Nothing Compares
NORTH CAROLINA

Joint Legislative Oversight Committee
on Health and Human Services
November 29, 2016

Department of Health and Human Services

Alcohol and Drug Abuse Treatment Centers Transition to Receipt-Supported Funding

Current Environment

- Nearly 21 million Americans – *more than the number of people who have all cancers combined* – suffer from substance use disorders *
- 1 in 7 people in the US is expected to develop a substance use disorder at some point in their lives, yet only 1 in 10 receives treatment *
- Nearly 705,000 youth and adults in North Carolina are in need of Substance Abuse Services **

** U.S. Department of Health & Human Services (2016). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health. Retrieved from https://addiction.surgeongeneral.gov/*

*** SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2013 and 2014, published 12/16/15, Table 20*

ADATC Evolution

- **1950 - 1988:** *Alcohol Dependence* treatment
- **1989 - 2000**: Alcohol *and other Drug Addiction* treatment
- **2001:** *Construction of locked units*
- **2002 - 2007:** *Detox, crisis stabilization and treatment for individuals on Involuntary Commitment (IVC)*
- **2008 - 2014:** *Co-occurring addiction and mental health* treatment
- **2015 – present:** Development of a business model transitioning the ADATCs from serving a primarily indigent population to serving a mix of indigent and those individuals with other third-party funding sources (i.e. 100% receipt-supported)

Changing ADATC Mission

SL 2015-241 SECTION 12F.12 - Terminate all direct State appropriations for ADATCs beginning with SFY16 and appropriate funds to DMH/DD/SAS to allow LME/MCOs to assume responsibility for managing the full array of publicly funded substance abuse services, including inpatient services delivered through the ADATCs, *so that the ADATCs shall be one hundred percent receipt-supported.*

CURRENT:	**CHANGE IN:**
• Provision of specialized inpatient indigent/safety net services for individuals with addiction, medical and psychiatric acuity that exceed the expertise and array of services available in the community	• **POPULATION** (e.g. adolescent services) • **PAYOR** (e.g. non-indigent) • **SERVICES** (e.g. different levels of ASAM (American Society of Addiction Medicine) care
• No Utilization Review (UR) department	• Create robust UR departments to recoup appropriation dollars from MCOs
• Billing processed through Controllers Office - Central Billing Office (CBO)	• Develop billing structure for multiple payors
• Minimal administrative structure	• Increase Administrative Structure to function like other receipt-supported providers

• Priority admission given to:
  • Pregnant/Perinatal
  • IV drug users
  • Indigent/Uninsured
	• Shift priority to payor source

Action Steps - Completed

- ☑ Preliminary call between DMH, DSOHF and LME/MCOs to discuss funding transition (5/24/16)
- ☑ First DMH, DSOHF and LME/MCO call to discuss details on transition (6/29/16)
- ☑ DMH, DSOHF and LME/MCO meeting to negotiate financial, UM and monitoring processes (9/8/16)
- ☑ DMH, DSOHF, DHHS attorneys and LME/MCO attorneys discussed changes in processes (10/21/16)
- ☑ DSOHF providing specific county-level data on a monthly basis to each MCO as to who they are serving (10/7/16)
- ☑ LME/MCOs have paid their respective ADATCs two-twelfths of 90% of the allocation (10/18/16)
- ☑ TRICARE approved as out-of-network provider for SA Rehab Services (10/31/16)
- ☑ ADATCs have made operational changes to model themselves after other “for-profit” providers and have repurposed direct care clinical positions to establish UR departments (ongoing)
- ☑ Established relationships with other third-party payors (ongoing)

Action Steps - Remaining

- Pilot of electronic UR process with Trillium MCO (by December 2016)
- 2 MCOs to be identified to pilot electronic billing process (by December 2016)
- Researching development of tiered service rates (by 6/30/17)
- Analyzing staff and financial requirements for ADATCs to bill LME/MCOs electronically (by 6/30/17)

Challenges We are Facing

Balancing third-party and indigent admissions:

- Challenging to balance SL 2015-241 SECTION 12F.12 (ADATCs 100% receipt supported) with existing safety net rule:
  - 10 NCAC 1C.0201(a) Priority for admission to facilities under Department of Human Resources will be given to the indigent where documentary evidence is furnished to provide such indigency
- Demand for services could likely exceed funding if the number of self-pay (e.g. walk-ins, EMTALA, IVCs) are greater than the allocation amount
  - EMTALA- Emergency Medical Treatment & Labor Act - Ensures public access to emergency services regardless of ability to pay

Costs of doing business:

- Funding the increase in costs related to payroll and inflationary adjustments
- Costs associated with establishing UR and billing processes
- Medical equipment replacement

Authorization/UR:

- Unauthorized and denied patient days - ADATCs will be held accountable for the cost for care for safety net patients (e.g. pregnant, Opioid Treatment Program (OTP), sex offender) in need of ADATC inpatient treatment, often with community placement barriers that impact appropriate discharge
- Due to Federal Confidentiality (42CFR), the ADATCs can bill third-party payors *only* if patient signs consent for release of information
- Current process for denial of authorizations gives appeal rights *only* to patients and not to the ADATCs

Moving Forward

CAPACITY:

Determine a limit to the number of beds that can be dedicated to serving the indigent/uninsured population

CONTRACTS:

Finalize details with existing third-party payors for designated number of contracted beds

PAYORS:

Expand relationships with third-party (e.g. TRICARE, VA, Acute Care Hospitals, Other HMOs/PPOs)

BILLING and UR:

Implement electronic authorization and billing functions

MISSION:

Assess change in population and mission to increase revenue