Long-Term and Behavioral Health Committee
Division Recommendation
Substance Use Disorder Bed Need Methodologies
in the 2021 Medical Facilities Plan
April 8, 2021

Several years ago, the SHCC committed to examining the methodologies in the State Medical Facilities Plan (SMFP) to assess whether some need revision. The substance use disorder (SUD) methodology was incorporated into the SMFP in 1985. The last substantive changes to the SUD methodology were made in the early 1990s. The SUD methodology is one of the oldest in the SMFP and is, therefore, overdue for examination.

The process of reviewing the methodology began with solicitation of public comments in the spring of 2020. Staff made a presentation to the May 14, 2020 meeting of the Long-term and Behavioral Health (LTBH) Committee in which they recommended elimination of the methodology. The committee requested an Interested Parties meeting and additional time to consider the issues. The Interested Parties meeting was to have occurred soon after the committee meeting, but the COVID-19 pandemic interrupted the process. As a result, an Interested Parties meeting was held on February 4, 2021.

Understanding the Number of Substance Use Disorder Beds in the State

Unlike most other inpatient and residential healthcare facilities, all SUD beds are not subject to the Certificate of Need (CON) law. Table 1 outlines the bed licensure categories in the North Carolina Administrative Code (NCAC). The Acute and Home Care Licensure Section licenses beds under 10A NCAC 13B .5200; the Mental Health Licensure Section licenses all other beds. The primary licensure distinction is that beds in the SMFP are in facilities where a physician and medical staff supervise and provide SUD treatment.

Table 1 shows the total number of SUD treatment beds in the state. It shows that most beds are not subject to the CON law and, consequently, are not in the SMFP. Overall, 3% of the child/adolescent (age 17 and younger) SUD beds licensed across the state require a CON, as do about 39% of the adult beds (licensure categories .3400, .5200, and .6000). An additional 450 beds serve all age groups.

Table 1 also shows that most child/adolescent beds in licensure categories that are not subject to the CON law may treat either mental health or SUDs or both. The regulations do not require facilities to designate a specific number of beds for one type of treatment versus the other. In short, the total number of SUD beds in the state is somewhat fluid.

Table 1: Substance Use Disorder Treatment Beds (December 2019)

License Category		Child/ Adolescent Beds	Adult Beds	Both Child/Adolescent and Adult
.1700	Residential, max. 12 beds, often single-family dwelling, mental health/SUD	633		
.1800	Residential, staff secure, max. 12 beds, often single-family dwelling, mental health/SUD	24		
.1900	Psychiatric, institutional, mental health/SUD	313		
*.3400**	Residential SUD	*14*	*305*	
.4100	Residential, individuals with SUD and their children		90	210
.4300	Therapeutic Community		650	178
.5000	Crisis services, mental health and SUD	25	192	62
*.6000**	Mental Health Hospital (10A NCAC 27G)	*4*	*182*	
*.5200**	Acute Care Hospital (10A NCAC 13B *)*	*12*	*120*	
Total		**1,025**	**1,539**	**450**

* CON required. Beds are in SMFP.

A facility in the SMFP is not free to adjust the distribution of beds by age group without a CON because the methodology projects need separately for adults and children/adolescents. The licensure process does not license beds separately by age group, but the SMFP methodology does require the distinction.

Although counting the number of licensed SUD beds in the SMFP is straightforward, identifying the type of bed in which a person receives treatment is more difficult. In all inpatient and residential settings, a person with a SUD may be treated in a bed licensed as a psychiatric bed (because a SUD is a mental disorder). As a result, the number of beds licensed as SUD beds may be fewer than the number of beds in which facilities actually provide SUD treatment. Some acute care hospitals with no licensed SUD beds report inpatient SUD days of care (DOC); these DOC are included in the need determination calculations, even though there is no associated bed inventory. In fact, among acute care hospitals, most of the total adult SUD DOC are provided by hospitals without licensed SUD beds.

Substance Use Disorder Methodology in the SMFP

Need projections are produced separately for children/adolescents and for adults. The methodology first aggregates facility data to the level Licensed Management Entity-Managed Care Organization (LME-MCO) level. Then to project bed needs, calculations aggregate LME-MCO data into three regions (western, central, and eastern). At its inception, the methodology assumed that the supply of treatment beds for problem drinkers was adequate and should only increase based on changes in DOC and population. It also assumed that 9% of the total SUD bed need reflects the need for child/adolescent beds. These methodology assumptions have not been reevaluated in about 35 years.

Public Comments and Staff Analysis

Most of the public comments received did not address the SUD methodology. Of the two specific comments, one recommended elimination of the methodology and the other recommended further study.

Since 2015, need determinations for adult SUD beds usually resulted in CON applications, while need determinations for child/adolescent beds almost never did (see Table 2). All beds for which a CON application was received since 2015 were approved. Most approved beds are in urban areas. Specifically, the 34 beds approved in 2015 and 2016 are in Wake County and the 32 beds approved in 2020 are in Forsyth County. The 70-bed need determination in 2021 is in the Eastern Region, which includes both urban and rural counties[1]. The bed needs in Richmond and Forsyth[2] counties were the result of summer petitions in 2017 and 2018, respectively. The 2017 petition (for the 2018 SMFP) was the first petition received since 2001.

Table 2. Substance Use Disorder Need Determinations, 2015-2021 SMFP

SMFP	Adult Beds				Child/Adolescent Beds			
	Need Determinations			CON Appli-cations	Need Determinations			CON Appli-cations
	Western	Central	Eastern		Western	Central	Eastern	
2015	0	12	25	12	0	18	10	0
2016	0	22	23	22	19	9	0	0
2017	0	0	0	-	0	17	0	0
2018	0	14	0	0	0	15	0	0
2019	0	32	2	0	3	17	0	0
2020	0	32	1	32	3	20	0	0
2021	0	0	70	*	2	20	0	*

Source: NC State Medical Facilities Plans, 2015-2021.

* CON application deadlines have not yet passed for the 2021 SMFP.

Conclusions

The primary question to address when examining the methodology is the validity of bed need projection calculations that cover substantially less than half of the licensed adult beds and

[1] This need determination was the result of an amendment to the 2021 SMFP.

[2] The 2019 32-bed need was the result of a petition. The petitioner did not file a CON application when first eligible, but they re-petitioned in 2020 and were approved.

almost none of the child/adolescent beds. On this basis alone, the current methodology is not valid on its face.

Another issue is the assumption that the beds in the SMFP serve a substantially different population than other types of beds. One of the basic principles of the methodology (SMFP, Chapter 15) states that "[h]ospitalization shall be considered the most restrictive form of therapeutic intervention…." This principle may also imply that residential facilities are one step below hospitalization in the continuum of care in terms of restrictiveness and intensity, although the methodology considers both types of beds to be equivalent for planning purposes. It further implies that hospitalization is uniform. However, anecdotal information indicates that acute care hospitals usually provide little more than detox because stays are reportedly typically less than 7 days. On the other hand, SUD treatment in mental health hospitals is longer and believed to be much more therapeutic.

Moreover, it seems likely that several of the other residential licensure categories may be similar to the residential beds in the SMFP. The mere fact that treatment in facilities in the SMFP is directed by a physician does not necessarily imply that the treatment received is inherently more intense or therapeutic than other modalities. It is also not clear that the facilities in the SMFP serve a substantially different population than some other types of residential facilities. Thus, the SMFP need projections are not useful: (1) to the extent that the beds subject to the CON law are not likely to serve a substantively different population than many of the beds <u>not</u> covered by the law; and (2) because the methodology covers a relatively small percentage of the total number of beds in the state.

One may assume that removal of the need methodology would increase the number of SUD beds in the state to such a degree that there would be unnecessary duplication of services. However, a CON would still be required before the beds could be licensed. The applicant would be required to identify the population to be served and to demonstrate the need that the population has for the proposed beds. The applicant must also demonstrate in the application that the proposal would not result in an unnecessary duplication. Given the small number of need determinations that resulted in CON applications and the dearth of petitions, it is unlikely that removal of the need methodology would result in unnecessary duplication. The need methodology in the SMFP is not the prime reason for the lack of CON applications. Rather, overwhelming, albeit anecdotal, evidence points to the low reimbursements for treatment services as the primary reason there have not been very many CON applications.

<u>Division Recommendations</u>

The Division recommends removal of the need determination methodology for child/adolescent and adult SUD beds. Experience indicates that removal of the need methodology is highly unlikely to result in unnecessary duplication of services. People who wish to develop additional SUD beds in the licensure categories covered under the CON law would continue to be required to apply for a CON. Representatives from other state agencies and organizations have expressed a clear and strong preference for the CON law to remain in effect for these facilities. Specific recommendations are:

- Remove need determination methodology beginning with the Proposed 2022 SMFP.
- Continue to provide inventory and utilization data in the SMFP to aid in the preparation of CON applications.
- Eliminate the distinction between child/adolescent and adult beds for existing and proposed facilities.
- Need determinations will no longer be published in the SMFP. Thus, entities may apply for a CON without regard to a need determination. Petitions will not be required.
- Do not designate certain people or entities to be qualified applicants for CONs.
- CON applications must contain a patient access and financial assistance policy that includes a plan to enable access to care for uninsured and other medically underserved patients. Reserve 15% of new beds for people who are indigent or otherwise medically underserved. However, the Division cannot guarantee compliance with this requirement.
- Make no changes to Policy MH-1.
- Conduct an annual review of changes for first two years of implementation

Inventory and Utilization. Reporting inventory and utilization is standard practice for most services and facilities that require a CON but that do not have a need determination methodology. Inclusion of this data is vital for entities that file CON applications and it is not likely to be easily available elsewhere.

Remove distinction between adult and child/adolescent beds. A facility's license does not determine the number of child/adolescent and adult beds. The CON makes this distinction only because the methodology projects need separately for the two age groups. If the need methodology is removed, this distinction would cease for new facilities. The Division recommends that this distinction be removed for both existing and proposed facilities

Process for applying for beds. In the absence of a methodology, two alternatives exist for ways that a facility may apply for a CON. The first is via an adjusted need determination petition (summer petition). If successful, the SMFP would include a need determination for the maximum number of beds that can be developed in a specific geographic area. Such applications could be competitive, although experience shows that this is unlikely. The second way is simply to allow people to apply for a CON on any date allowed in the CON review schedule. The CON application would have to demonstrate a need. The applicant could not apply for more beds than the number for which they demonstrated a need. The Division recommends the latter because it affords the widest opportunity to develop additional SUD beds.

Qualified Applicants. It is possible to set parameters for eligibility to file a CON application. It is important to note that any person proposing to develop a new facility must be able to show that the facility is eligible for licensure under a code that is subject to the CON law. Therefore, further restrictions in this area are not necessary.

Medically Underserved. It can be challenging for privately insured people to obtain SUD treatment. It is even more challenging for people with government payers and those with no coverage. In addition, people with co-occurring disorders can face challenges in obtaining SUD services. These are only two examples of people who may be considered medically underserved. The Division, therefore, recommends that the SMFP include a policy to require CON applicants to include in the CON application a proposed patient access and financial assistance policy that includes a description of how the facility shall provide access to care for uninsured patients.

However, it is very difficult for CON to enforce strict compliance with such a policy after the beds are licensed and occupied.

As a suggestion to the LTBH Committee, CON applicants for new beds may be required to reserve a proportion of beds for medically underserved patients. In this context, people who are medically underserved are defined as: people who are members of minority racial or ethnic groups; children and adolescents; those without employer-provided or private insurance; those with government-funded insurance (e.g., Medicaid); people with co-occurring disorders; and people who are homeless, elderly, or ex-offenders. However, it is very difficult for CON to enforce strict compliance with such a policy after the beds are licensed and occupied. While it may be tempting to reserve a large proportion of beds for people who are medically underserved, doing so may have the unintended consequence of causing a new facility to not be able to be financially viable.

Policy MH-1. This policy requires CON applicants to invite the LME-MCO to comment on a CON application. The Division recommends no changes to this policy.

Annual Review. It is common that redesigned methodologies in the SMFP undergo annual review for a period of time to examine whether changes may be warranted. The Division recommends annual review of the approved changes for the first two years of implementation.