Funds for Local Inpatient Psychiatric Beds or Bed Days Purchased in State Fiscal Year 2017-2018 and Other Department Initiatives to Reduce State Psychiatric Hospital Use

Session Law 2017-57, Section 11F.3.(f)

Report to the

Joint Legislative Oversight Committee on Health and Human Services

and

Fiscal Research Division

By

North Carolina Department of Health and Human Services

November 30, 2018

Reporting Requirements

Session Law 2017-57, Section 11F.3.(f) *Reporting by Department. – By no later than December 1, 2018, and by no later than December 1, 2019, 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 preceding fiscal year 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) An explanation of the process used by the Department to ensure that, except as otherwise provided in subsection (a) of this section, local inpatient psychiatric beds or bed days purchased in accordance with this section are utilized solely for individuals who are medically indigent, along with the number of medically indigent individuals served by the purchase of these beds or bed days.

(3) The amount of funds used to pay for facility-based crisis services, along with the number of individuals who received these services and the outcomes for each individual.

(4) The amount of funds used to pay for nonhospital detoxification services, along with the number of individuals who received these services and the outcomes for each individual.

(5) Other Department initiatives funded by State appropriations to reduce State psychiatric hospital use.

Use of Funds and Distribution and Management of Beds/Bed Days

Session Law 2017 – 57, Section 11F.3.(a). *Use of Funds. – Of the funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for crisis services, the sum of forty-one million three hundred fifty-one thousand six hundred forty-four dollars ($41,351,644) in recurring funds and the sum of forty-one million three hundred fifty-one thousand six hundred forty-four dollars ($41,351,644) in recurring funds for the 2018-2019 fiscal year shall be used to purchase additional new or existing local inpatient psychiatric beds or bed days not currently funded by or though LME/MCOs. The Department shall continue to 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. The enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels shall not exceed the lowest average cost per patient bed day among the State psychiatric hospitals. In addition, at the discretion of the Secretary of Health and Human Services, existing funds allocated to LME/MCOs for community-based mental health, developmental disabilities, and substance abuse services may be used to purchase additional local inpatient psychiatric beds or bed days.*

Funds designated in this subsection for the purchase of local inpatient psychiatric beds or bed days shall not be used to supplant other funds appropriated or otherwise available to the Department for the purchase of inpatient psychiatric services through contracts with local hospitals.

SECTION 11F.3.(b) *Distribution and Management of Beds or Bed Days. – Except as provided in this subsection, the Department shall work to ensure that any local inpatient psychiatric beds or bed days purchased in accordance with this section are utilized solely for individuals who are medically indigent, as defined in this subsection. In addition, the Department shall work to ensure that any local inpatient psychiatric beds or bed days purchased in accordance with this section are distributed across the State in LME/MCO catchment areas and according to need as determined by the Department. The Department shall ensure that beds or bed days for individuals with higher acuity levels are distributed across the State in LME catchment areas, including any catchment areas served by managed care organizations, and according to greatest need based on hospital bed utilization data. The Department shall enter into contracts with LME/MCOs and local hospitals for the management of these beds or bed days. The Department shall work to ensure that these contracts are awarded equitably around all regions of the State. LME/MCOs shall manage and control these local inpatient psychiatric beds or bed days, including the determination of the specific local hospital or State psychiatric hospital to which an individual should be admitted pursuant to an involuntary commitment order.*

The Department may use up to ten percent (10%) of the funds allocated in this section for each year of the 2017-2019 fiscal biennium to pay for facility-based crisis services and nonhospital detoxification services for individuals in need of these services, regardless if the individuals are medically indigent, defined as uninsured persons who (i) are financially unable to obtain private insurance coverage as determined by the Department and (ii) are not eligible for government-funded health coverage such as Medicare or Medicaid.

Executive Summary

Session Law 2017 – 57, Section 11F.3.(a) – (f) legislated the continuation of the appropriation, provisions, and requirements to pay for psychiatric and substance use inpatient care provided by community hospitals to individuals who are medically indigent in North Carolina. The appropriation for State Fiscal Year (SFY) 2017 – 2018 was $41,351,644 in recurring funds. https://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2017-2018/SL2017-57.html

The North Carolina Office of State Budget and Management subsequently certified the budget for community hospital psychiatric and substance use inpatient care described hereunder at $40,621,644, with $730,000 being certified to fund a service initiative, Critical Time Intervention, as part of a settlement agreement with the U.S. Department of Justice.

Section 11F.3.(f) of this Session Law requires the North Carolina Department of Health and Human Services (DHHS) to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the following:

1. the use of state and local funds to pay for hospital beds for psychiatric and substance use inpatient care for persons who were medically indigent;
2. how DHHS ensures the state funds that have been appropriated for local inpatient beds/bed days are used solely for persons who are medically indigent;
3. the number of persons served by, and the amount of the state funds appropriated for local inpatient beds/bed days that were carved out to pay for, Facility-Based Crisis and Non-Hospital Medical Detoxification services;
4. other state-funded Department initiatives to reduce State psychiatric hospital use.

State-Funded Local Inpatient Psychiatric Beds or Bed Days (Three-Way Contracts) for Persons Who are Medically Indigent in SFY 2018

The local psychiatric and substance use inpatient beds or bed days funded by Session Law 2017 – 57, Section 11F.3. (a) – (f) are administered by the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) via contracts with Local Management Entities – Managed Care Organizations (LME/MCOs) and community hospitals. These contracts have been dubbed "Three-Way Contracts," as three organizations (DMHDDSAS, LME/MCOs, and community hospitals) are partners to the contracts.

In SFY 2018, there were twenty-nine (29) Three-Way Contracts for psychiatric and substance use inpatient care between DMHDDSAS, the seven LME/MCOs, and 29 community hospitals. The 29 Three-Way Contracts were funded at an overall amount of $40,621,644 to provide psychiatric and substance use inpatient care for persons who were medically indigent in approximately 166 available beds, for 54,109 bed days. Tiered rates have previously been established, per the Session Law, based on the acuity of the persons served: lower rate (procedure code: YP 821) is $750 per bed day; and the higher rate (procedure code: YP 822) is $900 per bed day.

As of August 28, 2018, DMHDDSAS has paid the LME/MCOs, which in turn, paid the community hospitals, for Three-Way Contract psychiatric and substance use inpatient care provided from July 1, 2017 through June 30, 2018 (SFY 2018) in the amount of $38,875,039. A total of 51,959 bed days were purchased, 6,789 persons were served. Claims will continue to be adjudicated for payment until the end of October 2018, for the inpatient services provided during SFY 2018. Note: the entire SFY 2018 budgeted amount of $40,621,644 was expended to pay for lagged claims for Three-Way Contract services from SFY 2016 – 2017, as well as the adjudicated claims for services provided in SFY 2018.

Carved out Funding for Facility-Based Crisis and Non-Hospital Medical Detoxification

Due to the increased utilization of the Three-Way Contracts for psychiatric and substance use inpatient care in SFY 2016-2017 and the continued high utilization during the first half of SFY 2018, none of the appropriated funding for Three-Way Contracts was carved out to pay for Facility Based Crisis (FBC) or Non-Hospital Medical Detoxification (NHMD) in SFY 2018.

Other State-Funded Inpatient Care in SFY 2018

In addition to the Three-Way Contract psychiatric and substance use inpatient services provided by way of the Section 11F.3.(a)-(f) appropriation summarized above, other state funding was used by the LME/MCOs to pay for psychiatric and substance use inpatient services that were delivered by community hospitals during SFY 2018. The North Carolina General Assembly appropriated funds, known as Single-Stream funding, to the LME/MCOs to pay for a continuum of services to people without health insurance coverage for mental health, substance use, and intellectual and developmental disabilities services and supports.

Single-stream state-funds that were directly allocated to the LME/MCOs were used to purchase psychiatric and substance use inpatient care in SFY 2018 for persons who were medically indigent. Six LME/MCOs paid for psychiatric inpatient services for 2,779 individuals in community hospitals at a cost of $15,472,098, paying for 22,121 bed days (procedure code: YP 820).

Other Locally-Funded Inpatient Care in SFY 2018

Four LME/MCOs reported to DMHDDSAS that they were able to access local funding to purchase or supplement additional psychiatric inpatient services in community hospitals. A total of $7,728,153 was paid to community hospitals for inpatient care. These local funds were reported to have purchased 10,120 bed days and served 922 people. However, one of the LME/MCOs used much, if not all, of its local funding to pay for YP 820 inpatient care, which was also reported in the Other State-Funded Inpatient Care. Hence, there is significant duplication across the Other State-Funded and Other Locally-Funded inpatient care data.

Three-Way Contract Inpatient: Expected Impact and Findings

By strengthening and expanding community psychiatric and substance use inpatient beds, Three-Way Contract funding was expected to have substantial impacts in several areas:

1. to reduce the need for short-term lengths of stay (7 days and less) at state psychiatric hospitals;
2. to decrease emergency department (ED) wait times and impact on law enforcement; and
3. to stop trend toward closure of community inpatient beds.

Regarding these three areas of expected impact, the report explains that the following:

1. short-term lengths of stay at state hospitals continues a downward trend; and that multiple reasons, including the increase in Three-Way contract beds in the community, may account for that desired decrease;
2. DMHDDSAS does not have recent ED wait time data for Three-Way Contract beds. With the implementation in March 2018, of the Behavioral Health Crisis Referral System (BH-CRSys), DMHDDSAS will have the capability to track and monitor ED

wait times on external referrals for those EDs that utilize the BH-CRSys. It is anticipated that initial data will be available by January 2019.

That being said, the problem of lengthy ED wait times or ED boarding is aptly described in the Strategic Plan for Improvement of Behavioral Health Services: "At its core, the 'ED boarding' issue in North Carolina is not a psychiatric bed issue. It is a community-based services issue (p. 5)." https://files.nc.gov/ncdma/documents/Reports/Legislative_Reports/SL2016-94-Sec12F-10-and-SL2017-57-Sect11F-6_2018_01.pdf

3. Since 2000, when the number of licensed psychiatric beds for adults was 1,813, the number of beds declined to a low of 1,216 in 2008; however, since then that number has risen each year to 1,755 in 2018; while this increase (42%) of 523 beds includes some of the 166 Three-Way Contract beds, a larger number of beds have become licensed in addition to those funded by Three-Way Contracts.

Three-Way Contract Inpatient: Improvements & Other Initiatives

After receiving input from LME/MCOs, community hospitals, and the DHHS General Counsel on a proposed revision to the Three-Way Contract, DMHDDSAS implemented a revised contract on February 1, 2017. The revised contract substantially improved upon the foundation of the original contract with respect to the service description by:

1. identifying service eligibility and medical necessity criteria;
2. clarifying requirements for initial authorization and continued stays; and
3. modifying some of the monitoring requirements.

DMHDDSAS has also reduced the reporting requirements of the hospitals, as DMHDDSAS has the capacity to access most of the needed monitoring data from claims in NCTracks.

Other funded initiatives are discussed in **Section V.** that are designed to reduce psychiatric and substance use admissions to EDs (i.e., 24-hour behavioral health urgent care centers (BHUCs) and case management services) and serve as an alternative to the psychiatric and substance use inpatient level of care (i.e., 24-hour FBC beds).

Suggestions to Sustain the Success of Three-Way Contract Inpatient and Alternative Crisis Response Initiatives

Hospital Emergency Departments and inpatient services should be reserved for and used to treat persons with acute behavioral health crises that cannot be treated at a lower level of care. The needs of individuals that are appropriate for hospital emergency departments include the need for acute medical stabilization (e.g., injuries, emergent medical illness) along with behavioral health crisis stabilization. Persons who need only behavioral health crisis response and stabilization can be appropriately served at lower levels of care, including FBCs, NHMD, BHUCs, Assertive Community Treatment, Community Support Team, and other intensive outpatient services.

To ensure the sustainability of effective community hospital psychiatric and substance abuse inpatient care, and other crisis response services, BHUCs, FBCs, and NHMDs, it is essential that these services are supported by a fully-funded, broadly available, and functioning foundation of lower level, integrated community services for North Carolinians who have mental illness, substance use disorders, and intellectual and developmental disabilities. In order to have a state-wide impact on unnecessary visits to hospital EDs and admission to behavioral health inpatient level of care, the number of Tier IV BHUCs, FBCs (for both adults and children/adolescents), and NHMDs should be increased, especially in locations having close proximity to hospitals with EDs and behavioral health inpatient beds.

Funds for Local Inpatient Psychiatric Beds or Bed Days Purchased in State Fiscal Year 2017-2018 and Other Department Initiatives to Reduce State Psychiatric Hospital Use

December 1, 2018

I. Uniform System for Beds/Bed Days

In 2008, NC Department of Health and Human Services (DHHS) convened a task force comprised of hospital administrators, psychiatrists, other clinicians and providers, Local Management Entity (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, over 200 adult psychiatric inpatient beds in community hospitals were reportedly closed.

During that same period, admissions to state psychiatric hospitals, Dorothea Dix Hospital (Wake County), John Umstead Hospital (Granville County), Broughton Hospital (Burke County), and Cherry Hospital (Wayne County) for inpatient care had steadily risen resulting in a length of stay of seven days or less representing more than fifty percent (50%) of all admissions in State Fiscal Year (SFY) 2006–2007. In catchment areas when 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. The North Carolina General Assembly (NCGA) appropriated $8,121,644 for community psychiatric inpatient care in SFY 2008-2009 (hereinafter, SFY 2009) though the funding was limited to new beds only.

In response to the closures of Dorothea Dix Hospital and John Umstead Hospital and the reduction of state psychiatric beds over the past two decades, the NCGA has appropriated state funds to increase access to psychiatric inpatient care in community hospitals beyond the state and local funds that had been already made available. The newly funded inpatient beds became known as Three-Way Contract psychiatric/substance use inpatient beds, reflecting the three partners involved in the contracted service: DMHDDSAS, LME/MCOs, and community hospitals. A rate of payment was established at $750/bed day per the Three-Way Contract psychiatric/substance use inpatient service.

The NCGA initially funded the Three-Way Contract psychiatric and substance use inpatient beds for SFY 2009 (Session Law 2008-107) and has appropriated funding for each SFY since then. The NCGA has increased the appropriated dollar amount several times since SFY 2009; in Session Law 2009-451, Session Law 2013-360, and most recently for SFY 2018 in Session Law 2017-57.

With the increases in the appropriations since SFY 2009, DMHDDSAS has been able to increase and fund community hospital inpatient psychiatric beds or bed days that were not already funded by or through LME/MCOs. The approximate number of available Three-Way Contract psychiatric and substance use inpatient beds has increased since SFY 2009 from 77 to 166 in SFY 2018. See Attachment 1 for a map showing all of the Three-Way Contract hospital locations with the number of available beds at each facility, effective July 1, 2018. Note the number of beds on the map was adjusted for SFY 2019 to better align the bed number with the contract amount for each hospital; this adjusted resulted in a slightly different number, 163, for the SFY 2019 Three-Way Contracts.

The overall purpose of the funds for community hospital psychiatric inpatient care is to strengthen and expand community capacity to ensure that medically indigent individuals, who experience crises related to their mental illness, substance use disorder or developmental disability, receive appropriate inpatient level of care, when necessary, in the communities in which they live. By serving an individual in the community, the hospital provides care closer to home, family, friends, and community service providers; thus, reserving the state hospitals' resources for individuals whose needs require more intensive and/or longer-term hospitalization or specialty services that only state hospitals can provide.

By strengthening and expanding community psychiatric inpatient beds, the funding was expected to have substantial impacts in several areas:

1. to reduce the need for short-term lengths of stay (7 days and less) at state psychiatric hospitals;
2. decrease emergency room wait times and impact on law enforcement; and
3. stop trend toward closure of community inpatient beds.

Discussion of the above expectations and the presentation of additional measures are included within the body of this report.

All beds created by way of the legislative appropriation must also be available for involuntarily committed individuals who would otherwise qualify for admission to a state psychiatric hospital. The inpatient beds contracted through the Three-Way contracts serve as a regional resource. Although Three-Way Contracts are awarded to each LME/MCO and selected community hospitals in the LME/MCO's catchment area, the hospital beds are available to any medically indigent individual from any county in North Carolina, who requires inpatient hospitalization. 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 utilization management, adjudicating and paying claims from community hospitals, and participating in discharge planning designed to connect individuals to community-based services upon discharge from the hospital.

Two-Tiered System Payment Rates and Services

At the request of representatives of several Three-Way Contract community hospitals, who expressed concerns about the costs of serving persons who have higher levels of acuity, the NCGA issued the following directive in Session Law 2013-360, Section 12F.2.(a) to DHHS:

> *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…*
> *https://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2013-2014/SL2013-360.html*

Subsequently, DMHDDSAS convened a workgroup, consisting of community hospitals, LME/MCOs, and DHHS representatives, to develop a second, higher payment rate and more resource-intensive service (dubbed Enhanced Three-Way Contract psychiatric and substance use inpatient), to the existing Three-Way Contract psychiatric inpatient service (lower tier). The workgroup developed the eligibility criteria for admission to Enhanced Three-Way Contract psychiatric and substance use inpatient care, and DHHS/DMHDDSAS established the rate of $900/bed day per the additional directive in the Session Law 2013-360, Section 12F.2.(a):

> *The enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels shall not exceed the lowest average cost per patient bed day among the State psychiatric hospitals.*
> *https://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2013-2014/SL2013-360.html*

Both the lower and higher tiered rates are inclusive of all professional and ancillary charges (laboratory tests, medications, physician's fees, etc.) and a week of psychotropic medication upon the individual's discharge.

With the SFY 2013-2014 appropriation of $38,121,644 in funding, $2 million was used to contract with three LME/MCOs and three community hospitals for the Enhanced Three-Way Contract psychiatric and substance use inpatient care in a total of six beds (two beds per hospital).

The $900 per bed day rate for Enhanced Three-Way Contract psychiatric and substance use inpatient level of care is intended to purchase a higher level of care in community hospitals for eligible patients who meet a higher level of behavioral and/or medical acuity, similar to the level of care provided in the regional State Psychiatric Hospitals.

Three-Way Contracts: Basic Agreement

The Three-Way Contract for psychiatric and substance use inpatient care is an agreement among three partners, DMHDDSAS, LME/MCOs, and community hospitals, to provide medically necessary psychiatric and/or substance use inpatient treatment to persons who are deemed to be

medically indigent. In accord with the contract agreement, the community hospitals make beds available to admit persons who are eligible for and whose care is authorized by the LME/MCOs. The community hospitals deliver the inpatient treatment and then submit claims to the LME/MCOs. The LME/MCOs adjudicate the claims, and then pay the hospitals for the episodes of care that were authorized and adjudicated for payment. The LME/MCOs then submit claims to DMHDDSAS via NC TRACKS for adjudication and reimbursement.

On February 1, 2017, DMHDDSAS implemented a revision to the Three-Way Contract. The revised contract substantially improved upon the foundation of the original contract with respect to the service description, identifying service eligibility and medical necessity criteria, authorization for admissions and continued stays, and monitoring of the contract requirements. DMHDDSAS has also reduced the reporting requirements of the hospitals, with the current capacity of accessing most of the needed monitoring data from NCTracks.

Three-Way Contract Inpatient Funds: Solely for Persons Who are Medically Indigent

NC DHHS, DMHDDSAS, ensures that the local inpatient beds or bed days purchased in accordance with Section 11F.(a) are used "solely for individuals who are medically indigent" via the requirements contained within Three-Way Contract, and by the claims adjudication process employed in NCTracks.

Three-Way Contract contains the following pertinent excerpts presented in part:

> The primary purpose of this contract is for the establishment and usage of New Local Psychiatric Inpatient Bed Capacity at the local community level to cover the cost of indigent acute care. (p. 1; Initial paragraph, stating the purpose of contract)
>
> The patient shall be medically indigent (uninsured), 18 years of age or older… (pp. 6, 7; Utilization Management Options for Admissions)

The NCTracks adjudicates claims for payment for Three-Way Contract psychiatric and substance use inpatient services that were provided only to persons who had no other health insurance payer for that inpatient care; that is, only for those who were medically indigent. NCTracks' adjudication process includes the identification of other existing health insurance payers for the person whose inpatient service is reflected by the claim. If another existing health insurance payer is discovered that covers the inpatient service, NCTracks will deny the claim; ensuring that the Three-Way Contract funds are used solely for persons who are medically indigent.

Three-Way Contracts: Dates of Service and Dates of Payment

The appropriated funds for each state fiscal year (SFY) for Three-Way Contract inpatient services do not carry forward beyond the end of the SFY for which they are appropriated. If any funds that were appropriated and budgeted in a SFY are unspent by the end of that SFY, the remaining unspent funds are reverted; that is, those funds are moved out of the DMHDDSAS reserve fund and become unavailable to pay for Three-Way Contract inpatient care.

Claims for Three-Way Contract psychiatric and substance use inpatient services that are provided near the end of the SFY are often adjudicated for payment after the end of that same SFY, due to claims lag (i.e., time period between a claim being submitted and being adjudicated). When the DMHDDSAS reserve fund for Three-Way Contracts has been expended prior to the end of the SFY or unspent DMHDDSAS reserve funds have been reverted at the end of the SFY, payments for those adjudicated claims from the prior SFY are funded from the new SFY's Three-Way Contract appropriation/budget.

In this report, the dollars paid (i.e., claims adjudicated for payment) columns in Table 4 reflect the amount of the SFY 2018 appropriation/budget that was paid for Three-Way Contract psychiatric and substance use inpatient services, which were provided between July 1, 2017 and June 30, 2018. These expenditures are tracked and reported as payments made based on dates of service (DOS), which is the way DMHDDSAS monitors each contract's utilization and expenditures for the SFY.

As described above, however, some of the SFY 2018 Three-Way Contract appropriation/budget had to be used to pay for the lagged claims for services in SFY 2017. Because the LME/MCOs and community hospitals received payments for services provided in SFY 2018 from two appropriations (i.e., SFY 2018 and SFY 2019), the expenditures have been tracked by date of payment (DOP) to monitor the funds spent and remaining in the DMHDDSAS reserve fund that was budgeted for Three-Way Contract inpatient services in SFY 2018.

Three-Way Contracts: LME/MCOs, Hospitals, Beds, and Amounts for SFY 2018

The following table (Table 1) provides an overview of the Three-Way contracts for SFY 2018. With DMHDDSAS as the state contracting partner, the LME/MCO contractors and community hospital contractors are identified, along with the number of beds and expected number of bed days to be used, and the dollar amount of each contract. Totals for the contracts within each LME/MCO catchment area are provided. Additionally, the state-wide totals are shown: 29 hospitals and contracts; 166 available beds, 54,109 bed days; and an overall amount of $40,621,643.

Table 1. Three-Way Contract Hospitals, Beds, and Contract Amounts in SFY18 from S.L. 2017-57 State Appropriation

LME/MCO	3-Way Contract Hospitals	Beds/Bed Days (Aligned with Contract Amount)	SFY 18 Contract Amounts
Alliance Behavioral Healthcare	Cape Fear Valley Hosp.	3 (950 bed days)	$ 712,603
	Duke University Health	4 (1,293 bed days)	$ 969,442
	Johnston Health System	5 (1,656 bed days)	$ 1,241,667
	UNC Hosp.-Wake Brook	5 (1,653 bed days)	$ 1,239,924
Alliance Total	**4 contracts**	**17**	**$ 4,163,636**
*Cardinal Innovations Healthcare Solutions	Cone Health Alamance Regional	3 (1,047 bed days)	$ 785,417
	Carolinas Healthcare: Charlotte & Davidson	7 (2,288 bed days)	$ 1,715,754

LME/MCO	3-Way Contract Hospitals	Beds/Bed Days (Aligned with Contract Amount)	SFY 18 Contract Amounts
	Halifax Regional Medical Center	4 (1,153 bed days)	$ 864,495
	*Novant Health Presbyterian Medical	8 (2,553 bed days)	$ 1,916,250
	Novant Health Forsyth Medical Center	10 (3,394 bed days)	$ 2,545,833
Cardinal Total	**5 contracts**	**32**	**$ 7,827,749**
Eastpointe Human Services	**Nash Hospitals (Coastal Plain Hospital)	2 (724 bed days)	$ 543,000
	Southeastern Health	4 (1,367 bed days)	$ 1,025,000
	Vidant Duplin Hospital	4 (1,380 bed days)	$ 1,035,364
Eastpointe Total	**3 contracts**	**10**	**$ 2,603,364**
*Partners Behavioral Health Management	*Catawba Valley Medical	12 (4,231 bed days)	$ 3,206,405
	Davis Regional Med. Center	5 (1,505 bed days)	$ 1,128,446
	DLP Frye Regional	8 (2,746 bed days)	$ 2,059,803
	Carolinas Healthcare Sys. Kings Mountain	7 (2,275 bed days)	$ 1,705,884
Partners Total	**4 contracts**	**32**	**$ 8,100,538**
Sandhills Center for MH/DD/SA Services	FirstHealth Moore Regional	5 (1,584 bed days)	$ 1,187,718
	Good Hope Hospital	5 (1,628 bed days)	$ 1,220,833
	Moses H. Cone Hospital	8 (2,677 bed days)	$ 2,007,915
Sandhills Center Total	**3 contracts**	**18**	**$ 4,416,466**
Vaya Health (formerly Smoky Mountain Center)	Charles A. Cannon Memorial Hospital	3 (1,052 bed days)	$ 788,907
	DLP Haywood Regional	4 (1,114 bed days)	$ 835,761
	Margaret R. Pardee Hosp.	5 (1,763 bed days)	$ 1,322,085
	Mission Hospital System	6 (2,153 bed days)	$ 1,614,473
	DLP Rutherford Regional	3 (735 bed days)	$ 551,581
Vaya Health Total	**5 contracts**	**21**	**$ 5,112,807**
*Trillium Health Resources	CarolinaEast Health Sys.	3 (869 bed days)	$ 652,083
	**Nash Hospitals (Coastal Plain Hospital)	7 (2,402)	$ 1,801,550
	New Hanover Regional	12 (4,100 bed days)	$ 3,075,000
	Vidant Beaufort Hospital	5 (1,497 bed days)	$ 1,122,917
	*Vidant Medical Center	4 (842 bed days)	$ 636,469
	Vidant Roanoke-Chowan Hospital	5 (1,479 bed days)	$ 1,109,064
Trillium Total	**5 contracts**	**36**	**$ 8,397,083**
TOTAL	**29 contracts**	**166 beds/54,109 bed days**	**$40,621,643**

*Only three hospitals, with their LME/MCO partners, have service code YP 822 beds (Enhanced Three-Way). The three hospitals each have one bed available for Enhanced Three-Way care.

**Nash Hospitals Coastal Plain's Three-Way Contract began the SFY 2018 with Eastpointe LME/MCO, but that contract was terminated on 9/6/2017, and replaced with a contract with Trillium due to Nash county's changing its association from Eastpointe to Trillium on July 1, 2017.

Three-Way Contracts by LME/MCO & Hospital: Utilization and Expenditures

DMHDDSAS has paid the LME/MCOs, which in turn, paid the community hospitals, for Three-Way Contract inpatient care provided from July 1, 2017 through June 30, 2018 (dates of service during SFY 2018) in the amount of $38,875,039. A total of 51,959 bed days were purchased, 6,789 persons were served, with an overall average of 7.7 units per person (i.e., bed days per person, which ranged from 6.4 to 8.3 days).

Table 2 provides the unduplicated number of persons served, bed days, and units per person for Three-Way Contract inpatient care in LME/MCO service areas provided in SFY 2017 and SFY 2018; while Table 3 shows the unduplicated number of persons served, bed days, and units per person for each community hospital. See Notes below each table.

Table 2. Three-Way Contract Inpatient Persons Served, Bed Days, and Units Per Person Purchased (service codes YP 821 & YP 822) by LME/MCO for Services During SFY 2017 and SFY 2018

LME/MCO	Persons Served – SFY17	Persons Served – SFY18	Bed Days – SFY17	Bed Days – SFY18	Units Per Person – SFY17	Units Per Person – SFY18
Alliance	582	640	5,062	5,253	8.7	8.2
Cardinal	1,283	1,191	9,703	9,916	7.6	8.3
Eastpointe	824	510	5,808	3,444	7.0	6.8
Partners	1,393	1,612	8,498	10,789	6.1	6.7
Sandhills	776	892	4,899	5,694	6.3	6.4
Trillium	865	1,392	6,406	10,082	7.4	7.2
Vaya	770	851	6,052	6,781	7.9	8.0
TOTAL	**6,255**	**6,789**	**46,428**	**51,959**	**7.4**	**7.7**

Note: the number of persons served, as reflected in the above table for each LME/MCO, is an unduplicated count; that is, persons are counted just once per LME/MCO, even if they received more than one episode of Three-Way Contract inpatient care in the same LME/MCO's service area. If a person received Three-Way Contract inpatient care in more than one LME/MCO service area, that individual is counted as a person served in each LME/MCO in which the inpatient services were provided.

Overall, Table 2 illustrates the following changes from SFY 2017 to SFY 2018:

- An increase of 534 persons served;
- An increase of 5,531 adjudicated bed days, corresponding with,
- an average increase of .3 units per person.

Table 3. Three-Way Contract Inpatient Persons Served, Bed Days, and Units Per Person Purchased (service codes YP 821 & YP 822) by Community Hospitals for Services During SFY 2017 and SFY 2018

LME/MCO	Hospital	Persons Served – SFY17	Persons Served – SFY18	Bed Days – SFY17	Bed Days – SFY18	Units Per Person – SFY17	Units Per Person – SFY18
Alliance	Cape Fear Valley	140	134	922	919	6.6	6.9
Alliance	Duke Univ. Health	110	134	930	1,285	8.5	9.6
Alliance	Johnston Health	213	241	1,561	1,579	7.3	6.6
Alliance	UNC-Wakebrook	122	134	1,649	1,470	13.5	11.0
Alliance	**Total**	**585**	**643**	**5,062**	**5,253**	**8.7**	**8.1**
Cardinal	Cone Health Alamance Regional	170	165	774	935	4.6	5.7
Cardinal	Carolinas Healthcare: Charlotte & Davidson	255	257	2,164	2,253	8.5	8.8
Cardinal	Halifax Regional Medical Center	127	152	1,136	1,117	8.9	7.3
*Cardinal	*Novant Health Presbyterian Medical	309	234	2,353	2,229	7.6	9.5
Cardinal	Novant Health Forsyth Medical Center	465	410	3,276	3,382	7.0	8.2
Cardinal	**Total**	**1,326**	**1,218**	**9,703**	**9,916**	**7.3**	**8.1**

LME/MCO	Hospital	Persons Served – SFY17	Persons Served – SFY18	Bed Days – SFY17	Bed Days – SFY18	Units Per Person – SFY17	Units Per Person – SFY18
**Eastpointe	**Nash Hospitals (Coastal Plain Hospital)	545	133	3,807	743	7.0	5.6
Eastpointe	Southeastern Health	150	196	987	1,352	6.6	6.9
Eastpointe	Vidant Duplin Hospital	133	182	1,014	1,349	7.6	7.4
Eastpointe	**Total**	**828**	**511**	**5,808**	**3,444**	**7.0**	**6.7**
*Partners	*Catawba Valley Medical	635	709	3,666	4,235	5.8	6.0
Partners	Davis Regional Med. Center	202	220	1,444	1,517	7.1	6.9
Partners	DLP Frye Regional	333	440	1,827	2,806	5.5	6.4
Partners	Carolinas Healthcare Sys. Kings Mountain	284	361	1,561	2,231	5.5	6.2
Partners	**Total**	**1,454**	**1,730**	**8,498**	**10,789**	**5.8**	**6.2**
Sandhills	FirstHealth Moore Regional	273	344	1,255	1,616	4.6	4.7
Sandhills	Good Hope Hospital	121	124	1,281	1,487	10.6	12.0
Sandhills	Moses H. Cone Hospital	385	431	2,363	2,591	6.1	6.0
Sandhills	**Total**	**779**	**899**	**4,899**	**5,694**	**6.3**	**6.3**
Trillium	CarolinaEast Health Sys.	119	131	746	828	6.3	6.3
**Trillium	**Nash Hospitals (Coastal Plain Hospital)		332		2,188		6.6

LME/MCO	Hospital	Persons Served – SFY17	Persons Served – SFY18	Bed Days – SFY17	Bed Days – SFY18	Units Per Person – SFY17	Units Per Person – SFY18
Trillium	New Hanover Regional	331	397	2,933	3,619	8.9	9.1
Trillium	Vidant Beaufort Hospital	182	235	1,234	1,410	6.8	6.0
*Trillium	*Vidant Medical Center	89	109	514	669	5.8	6.1
Trillium	Vidant Roanoke-Chowan Hospital	160	228	979	1,368	6.1	6.0
Trillium	**Total**	**881**	**1,432**	**6,406**	**10,082**	**7.3**	**7.0**
Vaya	Charles A. Cannon Memorial Hospital	157	169	992	1,041	6.3	6.2
Vaya	DLP Haywood Regional	133	162	957	1,130	7.2	7.0
Vaya	Margaret R. Pardee Hosp.	243	266	1,484	1,923	6.1	7.2
Vaya	Mission Hospital System	195	218	1,924	1,974	9.9	9.1
Vaya	DLP Rutherford Regional	75	81	695	713	9.3	8.8
Vaya	**Total**	**803**	**896**	**6,052**	**6,781**	**7.5**	**7.6**

SFY17 data: retrieved for claims adjudicated for payment through September 6, 2017 for service dates in SFY 2017.
SFY18 data: retrieved for claims adjudicated for payment through August 28, 2018 for service dates in SFY 2018.

*Three-Way Contracts for Cardinal/Novant Health Presbyterian Medical, Partners/Catawba Valley Medical, and Trillium/Vidant Medical Center provide funding for both lower tier and upper tier (Enhanced) Three-Way Contract inpatient care. In this table the data for both tiers of inpatient service is combined. Note: Cardinal/Novant Health Presbyterian Medical claims reflected no upper tier (Enhanced) inpatient care during SFY 2018, while Trillium/Vidant Medical Center had $11,700 and Partners/Catawba Valley Medical had $202,078 in Enhanced Three-Way Contract claims that were adjudicated for payment in SFY 2018.

**Nash Hospitals Coastal Plain's Three-Way Contract began SFY 2018 with Eastpointe LME/MCO, but that contract was terminated on 9/6/2017, and replaced by a contract with Trillium LME/MCO that became effective on 9/7/17, due to Nash county's changing its association from Eastpointe to Trillium on July 1, 2017.

Note: the number of persons served, as reflected in the above table, by each community hospital, is an unduplicated count; that is, persons are counted just once, even if they received more than one episode of Three-Way Contract inpatient care in that same community hospital. If a person was served by more than one community hospital that individual is counted as a person served for each community hospital in which the inpatient care was provided.

Table 4 reflects the expenditures for SFY 2017 and SFY 2018 to ascertain any substantial changes in the claims adjudicated for payment across the two-year period.

Table 4. Three-Way Contract Inpatient Service Purchased (service codes YP 821 & YP 822) with State Appropriations by LME/MCOs and Community Hospitals for Services During SFY 2017 (as of 9/6/17) and SFY 2018 (as of 9/28/18)

LME/MCO	Hospital	Dollars Paid – SFY17	Dollars Paid – SFY18	Difference
Alliance	Cape Fear Valley	$687,000	$681,853	($5,147)
Alliance	Duke Univ. Health	$697,500	$936,008	$238,508
Alliance	Johnston Health	$1,165,427	$1,184,250	$18,823
Alliance	UNC-Wakebrook	$1,201,971	$1,090,674	($111,297)
Alliance	**Total**	**$3,751,898**	**$3,892,785**	**$140,887**
Cardinal	Cone Health Alamance Regional	$580,104	$701,250	$121,146
Cardinal	Carolinas Healthcare: Charlotte & Davidson	$1,622,066	$1,689,750	$67,684
Cardinal	Halifax Regional Medical Center	$851,745	$837,702	($14,043)

LME/MCO	Hospital	Dollars Paid – SFY17	Dollars Paid – SFY18	Difference
*Cardinal	*Novant Health Presbyterian Medical	$1,764,415	$1,671,750	($92,665)
Cardinal	Novant Health Forsyth Medical Center	$2,457,000	$2,531,250	$74,250
Cardinal	**Total**	**$7,275,330**	**$7,431,702**	**$156,372**
**Eastpointe	**Nash Hospitals (Coastal Plain Hospital)	$2,855,200	$557,250	Contract ended on 9/6/17.
Eastpointe	Southeastern Health	$736,922	$1,014,000	$277,078
Eastpointe	Vidant Duplin Hospital	$760,500	$1,011,364	$250,864
Eastpointe	**Total**	**$4,352,622**	**$2,582,614**	**($1,770,008)**
*Partners	*Catawba Valley Medical	$2,731,985	$3,158,210	$426,225
Partners	Davis Regional Med. Center	$1,065,971	$1,126,196	$60,225
Partners	DLP Frye Regional	$1,369,714	$2,104,500	$734,786
Partners	Carolinas Healthcare Sys. Kings Mountain	$1,168,050	$1,672,500	$504,450
Partners	**Total**	**$6,335,720**	**$8,061,406**	**$1,725,686**
Sandhills	FirstHealth Moore Regional	$909,750	$1,212,000	$302,250
Sandhills	Good Hope Hospital	$960,750	$1,115,250	$154,500

LME/MCO	Hospital	Dollars Paid – SFY17	Dollars Paid – SFY18	Difference
Sandhills	Moses H. Cone Hospital	$1,772,250	$1,943,250	$171,000
Sandhills	**Total**	**$3,642,750**	**$4,270,500**	**$627,750**
Trillium	CarolinaEast Health Sys.	$559,206	$621,000	$61,794
**Trillium	**Nash Hospitals (Coastal Plain Hospital)		$1,641,000	Contract started on 9/7/17.
Trillium	New Hanover Regional	$2,199,634	$2,714,250	$514,616
Trillium	Vidant Beaufort Hospital	$925,500	$1,053,750	$128,250
*Trillium	*Vidant Medical Center	$388,564	$503,700	$115,136
Trillium	Vidant Roanoke-Chowan Hospital	$733,614	$1,026,000	$292,386
Trillium	**Total**	**$4,806,518**	**$7,559,700**	**$2,753,182**
Vaya	Charles A. Cannon Memorial Hospital	$735,536	$780,750	$45,214
Vaya	DLP Haywood Regional	$710,338	$847,500	$137,162
Vaya	Margaret R. Pardee Hosp.	$1,110,541	$1,442,250	$331,709
Vaya	Mission Hospital System	$1,443,000	$1,480,500	$37,500
Vaya	DLP Rutherford Regional	$513,853	$525,331	$11,478
Vaya	**Total**	**$4,513,268**	**$5,076,331**	**$563,063**
TOTAL		**$34,678,106**	**$38,875,039**	**$4,196,933**

*Three LME/MCOs/hospitals have Enhanced (YP 822, $900/day) Three-Way Contract beds, as well as the lower rate tier (YP 821, $750/day) Three-Way Contract beds. The YP 822 beds continue to have relatively low utilization, and thus were combined on this table with the more frequently used lower tier Three-Way Contract beds (YP 821).

Table 4 shows an overall increase (12%) of $4,196,933 in the dollar value of claims that were adjudicated for payment from SFY 2017 to SFY 2018. Twenty-four hospitals had increases in claims amounts adjudicated for payment, ranging from 2% to 54%. Three hospitals had reductions in claims amounts of 23%, 9%, 5%, 2%, and 1% that were adjudicated for payment. Claims for dates of service in SFY 2018 will continue to be adjudicated by NCTracks through October 2018, making increases possible in the total claims amounts for some or all hospitals.

Due to utilization trends of individual hospitals during SFY 2018, two (2) hospitals received amendments that reduced their contract amounts, which allowed twenty-two (22) other hospitals with higher-than expected utilization to receive contract amendment funding increases, with nine (9) hospitals receiving two or three contract amendments that increased their funding. During SFY 2018, more than sixty (60) contract amendments were issued to twenty-four (24) of the twenty-nine (29) hospitals.

Facility Based Crisis and Non-Hospital Medical Detoxification Services Paid from Local Inpatient Beds/Bed Days Appropriation

During the SFY 2018, DMHDDSAS elected not to use any of the funds allocated in **Session Law 2017 – 57, Section 11F.3.(a)** to pay for Facility-Based Crisis or Non-Hospital Medical Detoxification services for individuals in need of these services. This decision was based on the increased utilization of the Three-Way Contracts for psychiatric and substance use inpatient care in SFY 2016-2017 and the continued high utilization during the first half of SFY 2018. None of the appropriated funding for Three-Way Contracts was carved out to pay for Facility Based Crisis or Non-Hospital Medical Detoxification in SFY 2018.

II. Other Hospital Beds/Bed Days Purchased from Generic State Appropriations in SFY 2018

In addition to the funds specifically appropriated by the NC General Assembly for community hospital psychiatric inpatient beds/bed days purchased through Three-Way Contracts, six of seven LME/MCOs used a portion of their generic allocation of state funding, known as Single Stream funding, to purchase hospital inpatient services (service code, YP 820). Further, it is known that Alliance Behavioral Health LME/MCO paid for this YP 820 psychiatric inpatient care with local funding.

Until January 2017, this YP 820 psychiatric inpatient service had differed from the Three-Way Contract funding (service codes, YP 821 and YP 822) in a notable way. The YP 820 inpatient payment rate, which varies across the LME/MCOs, only paid the hospital for the bed fee, not for

the professional services provided by the psychiatrists and other caregivers, which was separately billed.

A revised service definition, however, modified the billing parameters and established an all-inclusive rate of $740/bed day, effective January 1, 2017. The revision brought the service and billing requirements and rate closer to the all-inclusive rate and requirements of the Three-Way Contract inpatient service. As described above, the Three-Way Contract rates are inclusive of the bed fee, all professional and ancillary charges, plus seven days of psychotropic medication upon the individual's discharge; whereas, the YP 820 inpatient all-inclusive rate set by DMHDDSAS at $740 per bed day was set as a flat-fee for all inpatient-related services, except for any medications provided to the individuals on the day of discharge.

Table 5 depicts the expenditures, bed days purchased, persons served, and units per person in State Fiscal Year 2018 per LME/MCO. Six (6) LME/MCOs paid for psychiatric inpatient services for 2,779 individuals in community hospitals at a cost of $15,472,098, paying for 22,121 bed days. The state-wide average was 8.0 units per persons (i.e., bed days), with a range across the identified hospitals from an average of 2.9 to 10.6 units per person.

Table 5. Inpatient Bed Days Purchased (service code YP 820) with LME/MCO Allocations of State Appropriations for Services in SFY 2018 in Community Hospitals (as of 8/28/18)

LME/MCO	Hospital	Persons Served	YP 820 Dollars Paid	Bed Days	Units Per Person
Alliance	**Duke University Health System**	**35**	**$ 22,400**	**310**	**8.9**
Alliance	**Holly Hill Hospital**	**839**	**$ 6,545,300**	**8,845**	**10.5**
Alliance Total		**874**	**$6,774,700**	**9,155**	**10.5**
Cardinal	**Charlotte-Mecklenburg Hospital – Albemarle**	**99**	**$ 486,715**	**917**	**9.3**
Cardinal	**High Point Regional Health**	**79**	**$ 124,220**	**227**	**2.9**
Cardinal	**Moses H. Cone Memorial**	**82**	**$ 276,116**	**484**	**5.9**
Cardinal	**North Carolina Baptist Hospital**	**102**	**$ 310,364**	**446**	**4.4**
Cardinal	**Old Vineyard Behavioral Health**	**446**	**$ 2,984,283**	**4,560**	**10.2**
Cardinal	**Holly Hill Hospital**	**152**	**$ 853,176**	**1,288**	**8.5**
Cardinal	**Rowan Regional Medical Center**	**161**	**$ 417,244**	**772**	**4.8**
Cardinal Total		**1,121**	**$5,452,118**	**8,694**	**7.8**
Eastpointe	**Southeastern Regional Medical Center**	**88**	**$ 491,930**	**547**	**6.2**
Eastpointe Total		**88**	**$491,930**	**547**	**6.2**
Partners	**CMC Blue Ridge**	**38**	**$ 230,880**	**312**	**8.2**
Partners	**Gaston Memorial Hospital**	**88**	**$ 253,820**	**343**	**3.9**
Partners Total		**126**	**$484,700**	**655**	**5.2**

LME/MCO	Hospital	Persons Served	YP 820 Dollars Paid	Bed Days	Units Per Person
Sandhills	**Good Hope Hospital**	**2**	**$ 11,100**	**15**	**7.5**
Sandhills	**High Point Regional Health**	**463**	**$ 1,221,000**	**1,650**	**3.6**
Sandhills	**Moses H. Cone Memorial Hospital**	**121**	**$ 533,540**	**721**	**6.0**
Sandhills	**Old Vineyard Behavioral Health**	**31**	**$ 242,720**	**328**	**10.6**
Sandhills	**Holly Hill Hospital**	**35**	**$ 237,540**	**321**	**9.2**
Sandhills Total		**652**	**$2,245,900**	**3,035**	**4.7**
Trillium	**Brynn Marr Behavioral Healthcare**	**5**	**$ 22,750**	**35**	**7.0**
Trillium Total		**5**	**$22,750**	**35**	**7.0**
Total		**2,779**	**$15,472,098**	**22,121**	**8.0**
Source: NCTracks					
Data retrieved for claims adjudicated for payment through August 28, 2018 for service dates in SFY 2018.					

III. Beds/Bed Days Purchased with Local Funds in SFY 2018

Four LME/MCOs reported to DMHDDSAS that they were able to access local funding to purchase or supplement additional psychiatric inpatient services in community hospitals. A total of $7,728,153 was paid to community hospitals for inpatient care. These local funds were reported to have purchased 10,120 bed days and served 922 people, with overall average units per person of 11.0, as reflected in Table 6. However, as previously noted, Alliance Behavioral Health LME/MCO used much, if not all, of its local funding to pay for YP 820 inpatient care. Hence, there is significant overlap between the data in Tables 5 and 6.

Table 6. Inpatient Bed Days Purchased by Local Management Entities-Managed Care Organizations with Local Funds for Services During SFY 2018 in Community Hospitals

LME/MCO	Hospital	Persons Served	Local Dollars Paid	Bed Days	Units Per Person
Alliance	Holly Hill Hospital	871	$7,402,104	9,837	11.3
Alliance Total		**871**	**$7,402,104**	**9,837**	**11.3**
Cardinal *	UNC Hospital *		$190,103		
Cardinal Total		**-**	**$190,103**		
Partners	Carolinas Health Blue Ridge	26	$15,858	123	4.7
Partners Total		**26**	**$15,858**	**123**	**4.7**
Vaya Health	Charles A. Cannon Memorial	2	$12,750	17	8.5
	DLP Haywood Regional	3	$12,750	17	5.7

	DLP Rutherford Hospital	4	$12,838	17	4.3
	Mission Hospital	7	$46,500	62	8.9
	Margaret Pardee Memorial	9	$35,250	47	5.2
Vaya Total		**25**	**$120,088**	**160**	**6.4**
Total		**922**	**$7,728,153**	**10,120**	**11.0**
Source: LME/MCOs reports on local funds used for inpatient care					

*The amount Cardinal Innovations paid to one community hospital using local funds is $190,200. These funds do not pay for actual bed days, though they are used to offset the costs of indigent inpatient care.

IV. Selected Measures of Performance for Three-Way Contract Inpatient Care in SFY 2018

Claims submitted by the LME/MCOs into NCTracks for Three-Way Contract psychiatric and substance use inpatient services contain valuable information that enables DMHDDSAS to monitor some of the basic aspects the contract. This section of the report focuses on several aspects that are being monitored on an ongoing basis.

Discharges and Average Length of Stay by Disability

Table 7 depicts two main measures by hospital for SFY 2018: number of discharges of persons with a principle mental health (MH) or substance use disorder (SUD) disability; and average length of stay (Avg LOS) of persons with a principle mental health or substance use disorder disability. The data in Table 7 are derived from claims that were adjudicated for payment in NC Tracks as of September 11, 2018, as presented in the State and 3-Way Contract Funded Community Psychiatric Inpatient Report (internal report produced by DMHDDSAS' Quality Management Team; accessed via email September 21, 2018)

Table 7. Three-Way Contract Discharges & Average Lengths of Stay by Principal Diagnostic Category in SFY 2018

	Count of Discharges			Avg LOS		
	Principal Disability			Principal Disability		
Hospital	**MH**	**SUD**	**Total**	**MH**	**SUD**	**Total**
Alamance Regional Medical Center	181	1	182	5.7	3.0	5.7
Beaufort Regional Medical Center	204	44	248	6.4	5.8	6.3
Cape Fear Valley Hospital	148	1	149	7.4	3.0	7.4
Carolina East Medical Center	151	0	151	6.3	0.0	6.3
Carolinas Medical Center	280	5	285	8.5	6.2	8.5
Catawba Valley Medical Center	480	373	853	6.2	5.7	6.0
Charles A. Cannon, Jr. Memorial Hosp	165	16	181	6.8	5.6	6.7

	Count of Discharges			Avg LOS		
	Principal Disability			Principal Disability		
Hospital	MH	SUD	Total	MH	SUD	Total
Davis Regional Medical Center	241	11	252	7.2	5.4	7.1
Duke University Health System	142	0	142	10.3	0.0	10.3
Duplin General	208	0	208	7.7	0.0	7.7
First Health/Moore Regional Hospital	283	108	391	5.4	4.9	5.2
Forsyth Memorial Hospital	351	112	463	7.9	7.1	7.7
Frye Regional	279	249	528	7.0	6.1	6.6
Good Hope	132	0	132	12.3	0.0	12.3
Halifax Regional	166	0	166	7.4	0.0	7.4
Haywood Regional Medical Center	165	5	170	7.5	11.0	7.6
Johnston Memorial	272	11	283	6.6	6.0	6.6
Kings Mountain Hospital	379	14	393	6.7	4.7	6.7
Margaret Pardee Memorial	158	203	361	7.5	5.6	6.4
Mission	263	3	266	12.2	11.0	12.2
Moses Cone	378	102	480	6.6	6.0	6.5
Nash Hospitals, Inc.	229	323	552	6.9	5.6	6.1
New Hanover Regional Medical Center	458	6	464	8.4	6.3	8.4
Northside	250	0	250	6.0	0.0	6.0
Pitt Memorial	118	2	120	6.1	4.0	6.1
Presbyterian	238	13	251	9.6	8.0	9.5
Rutherford	92	0	92	8.8	0.0	8.8
Southeastern Regional Medical Center	200	33	233	7.0	5.8	6.8
UNC-Wakebrook	131	17	148	12.7	7.5	12.1
Total	**6,742**	**1,652**	**8,394**	**7.6**	**5.8**	**7.2**

The total number of discharges was 8,394 with 78% of the discharges of persons having a principle MH disability and 22% having a principle SUD disability. The average LOS for persons having a principle MH disability was 7.6 days, while persons having a principle SUD disability was 5.8 days. The overall average LOS was 7.2 days, with a range across the hospitals of 5.2 to 12.3 days.

Clearly, the predominant overall principle disability at discharge was MH. The data also indicate seven (7) of the hospitals submitted claims that did not reflect any principle SUD disability among the persons discharged from their care, and seven other hospitals had fewer than ten (10) discharges with principle SUD disability. Nine (9) hospitals submitted claims indicating services were provided to both persons with principle MH disabilities as well as persons with principle SUD disabilities (minimum count of 20) at discharge. It is well known that many individuals have co-occurring behavioral health needs that include both MH and SUD treatment.

As noted above, the average LOS among the 29 hospitals had a fairly wide range; though 22 of the hospitals had average LOS between 6 and 9 days. Two hospitals had average LOS between 5.2 days and 6.0 days, while five were between 9.5 and 12.3 days. In a bit of a departure to previous years, the state-wide or overall average LOS was above seven days (7.2 days) in SFY 2018.

Differences across the 29 hospitals in LOS likely has a variety of possible explanations. Higher LOS would be expected for hospitals that have the following:

- Staffing with the willingness, expertise, and resources to serve a higher proportion of the persons who have more complex psychiatric or substance use needs, and/or behavioral challenges;
- Location in areas with few community services that could prevent crises from occurring or escalating to a level requiring psychiatric or substance use inpatient care, for medically indigent people;
- Difficulty working with LME/MCOs or providers in developing proactive discharge plans and finding appropriate community services, thus delaying discharge;
- Combinations of the aforementioned factors (e.g., scarce community resources and hospital staff with the willingness, expertise, and resources to admit and treat persons with more complex psychiatric or substance use needs and/or behavioral challenges).

Lower LOS would be expected for hospitals that have the following:

- Staff who were more reluctant, have insufficient expertise, or inadequate resources to serve a higher proportion of the persons presenting with more complex psychiatric or substance use needs, and/or behavioral challenges;
- Locations in areas with few community services for medically indigent people, thus persons with less complex needs and challenging behaviors may be referred to inpatient care for short stays, in the absence of other non-hospital alternatives (e.g., Facility Based Crisis, Non-Hospital Medical Detox);
- Combinations of the aforementioned factors (e.g., scarce community resources and hospital staffing who may be more reluctant, have insufficient expertise, or inadequate resources to serve a higher proportion of the persons presenting with more complex psychiatric or substance use needs, and/or behavioral challenges).

Re-admissions to Inpatient Care

The National Committee for Quality Assurance includes follow-up care after hospitalization for mental illness among its numerous measures in the Healthcare Effectiveness Data and Information Set (HEDIS), which are applicable to the provision of care funded by commercial, Medicaid, and Medicare health insurers. This HEDIS measure considers re-admissions to inpatient hospitals when evaluating effectiveness of care.
http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2016/HEDIS%202016%20List%20of%20Measures.pdf

Likewise, DMHDDSAS tracks hospital re-admissions within 30 days of discharge as one way to assess performance of the publicly-funded system of care. It must be noted, however, that multiple factors can affect re-admission to inpatient care, such as:

- Incomplete stabilization/treatment: individuals may be discharged before stabilization occurred or treatment was completed during inpatient care;
- Lack of availability of more intensive recovery services and supports following inpatient: without higher levels of recovery care after discharge from hospitalization, persons with severe mental illness and substance use disorders often experience relapses and additional crisis events; more intensive step-down services include but are not limited to Partial Hospitalization, Assertive Community Treatment; Critical Time Intervention; Substance Abuse Non-Medical Community Residential Treatment; and Substance Abuse Medically Monitored Community Residential Treatment;
- Insufficient access to or availability of outpatient (e.g., prescribers), community services or support system;
- Inadequate care coordination or linkage to follow-up care; and
- Untimely follow-up care.

For persons discharged from Three-Way Contract inpatient care during SFY 2018, the overall re-admission rate to any community hospital for psychiatric/substance use inpatient care was 9% (see Table 8). Across LME/MCOs the range varied from 6% to 12%, while across hospitals the range was broader, 4% to 15%. The reported data in Table 8 are derived from claims that were adjudicated for payment in NC Tracks as of September 11, 2018, as presented in the State and 3-Way Contract Funded Community Psychiatric Inpatient Report (internal report produced by DMHDDSAS' Quality Management Team; accessed via email September 21, 2018)

Table 8. Re-admission (Post Discharge from Three-Way Contract Hospital) within 30 Days to Any Community Hospital Psychiatric/Substance Abuse Inpatient Bed in SFY 2018

LME/MCO	Hospital	Total Discharges	Readmit within 30 Days	Readmit as % of Total
ALLIANCE	Cape Fear Valley Hospital	149	7	5%
	Duke University Health System	142	6	4%
	Johnston Memorial	283	26	9%
	UNC-Wakebrook	148	12	8%
ALLIANCE Total		722	51	7%
CARDINAL	Alamance Regional Medical Center	182	24	13%
	Carolinas Medical Center	285	32	11%
	Forsyth Memorial Hospital	463	28	6%
	Halifax Regional	166	9	5%
	Presbyterian	251	16	6%
CARDINAL Total		1,347	109	8%
EASTPOINTE	Duplin General	208	16	8%

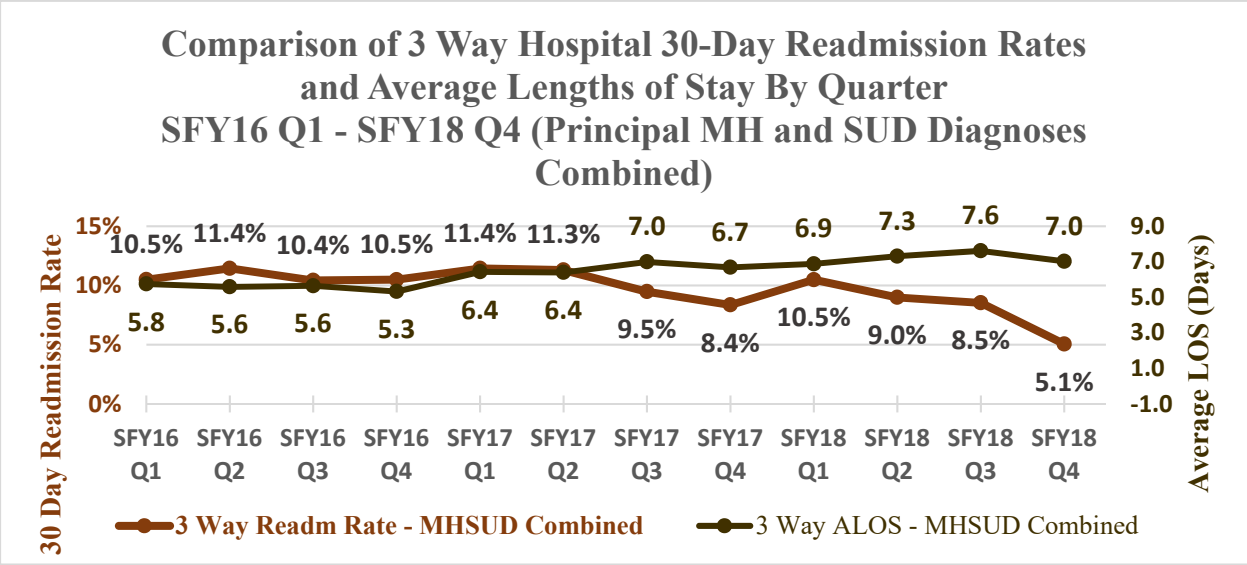
LME/MCO	Hospital	Total Discharges	Readmit within 30 Days	Readmit as % of Total
	*Nash Hospitals, Inc.	552	49	9%
	Southeastern Regional Medical Center	233	20	9%
EASTPOINTE Total		993	85	9%
PARTNERS	Catawba Valley Medical Center	853	100	12%
	Davis Regional Medical Center	252	29	12%
	Frye Regional	528	78	15%
	Kings Mountain Hospital	393	28	7%
PARTNERS Total		2,026	235	12%
SANDHILLS	First Health/Moore Regional Hospital	391	28	7%
	Good Hope	132	7	5%
	Moses Cone	480	38	8%
SANDHILLS Total		1,003	73	7%
TRILLIUM	Beaufort Regional Medical Center	248	12	5%
	Carolina East Medical Center	151	14	9%
	New Hanover Regional Medical Center	464	24	5%
	Northside	250	18	7%
	Pitt Memorial	120	8	7%
TRILLIUM Total		1,233	76	6%
VAYA	Charles A. Cannon, Jr. Memorial Hosp	181	14	8%
	Haywood Regional Medical Center	170	8	5%
	Margaret Pardee Memorial	361	49	14%
	Mission	266	24	9%
	Rutherford	92	8	9%
VAYA Total		1,070	103	10%
Total Discharges		**8,394**	**732**	**9%**

*In the above table, Nash Hospitals, Inc. is only shown among the Eastpointe LME/MCO community hospitals. However, Nash Hospitals, Inc's contract with Eastpointe terminated on September 6, 2017, and the new contract with Trillium LME/MCO became effective on September 7, 2017. However, the reported data shown for Nash Hospitals, Inc. are the sum across both Eastpointe LME/MCO and Trillium LME/MCO.

Figure 1 provides a line graph comparison, with a correlation statistic, of the 30-day readmission rates and average LOS by quarter for both principal mental health and principal substance use disorders, from SFY 2016 through SFY 2018 for all 29 community hospitals. As the quarterly average LOS increased to 7.0 days in the third quarter of SFY2017, the readmission rate began to show a downward trend. From the third quarter of SFY 2017 through the fourth quarter of SFY 2018, the average LOS ranged from 6.7 days to 7.6 days, while the readmission rates ranged from 10.5% to 5.1%. The average LOS and readmission rates over the last three SFYs, as

reflected in Figure 1, have a moderate negative correlation of -.56; that is, as the average LOS increased over the twelve quarters from SFY 2016 through SFY 2018, the readmission rates decreased. Note: the correlation does not imply causation.

Figure 1



The data depicted in Figure 1 are derived from claims that were adjudicated for payment in NC Tracks as of September 11, 2018, as presented in the State and 3-Way Contract Funded Community Psychiatric Inpatient Report (internal report produced by DMHDDSAS' Quality Management Team; accessed via email September 21, 2018)

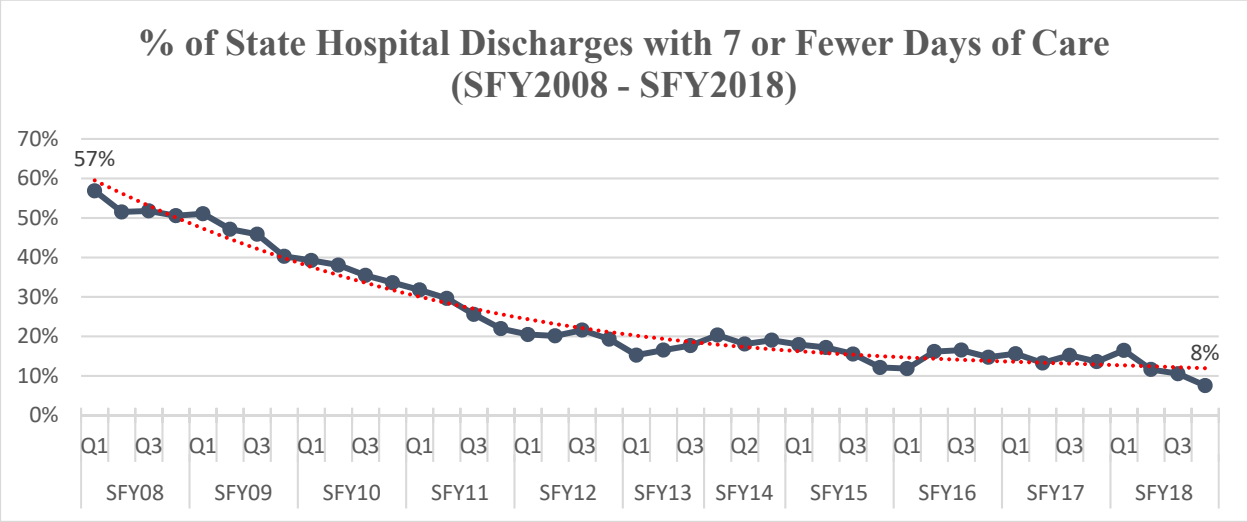
In order to impact the overall rate of readmissions to Three-Way Contract inpatient care and consequently the effectiveness of care, it is important to consider that funding to restore community services is needed at multiple levels of the service continuum and within the systems that fund and manage care.

State Psychiatric Hospitals' Lengths of Stay

With respect to one expected impact of the increased number of psychiatric inpatient beds in the community hospitals, that is, a reduction of short-term stays in the state psychiatric hospitals, Figure 2, on the next page, illustrates the downward trend of lengths of stay of seven days or less in the state hospitals since calendar year 2008.

The data below are presented as the percentage of state hospital discharges by quarter over the last 11 years. As indicated in the note beneath Figure 2, the source for this data is inclusive of only those persons discharged for whom the LME/MCOs are responsible for serving in the community service system.

Figure 2. Short-term (7 days or less) Lengths of Stay at State Hospitals: SFY 2008 through SFY 2018



At the beginning of State Fiscal Year 2008, more than half (57%) of the discharges from the state hospitals had a length of stay of seven days or less. By the end of State Fiscal Year 2018, only 8% of discharges had a length of stay of seven days or less. During that same period, reflected in Figure 3, below, the number of discharges significantly decreased from 3,381 to 345, while the average length of stay (ALOS), depicted in Figure 4 for persons treated at the state psychiatric hospitals increased from 22.6 days to 99.2 days.

Figure 3. Number of Discharges from State Hospitals: SFY 2008 through SFY 2018

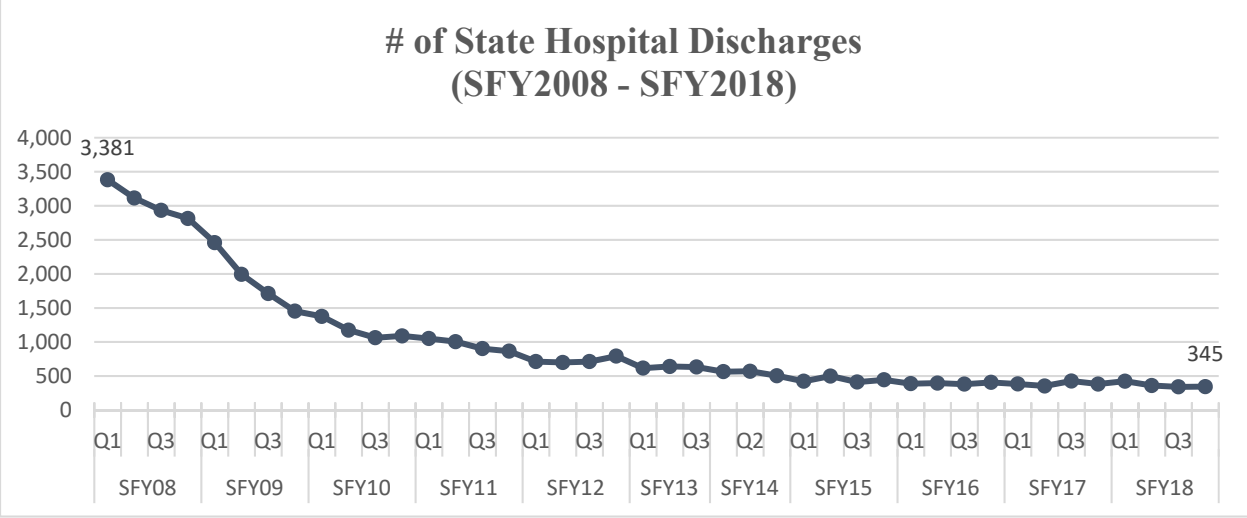
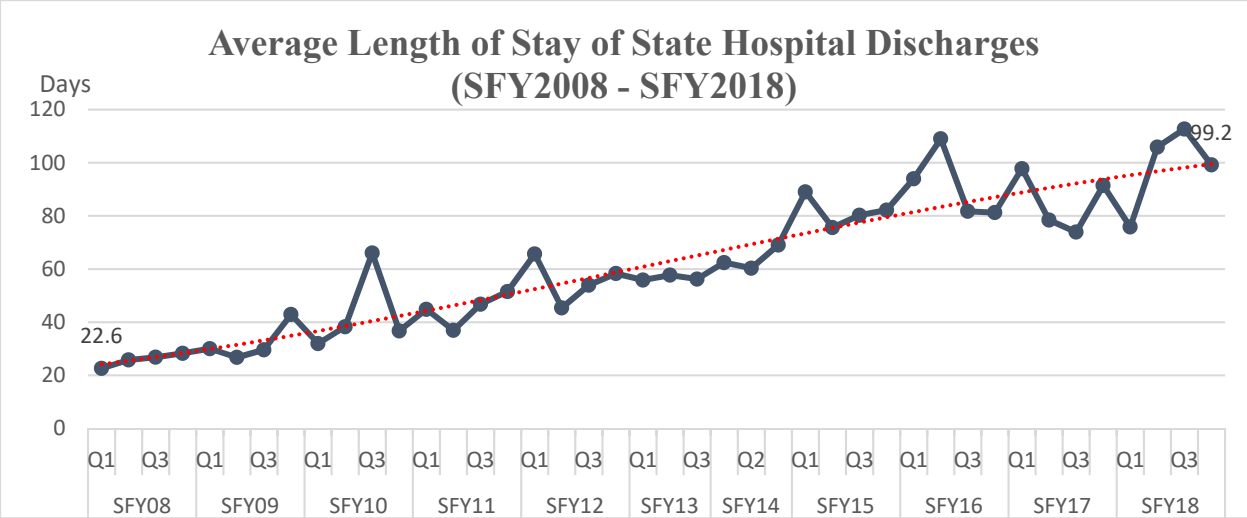


Figure 4. Average Lengths of Stay at State Hospitals: SFY 2008 through SFY 2018



Data Source: DMHDDSAS Performance Measure 5.1 Short-Term Care in State Psychiatric Hospitals. State Psychiatric Hospital data in the CDW. Discharges include only "direct" discharges to sources that fall within the responsibility of an LME/MCO to coordinate services (e.g. to other outpatient and residential non-state facility, self/no referral, unknown, community agency, private physician, other health care, family friends, nonresidential treatment/habilitation program, acute care hospital, outpatient services, residential care, other). Discharges for other reasons (e.g. transfers to other facilities, out-of-state, to correctional facilities, deaths, etc.) are not included as LME/MCOs would not be expected to coordinate services for these individuals nor to have any impact on readmission rates.

While the increase of available community hospital beds, through Three-Way Contracts, likely was a considerable reason for the reduced percentage of short-term stays in the state hospitals, other factors likely have shared contribution to this desired outcome. These factors include:

- Decrease in operational beds in the state hospitals between SFY 2008 and SFY 2010, making fewer beds available for short term admissions;
- State hospitals having a higher percentage of admission diagnoses of schizophrenia and other major psychiatric disorders (i.e., longer-term inpatient treatment needs) and lower percentage of substance use diagnoses, which occurred primarily due to the state-operated Alcohol and Drug Abuse Treatment Centers beginning to admit individuals who involuntarily committed for substance use treatment;
- Admission delays at the state hospitals resulting in individuals with less significant needs being admitted to local inpatient units (including Three-Way Contract beds) or discharged from the ED; only those with the most significant needs remain in the ED until a bed is available in the State hospital; thus, the lengths of stay increases as the higher proportion of admitted individuals have more severe and chronic impairments; and
- Fewer community discharge options for individuals with high-support needs tends to increase lengths of stay in the state hospitals.

It should also be noted that the downward trend, depicted in Figure 2, began a few quarters before the inception of Three-Way Contract inpatient care in community hospitals.

Emergency Department Wait Times

The Division of State Operated Health Facilities has been able to perform ongoing monitoring of the wait times in EDs for persons who are admitted to state psychiatric hospitals, as the tracking is performed by a collaborative and standardized effort between the LME/MCOs and the state hospitals. DMHDDSAS, in collaboration with the North Carolina Hospital Association and numerous community hospitals, reported to the North Carolina General Assembly on ED wait times for state hospitals and community hospitals (NCDHHS, DMHDDSAS, March 2011) https://www2.ncdhhs.gov/mhddsas/statspublications/Reports/reports-generalassembly/generalreports/edreport-3-11.pdf.

In that March 2011 report of a one-month (November 2010) period, the average wait times for state hospital beds (26 hours, 38 minutes) were found to be higher than the wait times for community hospital beds (14 hours, 7 minutes). DMHDDSAS does not have recent ED wait time data for Three-Way Contract beds. However, with the recent implementation (March 2018) of the Behavioral Health Crisis Referral System (BH-CRSys), DMHDDSAS expects to attain data that will generate reports, beginning in calendar year 2019, on ED wait times for external referrals for those EDs that utilize BH-CRSys.

However, the problem of lengthy ED wait times or ED boarding is aptly described in the Strategic Plan for Improvement of Behavioral Health Services: "At its core, the 'ED boarding' issue in North Carolina is not a psychiatric bed issue. It is a community-based services issue (p. 5)." https://files.nc.gov/ncdma/documents/Reports/Legislative_Reports/SL2016-94-Sec12F-10-and-SL2017-57-Sect11F-6_2018_01.pdf

Trend of Closure of Community Inpatient Beds

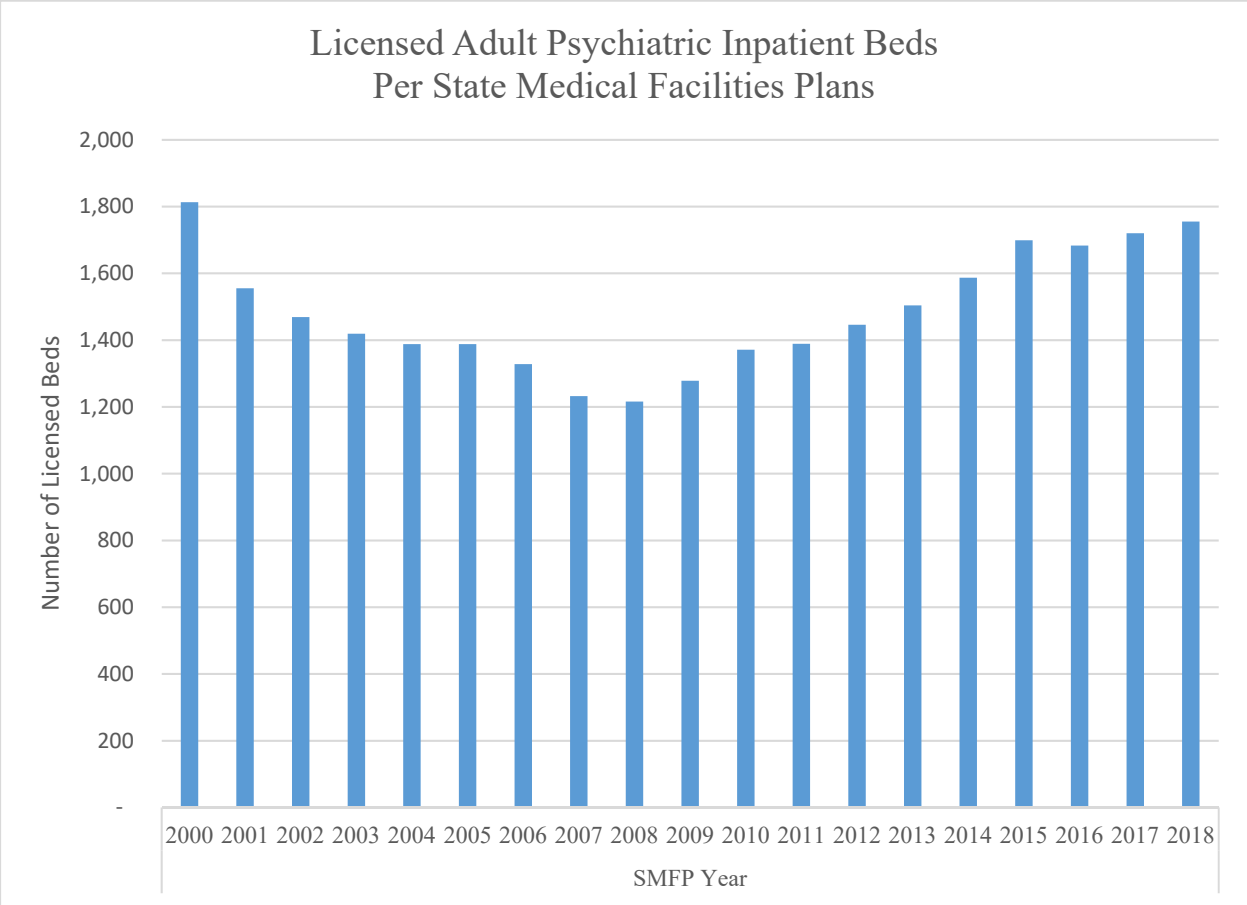
In order to track the number of community hospital adult psychiatric inpatient beds for this report, data from the North Carolina State Medical Facilities Plans (SMFPs) were accessed from the NCDHHS, Division of Health Service Regulation web site for 2007 through 2018. https://www2.ncdhhs.gov/dhsr/ncsmfp/index.html and https://www2.ncdhhs.gov/dhsr/ncsmfp/archive.html.

Previous SMFPs were not available on-line, but licensed psychiatric inpatient beds for adults, as identified in SMFPs from 2000 to 2006, were communicated via a personal email from Amy D. Craddock, Ph.D., Division of Health Service Regulation, Healthcare Planning and Certificate of Need Section. The 2000 SMFP reported there were 1,813 licensed psychiatric beds for adults in the community hospitals. From the 2000 SMFP through the 2008 SMFP, the number of those licensed beds declined to 1,216, as depicted in Figure 5, on the next page. However, the number of licensed beds has increased since the 2008 SMFP.

By 2018, the number of licensed psychiatric beds for adults had increased by 523 (42%) to 1,755. This data suggests that community hospitals were motivated to apply for Certificates of Need and psychiatric bed licensure in the ten years since the 2008 nadir for licensed beds thus far in the 21st century for North Carolina. The reasons for the increased number of beds are unclear;

and because the increase of 523 beds substantially exceeds the number of beds that have been identified for Three-Way Contract inpatient care (i.e., 166), the creation of the 523 licensed beds cannot be primarily attributed to the existence of Three-Way Contracts.

Figure 5: Licensed Adult Psychiatric Inpatient Beds in Community Hospitals



V. Other Department Initiatives Funded by State Appropriations to reduce State Psychiatric Hospital Use.

S.L. 2014-100, SECTION 12F.5.(b) *From funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for community services for the 2014-2015 fiscal year, the Division shall use two million two hundred thousand dollars ($2,200,000) in recurring funds to accomplish the following:*

(1) To increase the number of co-located or operationally linked behavioral health urgent care centers and facility-based crisis centers.

(2) To increase the number of facility-based crisis centers designated by the Secretary as facilities for the custody and treatment of involuntary clients pursuant to G.S.122C-252 and 10A NCAC 26C .0101. The Department shall give priority to areas of the State experiencing a shortage of these types of facilities.
(3) To provide reimbursement for services provided by facility-based crisis centers.
(4) To establish facility-based crisis centers for children and adolescents.

The initiatives described below are intended to divert individuals who experience behavioral health crises from seeking psychiatric or substance use crisis response from EDs. These initiatives offer alternative crisis response, and when people with behavioral health crises are successfully diverted from ED visits, the need for psychiatric and substance use inpatient hospital care is reduced. It is anticipated that these alternative community crisis response resources will consequently reduce some of the need for State Psychiatric Hospital admissions.

Increasing Behavioral Health Inpatient and Facility Based Crisis Beds via Dorothea Dix Hospital Property Fund Contracts

Seven construction contracts have been developed and executed to convert existing licensed acute medical inpatient beds into licensed psychiatric or substance use inpatient beds or to create new licensed psychiatric or substance use inpatient beds. Another construction contract has been developed and executed to new beds in a Facility Based Crisis program. Upon completion of construction, at least 50% of the newly licensed beds are required by Session Law 2016-94, Section 12F.4.(b), and Session Law 2017-57, Section 11F.5.(d), to be reserved for "(i) purchase by the Department under the State-administered, Three-Way Contract and (ii) referrals by local management entities/managed care organizations (LME/MCOs) of individuals who are indigent or Medicaid recipients."

The implementation of the construction contracts is on-going, with completion dates of the eight projects anticipated over the course of several years.

Three-Way Contract psychiatric inpatient care is intended to provide short-term inpatient care in community hospitals, thereby reducing the need for short-term inpatient care in State Psychiatric hospitals. Using the current rate of $750 per bed day, the demand upon the annual Three-Way Contract budget is estimated to increase by $20,257,500. This figure reflects the costs when fifty percent (about 74 beds) of all the newly created beds are licensed and operational.

Community Behavioral Health Paramedicine Pilot

The Community Behavioral Health Paramedicine Pilot was originally funded by the NCGA in Session Law 2015-241, Section 12F.8, and has more recently received additional funding through an appropriation in Session Law 2017-57, Section 11G.1.(a).

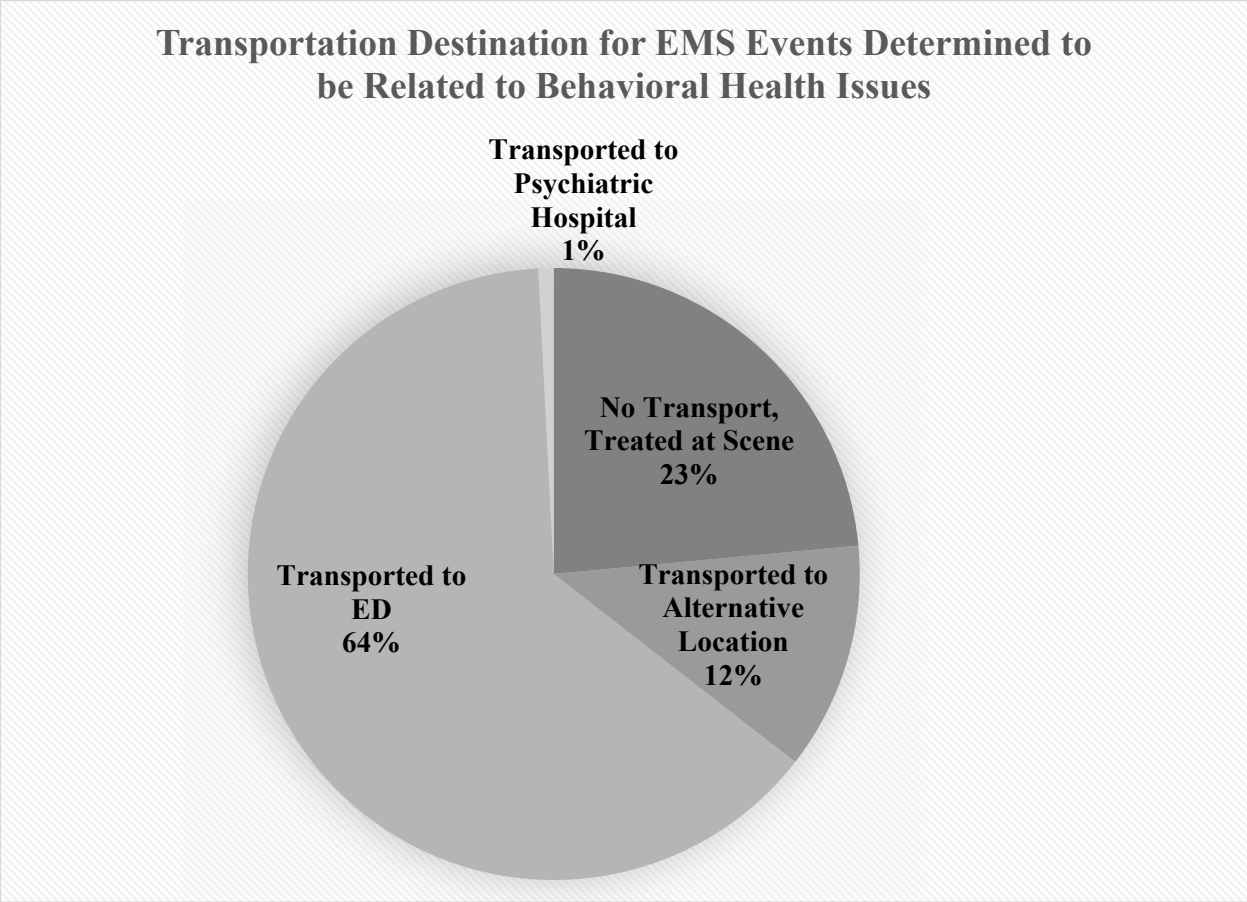
https://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2017-2018/SL2017-57.html

The intent of the pilot is described in the November 2016 report to the Joint Legislative Oversight Committee for Health and Human Services and the Fiscal Research Division:

"to use specially-training Emergency Medical Services (EMS) staff to intervene with patients experiencing behavioral health crises, and provide incentives for the participating EMS to either treat on-scene or route those patients not needing medical treatment to lower cost alternatives to hospital emergency departments (EDs). (p. 3)" https://files.nc.gov/ncdhhs/SL%202015-241%20Section%2012F%208%20d%20Community%20Paramedicine.pdf

In SFY 2018, as reported in the Behavioral Health Community Paramedicine Pilot Program (internal report produced by DMHDDSAS' Quality Management Team; accessed via email September 18, 2018), specially trained EMS workers in five counties in North Carolina (Forsyth EMS, Halifax EMS, Lincoln EMS, McDowell EMS, and Onslow EMS) responded to behavioral health emergencies under the aegis of the Community Behavioral Health Paramedicine initiative. A total of 1,233 community behavioral health paramedicine encounters were reported. Of those 1,233 emergency encounters, 290 were treated on the scene, and required no transport to a higher level of emergency response; another 148 encounters resulted in the individuals being transported to alternative emergency response facilities (e.g., BHUCs, FBCs) instead of hospital EDs. Figure 6 below presents the transportation destination by percent, with a combined total of 35% either being treated on the scene without transport (23%) or being transported to alternative emergency response facilities (12%).

Figure 6



Case Management Pilot Programs

1. Vaya Health – Mission Hospital – RHA Health Services, Inc

   This current pilot was implemented and receives funds from the Mental Health and Substance Use Task Force Reserve Fund, as established by Session Law 2016-94, Section 12F.3(b)., Resource Intensive Comprehensive Case Management (RICCM). The goal of this pilot was to reduce utilization of EDs and behavioral health inpatient through targeted and enhanced case management practices.

   Some of the high points:

   - Data showed a roughly 61% decrease in ED visits for people engaged in RICCM, with participants having an average 7.03 visits in the six months prior to receiving RICCM, and 2.69 visits in the six months post RICCM
   - Data showed a roughly 45% drop in behavioral health inpatient stays, with participants having an average 1.64 visits in the six months prior to receiving RICCM, and 0.89 visits in the six months post RICCM
   - Data showed a 17% increase in the Daily Living Activities (DLA-20) scores, which is a nationally recognized evidence based functional assessment. The increase in scores indicates an increased capacity in daily living domains.

2. Alliance Health – WakeMed Health and Hospitals
   This two-year Community Case Management Pilot program was funded by Session Law 2017-57, Section 11F.5A., at $2,000,000 to provide comprehensive community case management. The purpose of this pilot is to reduce ED readmissions and wait times (i.e., boarding times) within the ED for persons whose primary reasons for going to the ED are related to mental health and/or substance use services.

   This Comprehensive Community Case Management program includes case management, medication administration assistance, and behavioral health respite. These activities are staffed by four master's level case managers, a registered nurse, two medication technicians, a licensed clinical social worker and addictions specialist, a population health medical director, and the behavioral health respite personnel.

   Of the 56 individuals who have WakeMed Health and Hospital reported an 82% reduction in emergency encounters, an 88% reduction in the number of individuals being held on the observation unit of the emergency department, and an 83% reduction in inpatient encounters for the first six months of this pilot program (January - June 2018).

3. Trillium Health Resources – Recovery Innovations, Inc. – New Hanover Regional Medical Center
   The purpose of the Mental Health/Substance Use Central Assessment and Navigation pilot program (funded for two years by Session Law 2017-57, Section 11F.7. at $250,000 per

year) is to assess the needs of and navigate individuals with primary mental health and/or substance use service needs to appropriate services and other supportive resources within New Hanover county, resulting in reduced utilization of the emergency department of New Hanover Regional Medical Center. The pilot program is staffed by three employees staff of Recovery Innovations, Inc., forming the Peer Navigation Team. The licensed clinician on the Team performs Comprehensive Clinical Assessments (CCA) of individuals who are referred from a variety of sources, but primarily from New Hanover Regional Medical Center emergency department and inpatient services. The qualified professional and peer support specialist on the Team navigate the individuals to appropriate services and resources.

Due to delays in implementation, an evaluation of the effectiveness of the pilot project has not yet been conducted. However, the project has already enhanced communication between involved parties and 23 individuals received assistance from the Peer Navigation Team in less than two months (May and June 2018) of the pilot's operation. These referrals are anticipated to increase by three or four-fold in the coming months, along with a corresponding increase in the number of completed Comprehensive Clinical Assessments.

Behavioral Health Urgent Care and Facility Based Crisis

In SFY 2013, the NC General Assembly appropriated funding for Facility Based Crisis (FBC) centers and Behavioral Health Urgent Care (BHUC) centers to serve as alternatives to EDs and inpatient hospitalization for persons who experience crises related to mental health, substance use, or intellectual/developmental disabilities diagnoses. Eight BHUCs (i.e., Tier IV BHUCs) and all of the FBCs operate on a 24-hour, seven days per week basis. The FBCs are licensed residential facilities, under Rule 10A NCAC 27G Section .5000, and provide facility-based crisis service as described in Rule 10A NCAC 27G .5001. The state currently has 23 adult FBC Service sites, 11 of those are designated for the treatment of persons who are under involuntary commitment (IVC). The 23 FBC's have 323 beds to offer alternative treatment to inpatient hospitalization.

In addition, North Carolina has expanded the crisis response services to include Child FBCs beginning this year. The state currently has two Child FBC Service sites fully operational, with one of them designated for the treatment of persons who are under voluntary and involuntary commitment (IVC). Each Child FBC services site has a 16-bed facility which will provide care and treatment for children and adolescents ages 6 through 17, who need crisis stabilization services and 24-hour supervision due to a mental health crisis, substance use or withdrawal from drugs or alcohol, and will provide access to timely, age-appropriate mental health care during a time of crisis. Each site will also provide crisis care to young people with intellectual or developmental disabilities. The first Child FBC in the state is the SECU Youth Crisis Center through Cardinal Innovations and Monarch, which opened in Charlotte, NC on December 29, 2017. The second Child FBC is the Caiyalynn Burrell Crisis Center for Children, which opened in Asheville on June 21, 2018. This child FBC was developed through the partnership between Vaya Health and Family Preservation Services of North Carolina (FPS of NC). There are also

two additional Child FBC Service sites currently in the planning stages and are anticipated to open within the next one to two years.

The Session Law 2014-100 definition of Behavioral Health Urgent Care (BHUC) was as follows:

> *Behavioral Health Urgent Care Center. – An outpatient facility that provides walk-in crisis assessment, referral, and treatment by licensed behavioral health professionals with prescriptive authority to individuals with an urgent or emergent need for mental health, intellectual or developmental disabilities, or substance abuse services*

Some of the Tier IV BHUC sites are equipped with additional resources to help stabilize individuals in crisis. These resources are 23-hour crisis stabilization/observation beds, which provide supervised care to deescalate the behavioral health crises and reduce the need for emergent care. This service provides prompt assessments, stabilization and linking to the appropriate level of care. The intended outcome is to avoid unnecessary hospitalizations for people experiencing crises that may resolve with time and observation.

Together, Tier IV BHUCs and FBCs provide alternative routes for crisis stabilization that allow individuals in crisis to completely avoid an ED visit. The BHUCs function as effective alternatives to EDs for persons in behavioral health crisis who are not experiencing any significant medical distress. Like EDs, BHUCs are capable of providing first evaluations for involuntary commitment (IVC), and are able to refer persons needing crisis stabilization to either a hospital inpatient level of care, an FBC level of care, or an intensive outpatient level of care, depending on an individual's needs. FBCs function as local alternatives to an inpatient level of care, and typically provide three to five days of behavioral health crisis stabilization in a unit of 16 beds or less, including treatment of persons who are under involuntary commitment.
The above appropriation has helped with the development of some of these facilities:

- Vaya Health LME/MCO and RHA a provider agency, have opened a 24 hour BHUC in Buncombe County, and have moved an existing adult FBC to the same location, and will re-apply to be an IVC designated facility. This one location also encompasses RHA's outpatient services, a peer living room, a pharmacy, and community resources. Of interest here is that Mission Hospital assisted with funding this project due to the expectation that ED diversion will be successful.
- Eastpointe LME/MCO and Monarch a provider agency in Robeson County renovated its existing adult FBC to add 5 additional beds making it a 16-bed facility. The facility opened on August 28, 2017 and is an IVC designated facility. It also added a co-located BHUC component with two 23-hour crisis stabilization/observation chairs. The provider has developed a working partnership with Southeast Regional Medical Center to ensure a broader continuum of crisis care is available nearby.
- Former CenterPoint, now Cardinal Innovations Healthcare Solutions LME/MCO, and Daymark, a provider agency, in Forsyth County, opened a Tier IV BHUC in May 2018. The BHUC is co-located with outpatient services and a medical clinic will be opening early Fall 2018. On August 31, 2017, Daymark had an opening for a new FBC in

neighboring Davidson County which will service the Forsyth BHUC. The FBC has applied for IVC designation through DMHDDSAS

- Cardinal Innovations Healthcare Solutions, LME/MCO, and Monarch, a provider agency, in Mecklenburg County, is constructing a child/adolescent FBC (no BHUC). The FBC functions as a viable alternative to behavioral health inpatient, when it has received designation as an IVC facility.

Attachment 2 on page 45, provides a map of the BHUCs and FBCs throughout the state, indicating the LME-MCO service area and county.

With respect to the main intent of the appropriation, that is, to reduce ED visits for persons who experience behavioral health crises, DMHDDSAS was able to report in the December 1, 2016 legislative report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division that EDs in counties, in which BHUCs that were open 24 hours/seven days a week, had 25% fewer ED visits in SFY 2015. https://ncdhhs.s3.amazonaws.com/s3fs-public/SL%202015-24112F%201%20-%20Uniform%20System%20Beds-Bed%20Day%20Report.pdf

The following projection was included in the December 2016 report:

> If similar BHUC and FBC centers could be made available statewide as an alternative to EDs and inpatient hospitalization, NC could see up to 30,000 fewer ED visits for this population per year and fewer subsequent inpatient admissions.

The NC Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT) is the primary data source used to evaluate ED usage for this population. While DHHS access to these data for this purpose had been inaccessible to DMHDDSAS for several years, DMHDDSAS has recently obtained an agreement with the North Carolina Healthcare Association to regain access in October 2018.

VI. Summary and Recommendations to Sustain Success of Behavioral Health Crisis Alternatives and Hospital Inpatient

In response to the closure of Dorothea Dix state psychiatric hospital and the reduction of state psychiatric beds over the past two decades, the NC General Assembly has appropriated state funds to increase access to psychiatric inpatient care in community hospitals. The number of available Three-Way Contract inpatient beds has increased since SFY 2008 from 77 to 166 in SFY 2018. For Three-Way Contract inpatient services provided between July 1, 2017 and June 30, 2018, DMHDDSAS has expended approximately $38.9 million, with another $15.5 million for state-funded psychiatric inpatient care paid through Single Stream allocation funds.

Local funding was reported by the LME/MCOs in the amount of $7.7 million (e.g., county contributions) to have been used to pay for psychiatric inpatient care. However, much of those

local dollars paid for the YP 820 psychiatric and substance use inpatient care; reflecting the bulk of the funding for that service.

Need to Prevent Unnecessary Hospital ED Visits and Behavioral Health Inpatient Admissions

In many communities, hospital EDs have become the default resource for many people without health insurance who experience behavioral health crises. Over-crowding of many Emergency Departments as well as lengthy wait times for persons in EDs who are referred for behavioral health inpatient care have been repeatedly reported by the media and hospitals. Fortunately, the NC General Assembly has provided some funding for BHUCs and FBCs to reduce the burden on hospitals, and to facilitate access for persons without health insurance to obtain effective behavioral health resources that divert individuals from unnecessary hospital admissions.

While hospital inpatient care offers the most intensive level of behavioral health crisis stabilization in the continuum of services for persons with mental illness, substance use disorders, and intellectual/developmental disabilities, it is the most restrictive and expensive care within our array of services; and may not be the most appropriate level of care to address some crisis situations. In order to access this level of care, individuals, especially those who have no health insurance and who often have received no behavioral health services, experience behavioral health crises, and do not receive intervention at a lower level of care; thus, the crises escalate until the most intensive, restrictive, and expensive intervention is determined necessary.

Hospital EDs and inpatient services should be reserved for and used to treat persons with acute behavioral health crises that cannot be treated at a lower level of care. The needs of individuals that are appropriate for hospital EDs include the need for acute medical stabilization (e.g., injuries, emergent medical illness) along with behavioral health crisis stabilization. Persons who need only behavioral health crisis response and stabilization can be appropriately served at lower levels of care, including FBCs, NHMD, BHUCs, Assertive Community Treatment, Community Support Team, and other intensive outpatient services.

As most would agree, it is better for the people who rely on services funded by DMHDDSAS, and more cost-efficient to prevent crises than to have to intervene, after crises have escalated, via the most restrictive and expensive services available. To avoid the over-crowding of and unnecessary visits to EDs and to prevent some of the need for inpatient admissions for persons without health insurance, planning and funding should focus on developing and implementing a strategy that strives to serve people in their communities within a comprehensive continuum of care.

Three reports that have been submitted by DHHS to the North Carolina legislature since 2013 all proffer recommendations about the integration of crisis services into a robust continuum of services that offer accessible and multiple levels of care within local communities that are intended to prevent crises and intervene earlier in a crisis episode, which will reduce some of the need for ED visits and psychiatric inpatient admissions. The most recent of the three reports, *Strategic Plan for Improvement of the Behavioral Health Services* (January 31, 2018), highlights a fundamental requisite to ensure timely access to high quality services:

> A critical component of achieving this vision is to build upon and enhance community-based networks of care. When individuals can access lower-level and less costly services before going into crisis, everyone benefits. However, there is a shortage of community-based providers in North Carolina. This shortage leads to significant increases in ED wait-times, more frequent ED visits, extended placements in institutional settings, and higher system costs (p. 32)

Links to each of the three of these reports are provided here:

- Report to Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division on *Strategies for Improving Mental Health, Developmental Disabilities and Substance Abuse Services*

  https://www2.ncdhhs.gov/mhddsas/statspublications/Reports/reports-generalassembly/generalreports/Strategies%20for%20Improving%20MHDDSAS.pdf

- Report to Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division on *Strategies to Increase Child and Adolescent Behavioral Health Inpatient Beds*

  https://files.nc.gov/ncdhhs/SL%202014-10012F%203%28b%29%281%29%20Child%20%20Adolescent%20Beds.pdf

- Report to Joint Legislative Oversight Committee on Health and Human Services, Joint Legislative Oversight Committee on Medicaid and NC Health Choice and Fiscal Research Division on *Strategic Plan for Improvement of Behavioral Health Services*

  https://files.nc.gov/ncdma/documents/Reports/Legislative_Reports/SL2016-94-Sec12F-10-and-SL2017-57-Sect11F-6_2018_01.pdf

Recommendations in each report cited above emphasize the need for integrated care, health promotion and wellness, prevention, early intervention, alternative crisis services and diversion programs.

To ensure the sustainability of effective community hospital psychiatric and substance abuse inpatient care, and other crisis response services, BHUCs, FBCs, and NHMDs, it is essential that these services are supported by a fully-functioning foundation of lower level, integrated community services for North Carolinians who have mental illness, substance use disorders, and intellectual and developmental disabilities.

In order to have a state-wide impact on unnecessary visits to hospital EDs and admission to behavioral health inpatient level of care, the number of Tier IV BHUCs, FBCs (for both adults and children/adolescents), and NHMDs should be increased, especially in locations having close proximity to hospitals with EDs and behavioral health inpatient beds.

Need to Improve Management of Three-Way Contract Psychiatric Inpatient Care

With respect to the two-tier system of payment for Three-Way Contract inpatient services, it has become evident that the upper tier (Enhanced Three-Way), intended to serve individuals with higher levels of acuity (e.g., violence, medical fragility), has been infrequently utilized. DMHDDSAS will continue to review the need for this Enhanced Three-Way level of care with the LME/MCOs and community hospitals.

Monitoring Impact of Efforts to Reduce ED Visits

Within the last several months, DHHS/DMHDDSAS came to an agreement with the North Carolina Health Care Association (formerly, North Carolina Hospital Association) to restore DMHDDSAS' access to NC DETECT data to track of ED utilization trends. DMHDDSAS will regain access to NC DETECT in October 2018.

References

1. **General Assembly of North Carolina. Session Law 2017 – 57, Senate Bill 257, Section 11F.3.(a) – (f).** ***Funds for Local Inpatient Psychiatric Beds or Bed Days.*** https://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2017-2018/SL2017-57.html. **Accessed September 17, 2018**

2. **National Committee for Quality Assurance.** ***Healthcare Effectiveness Data and Information Set.*** **HEDIS 2016 Measures. Washington, D.C. National Committee for Quality Assurance; 2016. Available from http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2016/HEDIS%202016%20List%20of%20Measures.pdf Accessed September 21, 2016.**

3. **North Carolina Department of Health and Human Services Division of Health Service Regulation, North Carolina State Health Coordinating Council.** ***North Carolina 2018 State Medical Facilities Plan.*** **January 1, 2018. Available from https://www2.ncdhhs.gov/dhsr/ncsmfp/index.html. Accessed September 15, 2018.**

4. **North Carolina Department of Health and Human Services Division of Facility Services, Medical Facilities Planning Section, North Carolina State Health Coordinating Council.** ***North Carolina 2007 State Medical Facilities Plan.*** **January 1, 2007. Available from https://www2.ncdhhs.gov/dhsr/ncsmfp/archive.html. Accessed September 29, 2017.**

5. **North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services Report to the Senate Appropriations Committee on Health and Human Services, House of Representatives Appropriations Subcommittee on Health and Human Services, Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services and Fiscal Research Division.** ***Report on the Provision of Behavioral Health Crisis Services by Hospital Emergency Departments.*** **March 1, 2011. Available from https://www2.ncdhhs.gov/mhddsas/statspublications/Reports/reports-generalassembly/generalreports/edreport-3-11.pdf. Accessed September 21, 2016.**

6. **North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services Report to Joint Legislative Oversight**

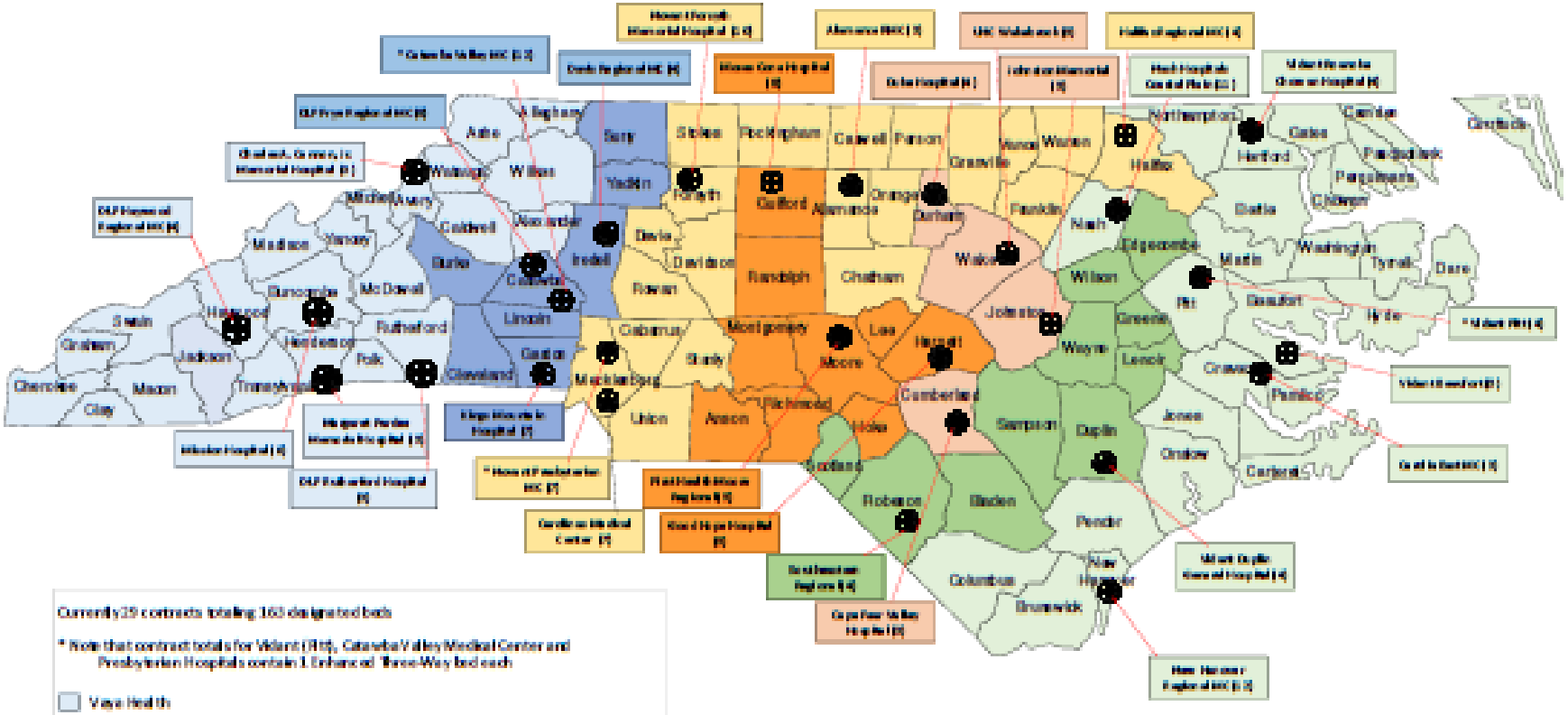
Committee on Health and Human Services and Fiscal Research Division. *Report on Strategies for Improving Mental Health, Developmental Disabilities and Substance Abuse Services.* November 1, 2014. Available from https://www2.ncdhhs.gov/mhddsas/statspublications/Reports/reports-generalassembly/generalreports/Strategies%20for%20Improving%20MHDDSAS.pdf Accessed September 30, 2017.

7. **North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services Report to Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division. *Report on Strategies Increase Child and Adolescent Behavioral Health Inpatient Beds.* March 1, 2015. Available from https://files.nc.gov/ncdhhs/SL%202014-10012F%203%28b%29%281%29%20Child%20%20Adolescent%20Beds.pdf. Accessed September 30, 2017.**

8. **North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services Report to Joint Legislative Oversight Committee on Health and Human Services, Joint Legislative Oversight Committee on Medicaid and NC Health Choice and Fiscal Research Division. *Strategic Plan for Improvement of Behavioral Health Services.* January 31, 2018. Available from https://files.nc.gov/ncdma/documents/Reports/Legislative_Reports/SL2016-94-Sec12F-10-and-SL2017-57-Sect11F-6_2018_01.pdf. Accessed September 15, 2018**

Attachment 1

North Carolina
Three-Way Contract Community Hospital Beds
As of July 1, 2018



Attachment 2

North Carolina Behavioral Health Facility-based Crisis & Behavioral Health Urgent Care locations (with and without Involuntary Commitment designation)