

**Report on Plan to Allow the ADATCs to Remain One  
Hundred Percent (100%) Receipt-Supported  
Session law 2015-241, SECTION 12F.12.(c)**



**Report to the  
Joint Legislative Oversight Committee on Health and  
Human Services  
and  
The Fiscal Research Division  
by  
North Carolina Department of Health and Human  
Services**

**March 1, 2016**

## Introduction

**SECTION 12F.12.(c)** *By March 1, 2016, the Department of Health and Human Services shall develop and report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division a plan to allow the ADATCs to remain one hundred percent (100%) receipt-supported. The report shall include an evaluation of (i) other community-based and residential services that could be provided by the ADATCs and (ii) potential funding sources other than payments from the LME/MCOs, including funding available from estimated receipts from Medicare, Medicaid, insurance, and self-pay.*

The following plan is a product of multiple collaborative meetings between the Division of State Operated Healthcare Facilities (DSOHF), the LME/MCOs and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS). Stakeholders have agreed that this legislation will only be successful if it is a joint effort, which resulted in willingness from all parties to exchange ideas and engage in open dialogue.

Having the ADATCs 100% receipt supported will create a market-driven utilization of the ADATCs, with an emphasis on increased state and local direction in the use of these state funds. It is important to note that state substance abuse disorder funds that are being allocated to LME/MCOs for the first time in SFY 15-16 for the purchase of inpatient levels of care are also needed for the state to maintain its Federal maintenance of effort level of expenditures.

In addition, it is important to note that current Administrative Rules (10 NCAC 1C.0201) require the ADATCs to serve as the safety net provider and to provide services to the indigent, regardless of their ability to pay, which remains a key factor regarding the base for receipt-supported efforts.

It is critical to ensure that statewide safety net services are retained for individuals with substance use and co-occurring mental health diagnosis that are indigent, homeless, unemployed and involved in the criminal justice system. (See Appendix A for SFY 15 ADATC patient profile data) Any impact to or reduction in available ADATC beds will further impact the Emergency Departments (EDs), psychiatric hospitals, and the criminal justice system that the Governor's Task Force is focused on addressing.

### **(i) Evaluation of other community-based and residential services that could be provided by the ADATCs:**

Increasingly, health care entities are emphasizing quality and caring for the whole person. In addition, new payment/reimbursement models are encouraging hospitals to focus on wellness and earlier care as a way to prevent costlier acute care in the future. These approaches focus on coordination of care, development of partnerships with other providers, development of an integrated delivery system, and creation of a relationship with the customer before the need for acute services arises.

As a revenue producing approach, inpatient hospitals are expanding their service lines to include lower levels of care (e.g. residential and intensive outpatient) to adjust to these new

payment/reimbursement models, but to also reduce readmissions, decrease costs, increase patient satisfaction. Inpatient settings that also offer lower levels of care have greater control over the entire continuum of care and places hospitals in a position of greater financial viability and enhanced relationships with their customers (Kutscher, 2012).

#### Collaboration and Consultation:

The ADATCs identified Dr. David Mee-Lee, a leading expert in co-occurring substance use and mental disorders, to provide guidance to the change process. He is Chief Editor of *The ASAM Criteria*, the most comprehensive set of guidelines for assessment, service planning, placement, continued stay and transfer/discharge of individuals with addiction and co-occurring conditions. The American Society of Addiction Medicine (ASAM) produces the criteria to improve access to care, multidimensional assessment, patient-centered service plans and efficient outcomes-driven treatment and recovery services (American Society of Addiction Medicine, 2013).

Consultation with Dr. Mee-Lee emphasized that inpatient substance abuse facilities will need to focus their efforts on following the trend of acute hospitals that are reducing inpatient treatment days and focusing on expanding the continuum of care. (D. Mee-Lee, Personal Communication, November 23, 2015).

Following the current trends and taking into consideration the suggestions of Dr. Mee-Lee, the ADATCs will continue their evaluation of the behavioral health and integrated health trends and will also continue to explore service expansion in response to results of the ongoing community needs assessments and will work to align services to be responsive to the needs of populations served.

An invitation was extended for the LME/MCOs to visit the ADATCs to discuss services and how to proceed with improving the current business partnerships. Each ADATCs clinical leadership team hosted the LME/MCO Chief Executive Officers (CEOs) in their catchment area for a facility tour and meeting.

The planning meetings were effective and provided the following key findings:

- Validated ADATCs as a resource for the acute, psychiatrically co-morbid patient that is unsuccessful at lower levels of care
- Confirmed that lower levels of inpatient rehabilitation services are not consistently available across the state
- Acknowledged a shared responsibility in providing indigent care
- Identified a lack of services for adolescents with acute substance use and other co-occurring needs as well as for those individuals that are often high utilizers of services
- Acknowledged that the ADATCs need to build financially viable system while continuing to provide safety net services
- Suggested that the ADATCs align themselves with other service providers that are established with different payer sources

- LME/MCOs stated that their role is to further identify needs across the state and to establish ongoing collaboration with the ADATCs concerning the need for services along the continuum of care
- Current service array and costs will be broken out into individual service lines, to align with community treatment needs along the continuum of care
  - ASAM 3.9 Medically supervised detox/crisis stabilization inpatient services
  - ASAM 3.7 Medically monitored intensive inpatient services
  - ASAM 3.5 Clinically managed high intensity residential service
  - Perinatal, Opioid Treatment Program and others as identified by the referral community

A uniform authorization process shall be developed by DHHS, in consultation with the LME/MCOs for those individuals whose care is managed and paid for by the LME/MCOs. The LME/MCO for the catchment area in which the individual resides is responsible for providing authorization for individuals referred to the ADATC. If the LME/MCO approves admission, the LME/MCO shall be financially responsible for services rendered by the ADATC to the individual, up to and including the day of discharge.

In addition, it is recommended that if the LME/MCO denies admission, the LME/MCO shall be financially responsible for services rendered by the ADATC and for making arrangements for the individual to receive alternative substance abuse services.

The Department, the LMEs/MCOs and other key stakeholders will continue to work together to assess service gaps and market dynamics to determine the demand for services statewide. Work will continue to determine appropriate costs and rates that will support new services toward the goal of providing the most effective and efficient services at the least cost while maintaining client safety and best outcomes.

### New Initiatives/Pilots

Smoky Mountain LME/MCO has been working with Julian F. Keith (JFK) and the DSOHF on a proposed process to facilitate a fast-track referral. This effort will ensure the continued availability and accessibility of inpatient safety net services for individuals with the most complex needs.

Cardinal LME/MCO, along with JFK and DSOHF are pursuing a pilot which will explore additional capacity in local communities to decrease the burden on EDs and Psychiatric Hospitals. They are in the process of reviewing data to determine JFKs ability to expand services into the community by:

- Creating a front door to increase access to JFKs specialized inpatient services
- Identifying individuals in local EDs in need of inpatient treatment at JFK
- Providing transportation to expedite access to acute inpatient services
- Developing a seamless community transition process
- Assessing the need for lower levels of care in Cardinal catchment area

R.J. Blackley (RJB) is assessing the statewide need for adolescent inpatient services to determine if additional capacity is needed, the feasibility of expanding services and the reimbursement options for providing these services. With an increase in demand, RJB could expand services (utilizing closed beds in the de-funded unit), as community providers operationalize the Adolescent Facility Based Crisis service definition which launched on January 1, 2016.

Due to the proximity to the Veterans Affairs (VA) outpatient clinic in Greenville, NC, Walter B. Jones (WBJ) has applied to become an in-network TRICARE provider which would enable any of the Eastern Region VA Clinics (Greenville, Elizabeth City, Fayetteville, Goldsboro, Jacksonville, and Wilmington) to make referrals for adults with co-occurring mental health/substance use disorders. The types and level of services cannot be determined until WBJ is certified by TRICARE. Coverage will vary, depending on the type of TRICARE Health Plan under which the service member, retiree, and/or dependent is covered (e.g. TRICARE Prime, TRICARE Remote or the TRICARE Reserve Select).

TRICARE requires that WBJ operate as a “distinct part” facility to provide substance use disorder services. When a facility provides both inpatient rehabilitation (medically monitored, interdisciplinary, addiction-focused treatment for adults who have psychoactive substance use disorders) and acute inpatient psychiatric services (treatment of acute biomedical/emotional/behavioral problems that require primary medical and nursing services) on the same campus or in the same building, the services must be separated physically and programmatically. WBJ has submitted a business case to DSOHF outlining development of a “distinct part” facility. Trillium and Eastpointe LME/MCOs are both supportive of WBJs efforts to be a TRICARE provider.

Recommendations for inpatient bed capacity must be determined locally through LME/MCO gap analyses, needs assessments and periodic reassessment to include factors that impact capacity and demand for inpatient services. Because demand is impacted by the availability of resources along the respective continuum, these factors may vary across the regions of the state and will be continually assessed to ensure high needs are met for the high acuity population with both medical and co-occurring needs. (See Appendix B)

The Department is working on a process to establish a statement of need from each LME/MCO as to what their service needs are for inpatient and other specialty services. It is imperative that statewide, all parties agree and commit to how the public system will be funded and what the proportions of services and funding priorities will be.

**(ii) Evaluation of potential funding sources other than payments from the LME/MCOs, including funding available from estimated receipts from Medicare, Medicaid, insurance and self-pay:**

Of the total admissions to ADATCs in SFY 15, 85% presented with no source of insurance coverage. For the remaining 15% of those admitted with some form of insurance coverage, there is no guarantee to the ADATC for payment for days served due to the variation in benefit coverage for the individual third-party insurance plans. Of those admitted with

commercial insurance, 46% of days were billable to insurance and 54% days were not covered by insurance. Of the total admissions in SFY 15, 75% had no ability to pay (ATP) which leaves only 25% of total admissions with any ability to pay.

Due to the nature of addiction, by the time individuals reach the ADATCs, they are typically unemployed and without access to health insurance and very few are covered by Medicare and Medicaid (e.g. older adults, women with children and some individuals with other disabilities). Medicaid funding is not available to Medicaid beneficiaries (age 21 - 64) residing in facilities that have been determined to be Institution for Mental Diseases (IMD) according to 42 C.F.R. §435.1010. There are relatively few substance use disorder clients who actually qualify for the North Carolina Medicaid program, and therefore, it is anticipated that state funds transferred to the LME/MCO and other LME/MCO revenue will continue to be the primary source of funding for these individuals. An analysis of the North Carolina Poverty Rate by County (Index Mundi, n.d.) data demonstrates that Eastern NC has a poverty rate of 20.8%, Central NC has a rate of 18.6% and Western NC has a rate of 18.2%.

This plan addresses solutions as the ADATCs continue with the mandate to serve as the safety net provider for an indigent population and continue the transition of remaining 100% receipt supported. Areas that the ADATCs are focused on identifying solutions include:

#### Billing

- Establishing a Medicaid and Full Cost rate for ADATC services through the annual rate setting process. The bundled daily rate will require modification to establish rates for additional services or lower levels of care to bill third-party sources
- Identifying the process and timeframe for the Central Billing Office (CBO) to create a limited charge master for unbundled services:
  - ASAM 3.9 Medically supervised detox/crisis stabilization inpatient services
  - ASAM 3.7 Medically monitored intensive inpatient services
  - ASAM 3.5 Clinically managed high intensity residential service
  - Perinatal, Opioid Treatment Program and others as identified by the referral community
- Invoicing each LME/MCO for the actual number of bed days utilized at each respective ADATC, for the level of service utilized (i.e., Medicaid, Full Cost, Lower Level and/or Additional Services)

Based on historical utilization and actual cost for operating each of the ADATCs, DSOHF developed a Cash Flow Analysis as a snapshot representation of operations for SFY 16/17. (See Appendix D for the Consolidated Statement of Cash Flow) Based on experience from the current fiscal year, in order to ensure continuity of care, it is important to continue to provide the ADATCs with 60 days of cash flow at the beginning of each state fiscal year, followed by a year-end settlement process.

#### Insurance

- DSOHF is exploring rate re-negotiations with Blue Cross/Blue Shield for the ADATCs
- ADATCs are exploring becoming in-network with TRICARE as they are estimated to be the next largest generator of third-party receipts

- RJB has a memorandum of agreement with The Veterans Leadership Council of North Carolina- Cares (VLC-NC Cares) as they plan to build a Veterans Life Center in Butner, NC to serve homeless and at-risk veterans. RJB will also explore becoming a community provider to assist the VA in reducing wait times and increasing access to care for Veterans.
- JFK will explore becoming an in-network TRICARE provider as they are discussing partnership opportunity with the VA clinic located in Asheville
- DSOHF will assess the cost effectiveness of other commercial contracts to address existing and new levels of care

#### HR and Personnel

- DSOHF is assessing hiring and training flexibility to accommodate change in service provision as needs arise for new or specialty services
- DSOHF continues to work with DHHS Human Resources to identify innovative hiring methods that mimic market-driven systems in order to recruit, hire and retain highly qualified staff:
  - Section 30.14 of Session Law 2015-241, Appropriations Act, granted medical flexibility in order for DHHS to be as competitive as possible in the jobs eligible for medical salary flexibility
  - Sign-on and retention bonuses
  - Career fairs and local community college presentations
  - Position re-allocations, job description revisions, and other creative strategies are being considered to flex staff and utilize existing staff to increase third-party revenue

#### Third-Party Billing

- Monthly meetings are held between DSOHF, CBO and Healthcare Enterprise Accounts Receivable and Tracking System (HEARTS) to review third-party payment data for all facilities. There is recognition that receipt income is dependent on many variables such as patient mix and census and varies from quarter to quarter.
- ADATC staff and HEARTS team have met to review billing and coding issues, using the existing HEARTS functionality to improve Utilization Review (UR) processes
  - Detailed UR process mapping was conducted on site at each ADATC to maximize efficiencies and to identify needs
  - System improvements, system issues, and training areas were identified to prepare the ADATCs to maximize third-party receipts
  - DSOHF hired a UR manager who will evaluate the factors involved in the review process, the cost effectiveness of expanding commercial contracts and development of receipt-supported services
  - Conducted a UR walk through at WBJ to map current process compared to “industry standard”
  - Apply recommendations and best practice standards at WBJ
  - Next step to review UR functions at JFK and RJB and incorporate recommendations for improvements
- ADATCs will have to develop marketing strategies to increase third-party payer referrals

### Licensure and accreditation

- Consideration will need to be given to the impact changes in service lines may have on current Joint Commission (JC) Accreditation and Centers for Medicare & Medicaid Services (CMS) certifications for inpatient services as a billing option to generate additional 3<sup>rd</sup> party receipts
- To continue services for the primary substance use population (See Appendix C), WBJ ADATC developed a mock Distinct Part Psychiatric Hospital and a Non-Psychiatric Hospital Program to evaluate the cost-effectiveness of Medicare and Medicaid receipts

There are multiple opportunities in transitioning the ADATCs to being 100% receipt supported that will generate additional third-party revenue. Ongoing research and evaluation will be required to identify the need for inpatient and lower level services, which of those services can be provided and billed for by the ADATC; and what the daily rate will be for those services. Some advantages of these new service models include improved continuity of care (care coordination) and utilization of services as individual's transition between outpatient and inpatient care. Improving internal systems as well as external processes would impact the management of available statewide resources. Based on the demand and need by the community for specialized services, the ADATCs will continue to fill a vital role in each local community.

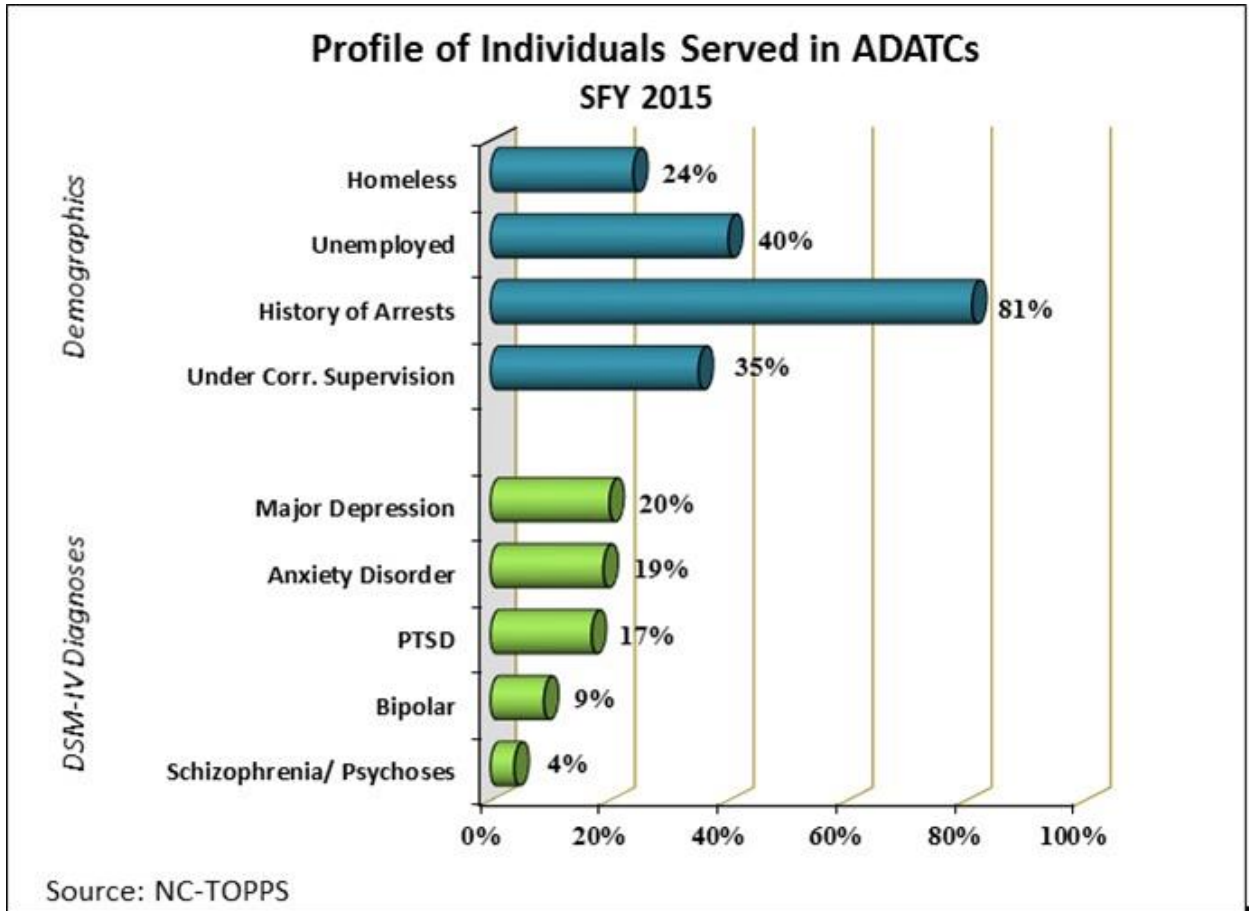
Beginning July 1, 2016, the ADATCs will submit a bill to each LME/MCO according to the established per diem rate. Throughout the course of SFY 17, the utilization of ADATC beds by each LME/MCO will be monitored to assess the need for different levels of care and correspondingly, the establishment of different rates. If needs arise during the course of SFY 17, service rates can be established mid-year as new services are brought up. Identified services and rates will be established and implemented for SFY 18.



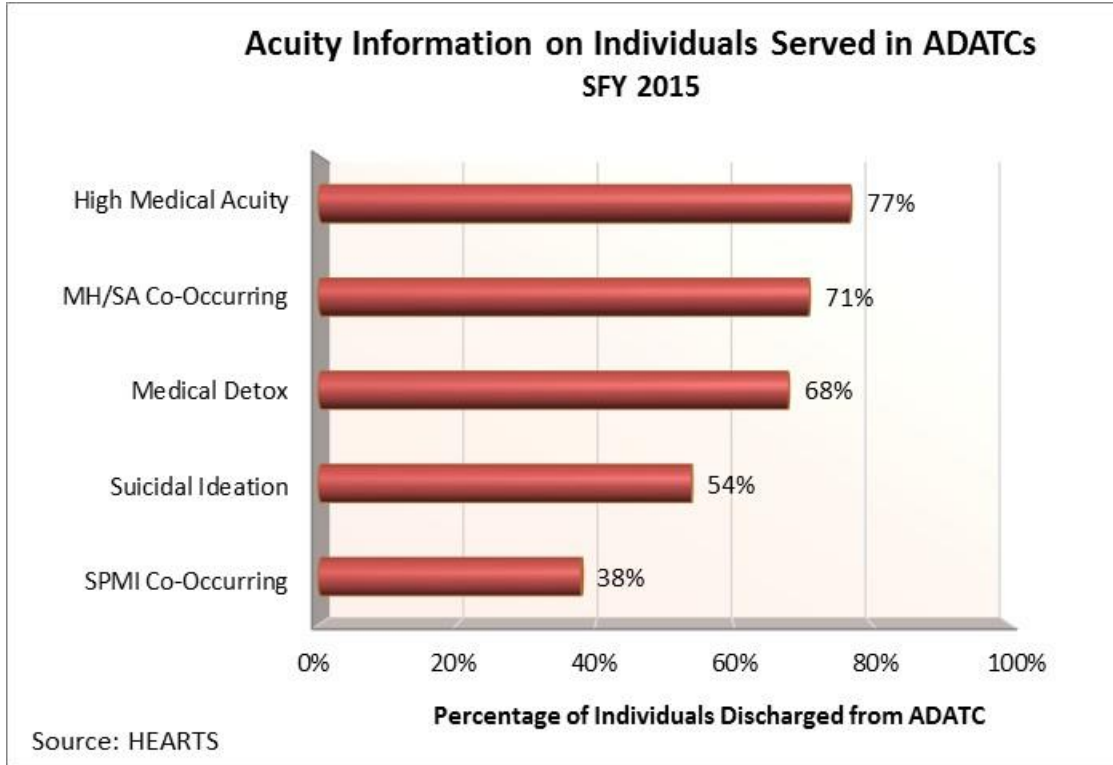
## References

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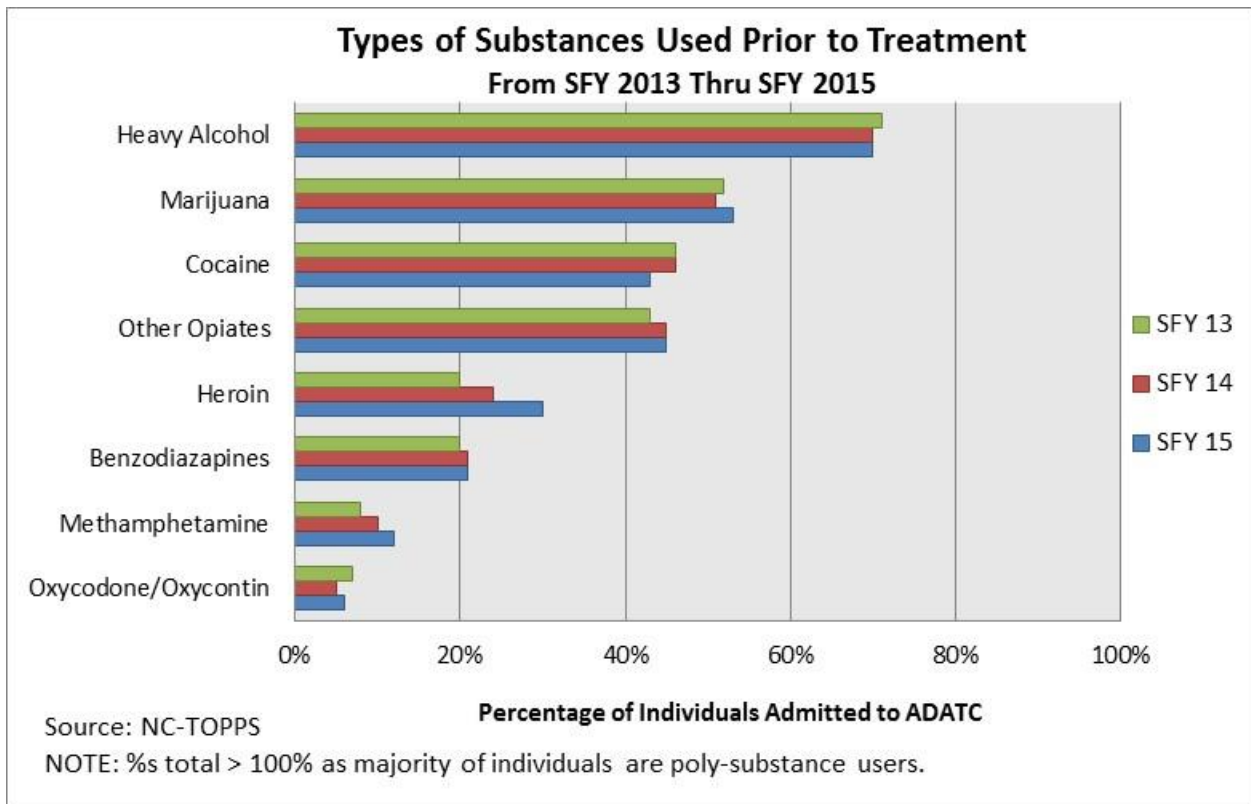
Appendix A



Appendix B



Appendix C



Appendix D

<b>N.C. DHHS - Division of State Operated Healthcare Facilities</b>	
ADATC Consolidated Statement of Cash Flow	
<b>as Projected for SFY 16/17</b>	
<b><u>Projected Cash Flow from Operations - Three ADATC's Combined</u></b>	
<b>Cash Receipts from:</b>	
LME/MCO 90% Reimbursement	\$ 33,643,635
Additional Services Provided to Meet LME/MCO Transitional Needs	1,752,000
Medicare	2,043,350
Medicaid	172,823
Self Pay/Government Benefits	135,000
Third Party Patient Insurance	3,098,398
Referrals from Non-State Inpatient Facilities	2,814,471
Miscellaneous Revenues	138,645
<b>Total Projected Receipts</b>	<b>\$ 43,798,322</b>
<b>Cash Payments for:</b>	
Personal Services - Salaries, Fringes & Other	\$ 32,933,752
Purchased Services - Contracts, Temps, & Other	7,387,776
Supplies - Food, Drug & Other	3,121,502
Property, Plant & Equipment	188,837
Other Expenses, Adjustments & Transfers	166,455
<b>Total Projected Cash Payments</b>	<b>\$ 43,798,322</b>
* Net Increase (Decrease) in Cash from Operating Activities	-
<b>Projected Cash at End of SFY 16/17</b>	<b>\$ -</b>

\* ADATCs will adjust their operating budgets based on projected/actual revenue throughout the year.