To: North Carolina Division of Health Service Regulation
Healthcare Planning and Certificate of Need Section

From: Alliance Health
Cardinal Innovations Healthcare
Trillium Health Resources
Vaya Health

Re: Comments on April 2020 presentation entitled "Review of Psychiatric and Substance Use Disorder Bed Need Methodologies in the State Medical Facilities Plan"

Date: May 6, 2020

On behalf of Alliance Health, Cardinal Innovations Healthcare, Trillium Health Resources, and Vaya Health, Local Management Entity/Managed Care Organizations (LME-MCOs) managing publicly funded behavioral healthcare services for the residents of 72 counties in North Carolina, we appreciate the opportunity to provide comments regarding the April 2020 presentation entitled "Review of Psychiatric and Substance Use Disorder Bed Need Methodologies in the State Medical Facilities Plan" (the "Presentation") prepared for the Long-Term and Behavioral Health Committee of the North Carolina State Health Coordinating Council.

The Presentation contains a proposal to eliminate North Carolina's Certificate of Need (CON) methodology for determining the state's need for psychiatric inpatient beds and substance use disorder (SUD) inpatient/residential beds. However, despite the significant scope and impact of such proposal, the Presentation fails to demonstrate how this change would result in improved access to these particular inpatient beds across the state. Therefore, we offer the following main comments which are explained herein:

- Eliminating the current bed need methodology will likely result in bed expansion in North Carolina's highest population centers and exacerbate treatment disparities across the state.
- Rather than eliminating the current methodology, it should be updated to account for the health coverage status of patients and the reality that a significant portion of licensed beds in the state are not operational. Additional beds may create more options for the insured population, but they will not address the needs of individuals who are uninsured, a population that is already over-represented in hospital emergency departments (EDs). If new beds become available through the elimination of the CON methodology, additional funding will need to be identified for inpatient care for those without insurance or significant ED boarding issues will continue and likely worsen.
- The changes proposed to the methodology in the Presentation will likely not resolve ED boarding issues. Long lengths of stay in EDs are the result of psychiatric patients with complex needs, such as intellectual and developmental disabilities, geriatric populations, and children with specialized needs. These populations often remain in the ED awaiting state hospital beds as many community-based psychiatric units are not equipped or staffed to admit and treat these complex needs.
- Migration of patients outside of their home LME-MCO catchment area for inpatient psychiatric treatment will continue and thereby continue to cause both front-end admission delays and longer patient lengths of stay due to discharge planning challenges.

- Facility-based crisis centers, a cost-effective alternative to inpatient beds that are not currently accounted for in the bed need methodology and do not require a CON to initiate, would be of greater utility to the state if their crisis services could be covered by commercial health insurance. Additional support for such crisis services could serve as an alternative to additional inpatient beds and, based on their smaller size and operating costs, facility-based crisis centers could help address bed disparities in rural areas of the state.

The Presentation does raise valid issues concerning the validity of the current bed need determination methodology. We share the concern that the methodology is outdated. The Presentation contains several alternate methodologies, however, none of these alternatives would yield significantly different results from the current methodology. The Presentation appears to cite this lack of variance as rationale for eliminating any need determination methodology for psychiatric inpatient beds and SUD inpatient/ residential beds. We find such conclusion to be unfounded. Rather, we recommend that the current methodology be reviewed and updated to provide a more accurate reflection of inpatient need and capacity. Mainly, any methodology should account for the lack of specialty inpatient care for populations with complex needs and available beds for the uninsured.

The following is our feedback classified by Presentation slide:

Slide 5 – The State Medical Facilities Plan

This slide lists specific types of beds that are covered under the State Medical Facilities Plan (SMFP). While the SMFP does not cover all healthcare facilities, it is very important to understand that "[o]ther facilities/beds that provide residential behavioral health treatment/services" are typically alternatives to inpatient beds unless a person is waiting for hospital placement. For example, crisis centers are designed to stabilize people experiencing a behavioral health crisis and return them as quickly as possible to their natural support systems with a plan for appropriate follow-up care. Therefore, a primary objective of a crisis center is divert people from having to be admitted to a hospital. Encompassing such treatment alternatives within this inpatient bed need methodology would be counter to the purpose of this methodology.

The other items on the list of what the SMFP does not cover – EDs, state facilities, NC residents who receive treatment out of state, and out-of-state residents who receive treatment in NC – should be accounted for within the methodology. For instance, accounting for state facility beds in the methodology would be useful in assessing total inpatient capacity across the state. That said, if state beds are included within the methodology, it would be important to also look at admission capacity. For example, the growing number of forensic patients with a priority for admission into state facilities should be taken into account. NC residents receiving care outside of the state could also be included in the methodology, but we suspect most of these people have sought specialized treatments not available in North Carolina.

Slide 8 – Does NC Need Additional Inpatient Psychiatric Beds?

This slides contains the following point: "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)." It is important to note that this ranking was tabulated based on access to all services, not solely inpatient services. Research demonstrates that access to healthcare coverage is a primary driver of access to healthcare services. Enhancing coverage through Medicaid and other means would enable more North Carolinians to access critical behavioral health treatments, primary care, and medications. For example, states that have boosted Medicaid coverage have experienced increases in access to care and declines in uninsured ED visits.

Slide 10 – Current Methodology

In assessing planning inventory, it is important to account for beds that are licensed but not operational. We understand that hospitals frequently request license for more beds than they use in the event they need them in the future. However, that contingency planning makes it difficult to assess true capacity if those licensed beds do not become operational.

Slide 11 – Calculations

While we do not have issues with the calculations described in this slide, we recommend adding multi-day stays in the ED to the days of care (DOC) calculation for reporting year. The current calculations do not account for complexity of need or need for specialty care. When people get stuck in EDs for behavioral health-related purposes, it is frequently because they have complex health issues (i.e., a co-occurring developmental disability, physical health care need, significant aggression, or geriatric/dementia issue) and hospitals may be unwilling to admit them if a hospital does not think it has the capacity to treat such complex issues.

Slide 14 – Table 2. Facility Bed Utilization by LME-MCO, 2018

This slide shows an analysis of facility bed utilization by LME-MCO. This analysis illustrates that facility utilization is uneven across the state and that statewide utilization is generally low. As noted above, we reiterate the importance of examining the number of beds that are in operation rather than solely the number of licensed beds. Also, it is not reasonable to expect that everyone will receive care in their county of residence. The Presentation does not detail why someone would go outside their county for care, but it is frequently a matter of clinical presentation. For example, a smaller hospital may not admit a patient who is exhibiting aggression, so that patient then migrates to a larger population center that can support larger facilities offering specialized care. This factor of clinical presentation bears no relationship to a rationale for eliminating the need determination methodology in the CON process. Discontinuing the methodology for assessing bed need will likely make patient migration more pronounced.

The low percentages of bed utilization illustrated on this slide are indicative of the behavioral health ED boarding crisis in the state. Simply adding adult and child psychiatric beds will not address this crisis. While EDs frequently have a high proportion of psychiatric patients, adult psychiatric bed utilization hovers around 60% statewide. This discrepancy reveals a severe mismatch between available resources and need. Adding psychiatric beds without providers adding the specialization and expertise needed to appropriately staff them will not fix this problem and eliminating the CON need determination methodology could make the problem worse. Without an updated methodology, psychiatric facilities will continue to open in higher-populated areas and many hospitals across the state will continue to face challenges transferring psychiatric patients from their EDs.

Slide 15 – Figure 1. Adult Inpatient Psychiatric Treatment: Migration by LME-MCO, 2018

The notes accompanying this slide state that the presenter has “no data on the reasons for patient migration.” However, the data on slide 14 contains important context on this point. For example, Eastpointe has no child/adolescent inpatient psychiatric beds in its catchment area, which would be a significant reason patients would migrate to other areas. Additionally, when examining patient migration across LME-MCO catchment areas it is important to note that these catchment areas are fairly arbitrary borders. People generally tend to seek services as close to their homes as possible and hospitals outside a person’s home catchment area can be geographically closer than another hospital in their home catchment area. This is a reason for patient migration not related service access/capacity.

Slide 17 – Option 1: Change the Service Area

Option 1 would use the same calculations as the current methodology, but it would expand the service area for calculating utilization and need. This service area expansion would introduce more of a regional approach compared to the status quo. Under this option, we recommend basing the service area regions on Health Service Area (HSA) regions or SUD regions and aligning with state hospital regions (pursuant with our recommendation above that state facilities be accounted for in the bed need methodology).

Slide 20 – Option 3: Eliminate Mathematically-Based Need Methodology

Rather than eliminating the mathematically-based need methodology, we recommend updating the methodology to account for the health coverage status of patients (i.e., Medicaid, Medicare, TRICARE, VA, uninsured, commercial insurance, etc.), which coverage information healthcare facilities collect, and exclude 18% of licensed beds from the calculation as such percentage would represent nonoperational beds.

If this methodology is eliminated, which we do not recommend, we would agree that the bed utilization 75% requirement be extended to a period that is longer than two operating years. Furthermore, if the mathematically-based need methodology was eliminated, then it is extremely important that parameters be set assess bed need across the state.

Slide 22 – Table 3. Summary of Need Determinations for Mathematically-based Methodology Options

The notes accompanying this slide state that "it appears that neither Option 1 nor Option 2 consistently substantially increases or decreases the number of need determinations in the SMFP." It does not appear that any clear link is made between this observation and a conclusion that the bed need methodology should be eliminated. Without such a tangible connection, the conclusion could very well be that there are not significant bed needs as opposed to the methodology being incorrect. Therefore, we do not recommend eliminating the methodology without clear evidence that it is incorrect and counterproductive.

Slide 27 – Need Determinations and CON Applications, 2015-2020, Substance Use Disorder Beds

The notes accompanying this slide indicate that the CON process "is not likely to be the main challenge to developing SUD treatment beds" and that "[p]roviders consistently report that low reimbursement rates are a major barrier." Additionally, the majority of SUD beds are not subject to CON (slide 24 states that only about 35% of all adult SUD beds in the state are covered under the CON law). Therefore, we conclude that the issue of bed need determination is far less pressing regarding SUD beds compared to psychiatric inpatient beds. Additionally, facility-based crisis centers provide cost-effective treatment options for people experiencing SUDs. These centers offer detoxification services, have shorter lengths of stay, and tend to be better connected to community continuums of care.