PSYCHIATRIC AND SUBSTANCE USE DISORDER METHODOLOGIES DISCUSSION

Long-Term and Behavioral Health Committee

May 14, 2020

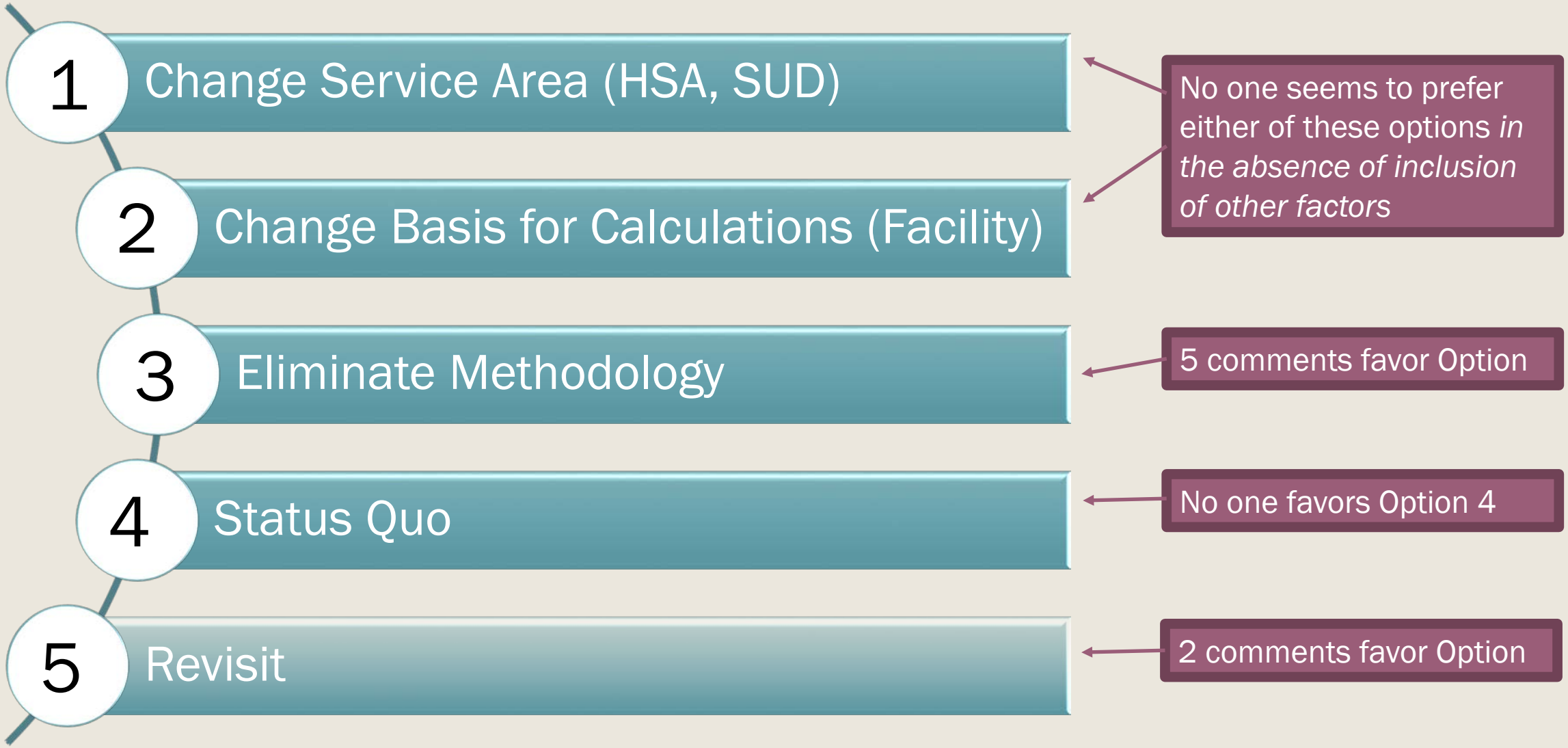
Summary of Comments

- 10 comments
- Multiple sources
  - *Hospitals*
  - *LME-MCOs*
  - *Private psychiatric facilities*
  - *Advocacy organizations*

What Should/Can an SMFP Methodology Do?

- Increase access to treatment – try to make more beds available
- Improve equity of access – make beds available for all types of people who need it
  - *Only the "advantaged" can be "guaranteed" treatment*
    - Financial resources (insurance)
    - Geography
    - Diagnosis – e.g., psychiatric illness and intellectual/developmental disability
    - Expression – violence
- One comment noted that our analysis fails to demonstrate how any of our options would improve/increase access or equity. This is correct.
  - *A methodology can only increase the potential number of beds, but cannot require them to be developed*
  - *We can have almost no influence over equity in access to treatment*
- How can <u>we</u> improve/increase access
  - *We cannot fund construction, renovation, and days of care*
  - *We can we stipulate that CON applicants must commit to reserving a certain percentage of new beds for people who are indigent or have publicly-funded insurance (Medicaid, Medicare). We cannot "police" that long-term.*

Options for Inpatient Psychiatric Bed Methodology



Pros and Cons of Option 3

Pros

- Allows providers to expand where needed
- Maintains CON oversight (requires CON applicants to show that they are likely to be able to fill the beds to a certain level in a specific timeframe)

Cons

- Exacerbates treatment disparities
- May hamper people from getting treatment close to home, which will cause admission delays and problems with discharge planning (e.g., concentrate treatment in urban areas)

“Wish List”

1. Payer/Health coverage
   - *Require percentage of beds to be set aside for indigent/publicly insured*
2. Need for treatment
   - *Data exists. Shows that NC needs roughly 2500 beds to serve those who self-report needing residential treatment. Current plans will develop roughly 2300.*
3. Population distribution
   - *Adult beds are already relatively well distributed.*
4. Days in Emergency Dept. or under observation
   - *Requires additional contractor resources for analysis*
   - *How to take into account? Include adjustment in calculations to allow more beds in areas with long waits?*
5. Outpatient resources
   - *Is there a timely compiled data source to identify and quantify the availability of these resources?*
   - *How to define? How to take into account? Include adjustment in calculations to allow additional beds in areas with few community resources? Would that remove any incentive for developing more community resources?*
6. Consider operational beds rather than licensed beds
7. Exclude underutilized facilities

Operational versus Licensed Beds

- Assumptions and **estimates**
  - *Assume all beds in private/freestanding mental health hospitals were operational*
  - *Hospitals do not break down operational beds by age group*
  - *About 155-160 non-operational beds*
  - *Methodology by **facility utilization***
- In most LME-MCOs, non-operational beds are scattered.
  - *Alliance, Cardinal – 92-95% operational*
  - *Sandhills, Trillium, Vaya - 84-89% operational*
  - *Partners – 78% operational*
  - *Eastpointe – 61% operational (87 of 143 licensed)*
- Re-ran methodology for 2020 SMFP using operational beds = 61 additional
  - *Increased need in Sandhills from 2 to 8*
  - *New need in Eastpointe for 37*
  - *New need in Trillium, for 18*
- Will putting more <u>needs</u> in Eastpointe and Trillium actually result in more <u>beds</u>?
  - *..but is it harmful to use this approach?*

Eliminate Underutilized Facilities

- Underutilized = less than 50% utilization
- Based methodology on facility utilization, not patient origin
- More need determinations
  - *Alliance = 14*
  - *Cardinal = 64*
  - *Eastpointe = 2*
  - *Trillium = 21*
- Using all facilities
  - *Cardinal = 22 needs*