Human Services on October 1, 2013. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

Please direct all questions concerning this report to Dave Richard, Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Mr. Richard can be contacted at (919) 733-7011.

Sincerely,

Aldona Wos, M.D.
Secretary

AW:mth

Attachment

cc:
Susan Jacobs
Denise Thomas
Patricia Porter
Sarah Riser
Kristi Huff
Brandon Greife
Pam Kilpatrick
Dave Richard
Jim Jarrard
Jim Slate
Adam Sholar
Representative Justin Burr
Representative Mark Hollo
Legislative Library (1 hard copy)
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October 1, 2013

The Honorable Marilyn Avila, Chair
Appropriations Subcommittee on
Health and Human Services
Room 2217, Legislative Building
Raleigh, NC 27601-1096

The Honorable William Brisson, Chair
Appropriations Subcommittee on
Health and Human Services
Room 405, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Mark Hollo, Chair
Appropriations Subcommittee on
Health and Human Services
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

Dear Representatives Avila, Brisson and Hollo:

The Subcommittee on Mental Health provided recommendations to the Joint Legislative Oversight Committee on Health and Human Services in the Report to the 2013 General Assembly. Attached is the Report on Local Community Hospital Payments and Review of Tiered Rate Structure for Future Community Hospital Payments, as required by Recommendation 2 in the Report to the 2013 General Assembly. This report is due to the Joint Legislative Oversight Committee on Health and Human Services on October 1, 2013. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

Please direct all questions concerning this report to Dave Richard, Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Mr. Richard can be contacted at (919) 733-7011.

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October 1, 2013

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 1026, Legislative Building
Raleigh, NC 27601-2808

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

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

Dear Senator Hise and Representatives Hollo and Burr:

The Joint Legislative Oversight Committee on Health and Human Services recommended that the Department of Health and Human Services work with hospitals to develop a plan to address delayed payments and create a tiered three-way contract payment rate based on patient acuity. The Committee requested that the Department submit a report on its actions by October 1, 2013, which is attached. The report contains information about the claims process as well as a plan, complete with rates and selection criteria, for a tiered three-way contract project.

Please direct all questions concerning this report to Dave Richard, Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Mr. Richard can be contacted at (919) 733-7011.

Sincerely,

Aldona Wos, M.D.
Secretary

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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

October 1, 2013

**North Carolina Department of Health and Human Services,
Division of Mental Health, Developmental Disabilities and
Substance Abuse Services**

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

October 1, 2013

In January 2013 the Joint Legislative Oversight Committee on Health and Human Services Subcommittee on Mental Health released a review of findings and recommendations for reform of the state mental health system. This report specifically addresses finding #2 and its recommendation. This finding and recommendation states:

FINDING 2: The Joint Legislative Oversight Committee on Health and Human Services Subcommittee on Mental Health, heard from several providers about the burdensome and sometimes delayed process by which community hospitals bill and receive payments under the three-way contracts. In addition, the existing rate of $750 per day is insufficient to cover the cost to serve higher-need mental health patients.

RECOMMENDATION 2: The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services, encourage the General Assembly to direct the Department of Health and Human Services to work with the community hospitals to develop a plan to (i) address delayed payments and (ii) revise three-way contract payment from a single rate model to a tiered rate structure based on the patient's acuity level. The Department shall submit a plan to the Joint Legislative Oversight Committee on Health and Human Services and the Chairs of the House and Senate HHS Appropriations Subcommittees no later than October 1, 2013.

In response to the Subcommittee's recommendations, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS or the Division) of the North Carolina Department of Health and Human Services (DHHS) has taken a number of actions to help address the findings in question. This work is also consistent with Section 12F.2 of Session Law 2013-360.

THREE WAY CONTRACT WORKGROUP: DMH/DD/SAS initiated a three-way contract workgroup during the early stages of implementing the community three-way inpatient hospital beds project. The workgroup is comprised of representatives of: DMH/DD/SAS; Division of State Operated Healthcare Facilities; North Carolina Hospital Association (NCHA); The North Carolina College of Emergency Physicians; Local Management Entity-Managed Care Organization (LME-MCO) staff - a Medical Director, a Care Coordinator and Finance staff; and various hospital representatives. The workgroup has proven to be very beneficial in the overall operation of the community

three-way inpatient bed program by focusing on the most acute type of patient, forging state and local collaborations, and addressing quality initiative issues.

ALTERNATIVE CLAIM PAYMENT PROCESS: The Division worked with the NCHA, LME-MCOs, and contracted hospitals to design a solution for claims payment issues. Per the special provision for Inpatient Psychiatric Beds or Bed Days (Session Law 2011-145 Section 10.8(b)) if "*...the LME has failed to comply with the prompt payment provisions of this subsection, the Department may contract with another LME to manage the beds or bed days, or, notwithstanding any other provision of law to the contrary, may pay the hospital directly.*" In State Fiscal Year (SFY) 2012, the Division implemented a process to allow for the local hospitals to submit an alternate claim directly to DMH/DD/SAS. These claims are submitted only when the LME-MCO has not paid that submitted claim within 60 days from the original claim submission date. During SFY 12 there were no instances whereby claims were paid directly to the local hospital.

DEVELOPMENT OF A 2 TIERED STRUCTURED RATE: The Three-Way Contract Workgroup reviewed the recommendation on the need to implement an additional and higher service tier to serve more challenging and complicated patients than those currently being served at the lower rate.

The Workgroup developed the following:

- Criteria for the determination of the level of care for the more acute type patient (Appendix A)
- Selection process for the appropriate type of facility to render services(Appendix B)
- A $900 daily rate for the more acute type patient per the legislation and will soon select the pilot hospitals for program implementation based on the above criteria.

CONCLUSION:

The Three-Way Contract Project has been successful in expanding community capacity for short term stay inpatient services, thereby improving access to this service close to home for most of these patients. As this program evolved, hospitals expressed concerns about the inadequacy of the $750 per day for the more complex and challenging patients. The recommendation therefore asked the DHHS to development a plan for a two-tiered 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 has become necessary to develop criteria for new hospital beds within an existing contract. Next steps involve selecting three hospitals - one from each region to pilot the higher of the two-tiered rates.

Appendix A

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 detox 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.

APPENDIX B

3 Way Contract Selection Criteria

Requirements (per Contract and Legislation)

1). Involuntary Commitment 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 just 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 under 7 days. Preference given to hospitals where LME-MCO catchment has relatively high utilization of state facility psychiatric inpatient beds where average length of stay < 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. (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 (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 average length of stay < 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.)