Review of Psychiatric and Substance Use Disorder Bed Need Methodologies in the State Medical Facilities Plan

April 2020

Prepared for: State Health Coordinating Council, Long-Term and Behavioral Health Committee

Prepared by: Healthcare Planning & Certificate of Need Section

- Healthcare Planning invites SHCC members and members of the public to submit comments on this annotated presentation.
- Email any comments you wish to make to
  - DHSR.SMFP.Petitions-Comments@dhhs.nc.gov .
  - **Deadline for Comments: May 6, 2020**
- Healthcare Planning will post all comments on our website and present them to the LTBH committee for consideration at the May 14, 2020 meeting.
- If you have specific questions not addressed in the presentation, please contact Amy Craddock (amy.craddock@dhhs.nc.gov).

Psychiatric Inpatient Bed Need Methodology

Reasons for Current Examination of Methodology

- Need methodology does not often show need for additional adult beds, but many mental health professionals and others are certain that more beds are needed
- What can SMFP and CON law/process do to address this disconnect?

- It's time to examine…
  - Principles and assumptions on which the methodology is based
  - Methodology calculations
  - Alternatives if current methodology is not adequate

The State Medical Facilities Plan

- Covers beds only in licensure categories that are subject to the Certificate of Need law
  - Private psychiatric hospitals
  - Psychiatric units in acute care hospitals
- SMFP does not cover
  - Other facilities/beds that provide residential behavioral health treatment/services (e.g., crisis centers)
  - Hospital emergency departments
  - State facilities
  - NC residents who receive treatment out of state
  - Out of-state residents who receive treatment in NC (account for about 4-5% of total adult days of care)
- Proportion of total licensed beds covered in SMFP
  - Adult – 89%
  - Child/adolescent – 23%
- Produces need determinations for adult and child/adolescent beds by LME-MCO
  - People can apply for CON to develop beds anywhere in any LME-MCO that shows a need
  - Cannot develop more beds than need determination indicates
- Petitions
  - People can petition the SHCC to develop beds based on characteristics of specific geographic area or population

Need Determinations and CON Applications, 2015-2020, Psychiatric Inpatient Beds

SMFP	Adult Beds		Child/Adolescent Beds	
	Need Determinations	Beds Applied for	Need Determinations	Beds Applied for
2015	69	63	46	0
2016	36	32	35	0
2017	40	25	106	0
2018	0	---	47	0
2019	0	---	48	0
2020	2	*	89	*

* All CON due dates have not yet passed for the 2020 SMFP

Number of Current and Planned Beds

Adult, 2018

- 1,977 licensed (2020 SMFP)
- 95 CON-approved under development
- Approximately 257 others
  - 124 - last group of SMFP Policy PSY-1 transfers
  - ~133 – sale of Dorothea Dix Hospital property/GA funds
- Within ? years, about 2,329

Child/Adolescent, 2018

- 386 licensed (2020 SMFP)
- 0 CON-approved under development
- 10 additional from last PSY-1 transfers

Does NC Need Additional Inpatient Psychiatric Beds?

- Overall utilization of inpatient psychiatric beds in NC, 2018 data from SMFP
  - Adults – 62%
  - Children/Adolescents – 86%
- In 2017, NC ranked 35th on combined measure of prevalence of mental illness and access to all types of care (rank of 1 is best).
  - Adults – 21st
  - Youth – 44th (age 12-17)
- 2012 study in NC, estimated need for 356 additional inpatient beds to reduce wait ED times to 1 day.

LME-MCO	Adult			Child/ Adolescent		
	Beds	Population	Beds per Capita	Beds	Population	Beds per Capita
Alliance	382	1,448,897	26	92	465,592	20
Cardinal	613	2,447,435	25	140	714,486	20
Eastpointe	143	508,482	28	0	154,729	0
Partners	250	797,236	31	27	216,925	12
Sandhills	146	866,230	17	30	257,507	12
Trillium	263	1,157,232	23	80	314,045	25
Vaya	180	860,718	21	17	192,446	9
TOTAL	**1,977**	**8,086,230**	**24**	**386**	**2,315,730**	**17**

Table 1. Bed Availability Per Capita by LME-MCO

Current Methodology

- Service (catchment) area is LME-MCO
  - Area for which needs are projected
- 75% is optimum occupancy to achieve before methodology calculates a need for additional beds
- Calculations project need 4 years beyond the reporting year
  - Data reported for 2018 is projected to 2022 (“projection year”)
- Planning inventory
  - Licensed beds in psychiatric hospitals and in units of acute care hospitals
  - CON-approved beds not yet licensed
  - Includes licensed beds that may not be operational/staffed
- Days of care (DOC) ***by patient’s LME-MCO of residence*** is basis for utilization
- Separate methodologies for adults and children/adolescents, but calculations are the same

Calculations

- Calculate DOC for reporting year
  - DOC in licensed beds in psychiatric facilities/units
  - DOC in “standard” beds in acute care hospitals
  - Not multi-day stays in EDs
- Calculate DOC for projection year
  - Multiply DOC by projection year population
  - Divide by reporting year population
- Calculate number of beds needed for projection year
  - Divide DOC for projection year by 75%
- Calculate need determination
  - Subtract number of beds needed for projection year from number of beds in planning inventory

Considerations in Assessing Current Methodology

- Principles and assumptions
- Bed availability in relation to population
- Bed utilization
- Patient migration out of home LME-MCO

Principles and Assumptions of the Methodology

Principles

- Inpatient beds provide more than stabilization but less than long-term institutionalization (less than 60 days).
- Admission to community-based facility is preferable to admission to state facility for people in acute distress.
- Continuum of services should be provided.
- Separate units for of adult and child/adolescent patients.

Assumptions

- Patients should be able to get services near their LME-MCO of residence.
- 75% is optimum occupancy
- Project needs 4 years beyond reporting year to allow for time to develop new beds

LME-MCO	Adult		Child/Adolescent	
	Beds	% Total Utilization	Beds	% Total Utilization
Alliance	382	67%	92	132%
Cardinal	613	71%	140	80%
Eastpointe	143	36%	0	0%
Partners	250	58%	27	17%
Sandhills	146	50%	30	50%
Trillium	263	71%	80	83%
Vaya	180	49%	17	80%
Total	**1,977**	**62%**	**386**	**86%**

Table 2. Facility Bed Utilization by LME-MCO, 2018

Figure 1. Adult Inpatient Psychiatric Treatment: Migration by LME-MCO, 2018



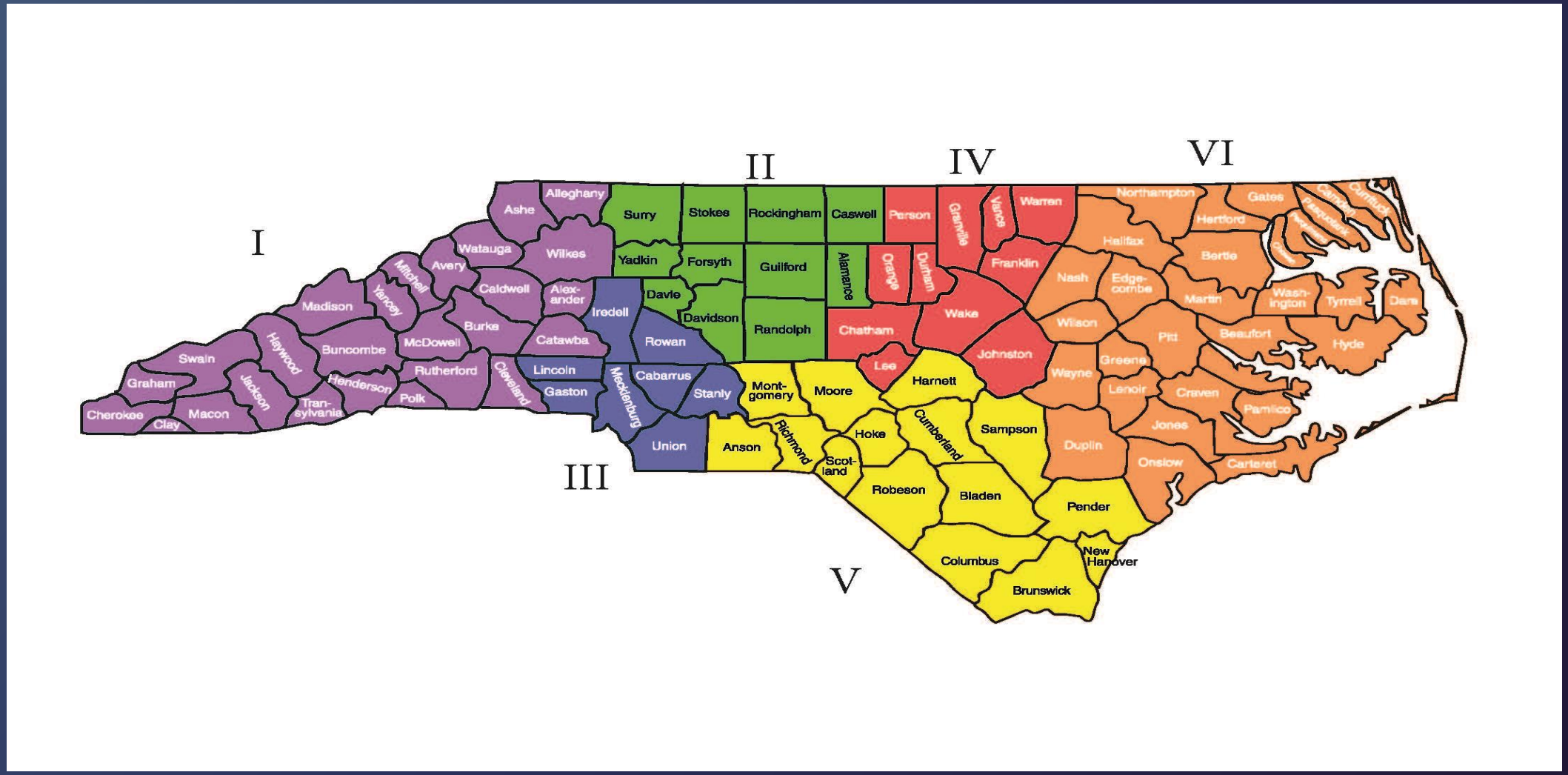
General Options to Current Methodology

1. Use same calculations as current methodology, but change the service area.
   - use patient county of residence as basis for calculating utilization and need
   - *Interpretation: Need determination reflects the need for beds to serve people who are residents of each service area*
2. Change the basis for calculating need
   - use location of the facility as basis for calculating utilization and need
   - *Interpretation: Need determination reflects the need for beds in each service area, based on the utilization of facilities in the service area*
3. Eliminate the mathematically-based need methodology
4. Status Quo - Do nothing

Option 1: Change the Service Area

- Use same calculations as current methodology, but…
- Change the Service Area – Still use patient county of residence. We considered three optional service area configurations as basis for need projections
  1. Patient's Health Service Area (HSA) of residence
     - DHSR uses 6 geographically-defined HSAs (see next slide)
     - Unlike LME-MCO, made up of contiguous counties
  2. Patient's Substance Use Disorder methodology region of residence
     - 3 regions based on LME-MCOs
       - Western – Partners, Vaya
       - Central – Alliance, Cardinal, Sandhills
       - Eastern – Eastpointe, Trillium
  3. Statewide service area
     - Calculate need for state as a whole

Figure 2. Health Service Areas



Option 2: Change Basis for Calculating Utilization

- Used same calculations as current methodology
- Changed BASIS FOR CALCULATING DAYS OF CARE
  - Days of care in each facility

- Used Same Service Areas as Option 1
  - LME-MCO of facility (used in current methodology)
  - Health Service Areas (HSA) of facility
  - Substance Use Disorder methodology region of facility
  - Statewide

Option 3: Eliminate Mathematically-Based Need Methodology

- Possible Rationales
  - The SMFP includes less than 25% of child/adolescent beds
  - Includes all licensed beds, but 18% of beds in acute care hospitals are not operational
  - Agency has no data to address social determinants of need for treatment or services provided, primarily ability to pay
  - Methodology excludes out-of-state residents who receive treatment in NC
- Could apply to all facilities or only to child/adolescent or adult

- SMFP does not require mathematically-based need methodology, but development of inpatient beds requires CON
  - Currently, CON application must project 75% utilization by end of second operating year
  - This requirement can change
- SMFP can set some requirements/thresholds/parameters regarding development of beds as long as they do not conflict with CON law (or other laws)

Option 4: Status Quo

- If, after consideration, the Committee finds that the current methodology is the best option, then the committee needs to take no action.

Table 3. Summary of Need Determinations for Mathematically-based Methodology Options

Bed Type	2020 SMFP	Change Service Area			Change Basis for Need Projections			
	LME-MCO	HSA	SUD	State	LME-MCO	HSA	SUD	State
Child/ Adolescent	89	96	64	63	97	94	86	66
Adult	2	52	0*	0*	22	16	0**	0***
Total	**91**	**148**	**64**	**63**	**119**	**110**	**86**	**66**

* Surplus of 274 beds
** Surplus of 414 beds
*** Surplus of 250 beds

Substance Use Disorder Inpatient/Residential Bed Need Methodology

Background

- Methodology implemented in 1984 SMFP – only a couple of minor tweaks since then
- SMFP includes only inpatient and residential beds that are covered in the CON law, which comprise
  - about 35% of all adult substance use disorder (SUD) beds in the state
  - about 2% of child/adolescent SUD beds in the state
- SMFP does not cover
  - Group homes
  - Therapeutic communities
  - State facilities
  - Detention/correctional facilities

Utilization

- Statewide utilization
  - 73% adults
  - 21% children/adolescents
- About 24% of days of care are provided in acute care hospitals
  - Probably stays of less than 7 days
- Only about 38% of the SUD beds in acute care hospitals are operational.

Methodology

- Bed need determinations are calculated separately for children/adolescents and for adults
- Produces bed need determinations by 3 LME-MCO-based planning regions
  - Western – Partners, Vaya
  - Central – Alliance, Cardinal, Sandhills
  - Eastern – Eastpointe, Trillium
- Based on days of care for patients by their region of residence
- Methodology calculates total need and then
  - assigns needed beds to children/adolescents that are sufficient to provide 9% of the total days of care projected (for adults children/adolescents combined)

Need Determinations and CON Applications, 2015-2020, Substance Use Disorder Beds

SMFP	Adult Beds		Child/Adolescent Beds	
	Need Determinations	Beds Applied for	Need Determinations	Beds Applied for
2015	37	12	28	0
2016	45	22	28	0
2017	0	---	17	8
2018	14	14	15	0
2019	34	0	20	0
2020	33	*	23	*

* All CON due dates have not yet passed for the 2020 SMFP

Why aren't beds in SMFP applied for?

- $$$$$
- A single need determination of just a few beds may not be efficient

Proposal

- Eliminate SMFP's mathematically-based methodology, but continue to report inventory and utilization
- Allow development of beds anywhere
- Currently, CON applications must show that applicant can meet performance standards:
  - Existing facilities must show in the 9 months preceding CON application:
    - 1-15 beds – 75% utilization
    - 16+ - 85% utilization
  - Proposed new facilities must show that by end of 2nd operating year
    - 1-15 beds – 75% utilization
    - 16+ - 85% utilization
- Policy MH-1 in the SMFP requires CON applicants to invite the LME-MCO to comment on the proposed service

Summary and Next Steps

- This annotated presentation has explained the rationale for examining the behavioral health bed methodologies in the SMFP and offered some options to the current methodologies.
- Next Steps: email any comments you wish to make to DHSR.SMFP.Petitions-Comments@dhhs.nc.gov .
  - **Deadline for Comments: May 6, 2020**
- Healthcare Planning will post all comments on our website and make them available to the LTBH committee for consideration at the May 14, 2020 meeting.
- At that meeting, the LTBH committee may choose to make recommendations to the SHCC regarding these methodolgies.