Uniform System for Beds or Bed Days Purchased in State Fiscal Year 2015-2016 and Other Department Initiatives to Reduce State Psychiatric Hospital Use

Session Law 2015-241, Section 12F.1.(f)

Report to the

Joint Legislative Oversight Committee on Health and Human Services

and

Fiscal Research Division

By

The North Carolina Department of Health and Human Services

December 1, 2016

Background

SECTION 12F.1.(f) *Reporting by Department. 1 – By no later than December 1, 2016, and by no later than December 1, 2017, 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) Other Department initiatives funded by State appropriations to reduce State psychiatric hospital use.

Session Law 2015-241, Section 12F.1.(f), 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 use of and expenditures for hospital beds for state-and locally-funded psychiatric and substance use inpatient care for persons who were medically indigent, and on other state-funded Department initiatives to reduce State psychiatric hospital use.

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 psychiatric beds has increased since State Fiscal Year (SFY) 2008 from 77 to 178 in SFY 2016.

For three-way contract psychiatric and substance use inpatient services (procedure codes YP 821 and YP 822) provided between July 1, 2015 and June 30, 2016, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS) has expended approximately $34.4 million. Another $13.2 million for psychiatric and substance use inpatient service (procedure code YP 820) was paid for with a combination of state and local funds.

Local funding was reported by the Local Management Entities-Managed Care Organizations (LME-MCOs) in the amount of $9.2 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; thus, reflecting the bulk of the funding for that service.

During SFY 2016, more than $4 million of the three-way contract appropriation was also used to pay for three-way contract inpatient care that was provided in SFY 2015. For SFY 2016, a total of 9,294 persons were served and paid for by state funds and some of the local funds for both three-way contract inpatient and YP 820 inpatient care. It should be noted that, beyond the scope of this report, LME-MCOs also paid hospitals for inpatient care funded by Medicaid dollars.

By strengthening and expanding community psychiatric 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 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. a substantial reduction in short-term lengths of stay at state hospitals has occurred, and that multiple reasons, including the increase in three-way contract beds in the community, may account for that desired decrease;
2. after an intensive collaborative effort by DMHDDSAS and community hospitals to collect and analyze emergency department wait times in November 2010, follow-up tracking of wait times has not been pursued in monitoring three-way contract performance; however, for the medically indigent individuals who were admitted to the three-way contract beds, which were created to fill a dearth of inpatient beds, it seems reasonable to hypothesize that those individuals had briefer wait times in emergency departments than they would have had prior to the inception of the three-way contract funding. Further intensive collaborative study would be needed to compare current wait times with the November 2010 data.
3. since 2007, the number of licensed psychiatric beds has risen each year, from 1,232 beds in 2007 to 1,683 in 2016; while this increase (37%) of 451 beds includes some of the 178 three-way beds, a larger number of beds have become licensed in addition to those funded by three-way contracts.

DMHDDSAS has recently received input from LME-MCOs, community hospitals, and DHHS General Counsel on a proposed revision to the three-way contract. The proposed contract substantially improves 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.

Other funded initiatives are discussed in Section V. that have either already reduced or are designed to reduce psychiatric and substance use admissions to emergency departments (e.g., 24-hour Behavioral Health Urgent Care centers) and other initiatives that serve as alternatives to the psychiatric and substance use inpatient level of care (e.g., 24-hour Facility Based Crisis beds).

Introduction

Session Law 2015-241, Section 12F.1.(f), 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 use of and expenditures for hospital beds for state-and locally-funded psychiatric and substance abuse inpatient care, and on other state-funded Department initiatives to reduce State psychiatric hospital use.

With state-funds appropriated by the NC General Assembly since State Fiscal Year 2008, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS or Division) or the North Carolina Department of Health and Human Services (NC DHHS or Department) has been able to increase and fund community hospital inpatient psychiatric beds or bed days that were not already funded by or through Local Management Entity – Managed Care Organizations (LME-MCOs).

The overall purpose of the funds for community hospital psychiatric inpatient care is to strengthen and expand community capacity to ensure 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. Historically, individuals in a crisis situation requiring short-term inpatient hospitalization have been served at the state's three psychiatric hospitals – Broughton Hospital in Morganton, Burke County, Central Regional Hospital in Butner in Granville County, and Cherry Hospital in Goldsboro in Wayne County. 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 additional measures is included within the body of this report.

I. Three-Way Contract Beds/Bed Days Purchased Using Funds Appropriated under:

> ***S.L. 2015 – 241, Section 12F.1.(a)*** *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.*

In 2008, NC DHHS convened a task force comprised of hospital administrators, psychiatrists, other clinicians and providers, Local Management Entity 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, 200 community psychiatric inpatient beds were closed. During that same period, admissions to state psychiatric hospitals 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 NC General Assembly appropriated $8,121,644 for community psychiatric inpatient care in SFY 2008-2009. Though the task force recommended some funding to stabilize the existing beds in community hospitals, the General Assembly limited the funding to new beds only.

As stated above, the initiative was initially funded in 2008 (Session Law 2008-107), and subsequently expanded in 2009 (Session Law 2009-451), in 2013 (Session Law 2013-360), and in 2015 (Session Law 2015-241). This initiative is commonly referred to as "three-way contracts" because psychiatric inpatient care is provided in the community hospitals, authorized by the LME-MCOs responsible for the counties in which the hospitals are located, and managed and monitored by DMHDDSAS. These three entities are integral to assuring that individuals without health insurance receive psychiatric inpatient care, when needed. Summary data on the use of those funds for the initiative are provided in this report.

All beds created through this initiative must also be available for involuntarily committed individuals who would otherwise qualify for admission to a state psychiatric hospital. Community hospitals may create new beds in several ways: 1) by increasing the number of beds actually in operation if their current license for psychiatric beds is greater than the number being operated; 2) by designating inpatient units for involuntarily committed persons if they had not previously held that designation; or 3) by increasing the number of licensed psychiatric inpatient beds in the hospital, either through a transfer of beds from a state hospital or a transfer of acute beds within the hospitals.

Participating hospitals are paid a standard rate of $750 per occupied bed day, with three hospitals also contracted to provide a higher level of care for $900 per occupied bed day. These 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.

The beds contracted through the three-way contracts serve as a regional resource. Although three-way contracts are awarded to each LME-MCO and the community hospitals in the LME-MCO's catchment area, the hospital beds are available to any 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 participating in discharge planning designed to connect individuals to community-based services upon discharge from the hospital.

In 2013, per directive of Session Law 2013-360, Section 12F.2.(a), *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…*(Sessional Law 2013-360, Section 12F.2.(a).

With the SFY 2013-2014 appropriation, the General Assembly established the two-tiered (i.e., two rates) system of payment for the provision of inpatient care based on the acuity level of the individual needing psychiatric inpatient care. Of the $38,121,644 in funding, $2 million were used to contract with three LME-MCOs and three hospitals for the enhanced three-way inpatient care.

The standard rate for the lower level of three-way contract care is $750 per day, and the enhanced three-way contract level of care was established at $900 per day. The higher rate was intended to purchase a higher level (enhanced three-way psychiatric inpatient) of care in community hospitals for eligible patients who met a higher level of behavioral and/or medical acuity, similar to the level of care provided in the regional State Psychiatric Hospitals. DMHDDSAS convened a workgroup, consisting of community hospitals, LME-MCOs, and DHHS representatives, which developed the eligibility criteria for admission to enhanced three-way inpatient care.

With the first appropriation in SFY 2008-2009 of $8,121,644, seventy-seven (77) beds were made available for three-way contract psychiatric inpatient care; equivalent to 10,829 bed days. Substantial subsequent appropriations have increased the total number of beds available to 178; approximately 54,111 bed days, which represents an increase in available bed days and contract funding by about 400% since SFY 2008-2009. The most recent appropriation by the NC General Assembly increased funding, by $2,461,750, for three-way contract psychiatric inpatient care in the Session Law 2015-241. This increase brought the total appropriation to $40,583,394 for SFY 2015-2016, and the same amount for SFY 2016-2017.

With the additional $2,461,750, DMHDDSAS was able to increase the number of beds available for three-way contract inpatient care to 178 in 29 community hospitals, across the catchment areas of all eight LME-MCOs. Beds/bed days were awarded to two new three-way contract hospitals, Southeast Regional Medical Center and Carolina East Medical Center, and to two existing three-way contract hospitals, Carolinas Medical Center and University of North Carolina Hospitals at the Wakebrook facility. A map is appended to this report showing all of the three-way contract hospital locations with the number of available beds at each facility.

Three-Way Contracts: Basic Agreement

The following table provides an overview of the three-way contracts for SFY 2016. With DMHDDSAS as the state contracting partner, the LME-MCO contractors and community hospital contractor 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; 178 beds 54,111 bed days; and an overall amount of $40,583,394.

Table 1. Three-Way Contract Hospitals, Beds, and Funding in SFY16 through State Appropriations

LME-MCO	3-Way Contract Hospitals	Number of Beds (Bed Days) Per Contract SFY16	SFY 16 Contract Amounts
Alliance Behavioral Healthcare	Cape Fear Valley Hosp.	10 (1,957 bed days)	$ 1,467,603
	Duke University Health	4 (1,081 bed days)	$ 810,541
	Johnston Health System	5 (1,551 bed days)	$ 1,163,177
	UNC Hosp.-Wake Brook	7 (1,714 bed days)	$ 1,285,233
Alliance Total	**4 contracts**	**26**	**$ 4,726,554**
*Cardinal Innovations Healthcare Solutions	Cone Health Alamance Regional	5 (984 bed days)	$ 738,104
	Carolinas Healthcare: Charlotte & Davidson	5 (2,291 bed days)	$ 1,718,082
	Halifax Regional Medical Center	5 (1,153 bed days)	$ 864,495
	Novant Health Presbyterian Medical	11 (2,366 bed days)	$ 1,774,264
Cardinal Total	**4 contracts**	**26**	**$ 5,094,945**
CenterPoint Human Services	Novant Health Forsyth Medical Center	11 (3,709 bed days)	$ 2,781,800
CenterPoint Total	**1 contract**	**11**	**$ 2,781,800**
Eastpointe Human Services	Nash Hospitals (Coastal Plain Hospital)	11 (3,976 bed days)	$ 2,981,800
	Southeastern Health	5 (729 bed days)	$ 547,056
	Vidant Duplin Hospital	2 (1,807 bed days)	$ 1,355,364
Eastpointe Total	**3 contracts**	**18**	**$ 4,884,220**
*Partners Behavioral Health Management	Catawba Valley Medical	14 (4,442 bed days)	$ 3,331,405
	Davis Regional Med. Center	5 (1,651 bed days)	$ 1,238,177
	DLP Frye Regional	5 (2,418 Bed days)	$ 1,813,177
	Carolinas Healthcare Sys. Kings Mountain	7 (2,275 bed days)	$ 1,705,884
Partners Total	**4 contracts**	**31**	**$ 8,088,643**
Sandhills Center for MH/DD/SA Services	FirstHealth Moore Regional	9 (2,032 bed days)	$ 1,523,718
	Good Hope Hospital	5 (1,751 bed days)	$ 1,313,177
	Moses H. Cone Hospital	5 (2,447 bed days)	$ 1,835,335
Sandhills Center Total	**3 contracts**	**19**	**$ 4,672,230**
Smoky Mountain Center LME/MCO	Charles A. Cannon Memorial Hospital	3 (811 bed days)	$ 607,906
	DLP Haywood Regional	4 (1,081 bed days)	$ 810,541
	Margaret R. Pardee Hosp.	4 (1,481 bed days)	$ 1,110,541
	Mission Hospital System	7 (2,658 bed days)	$ 1,993,750
	DLP Rutherford Regional	3 (812 bed days)	$ 609,353
Smoky Mountain Total	**5 contracts**	**21**	**$ 5,132,091**
*Trillium Health Resources	CarolinaEast Health Sys.	2 (263 bed days)	$ 197,056

LME-MCO	3-Way Contract Hospitals	Number of Beds (Bed Days) Per Contract SFY16	SFY 16 Contract Amounts
	New Hanover Regional	10 (3,384 bed days)	$ 2,538,227
	Vidant Beaufort Hospital	4 (1,295 bed days)	$ 971,250
	Vidant Medical Center *	5 (921 bed days)	$ 691,014
	Vidant Roanoke-Chowan Hospital	5 (1,074 bed days)	$ 805,364
Trillium Total	**5 contracts**	**26**	**$ 5,202,911**
TOTAL	**29 contracts**	**178 (54,111 bed days)**	**$40,583,394**

*Only three hospitals, with their LME-MCO partners, have YP 822 beds (enhanced three-way). The three hospitals each have two beds available for enhanced three-way care.

Three-Way Contracts: 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, 2015 through June 30, 2016 (State Fiscal Year 2016) in the amount of $34,394,614. A total of 45,864 bed days were purchased, 6,979 persons were served, with an overall average of 7.0 units per person (i.e., bed days per person, which ranged from 4.6 to 12.2 days). Table 2 provides the expenditures, bed days, persons served, and units per person by LME-MCO.

Table 2. Three-Way Contract Inpatient Bed Days Purchased (service codes YP 821 & YP 822) with State Appropriations by Local Management Entities-Managed Care Organizations and Community Hospitals for Services During SFY 2016 (as of 9/27/16)

LME-MCO	Hospital	Persons Served	Three-Way Contract Dollars Paid	Bed Days	Units Per Person
Alliance	Cape Fear Valley Hosp.	293	$ 1,308,475	1,750	6.0
	Duke University Health	95	$ 731,250	979	10.3
	Johnston Health System	222	$ 1,084,821	1,460	6.6
	UNC Hosp.-Wake Brook	101	$ 924,750	1,233	12.2
Alliance Total		**711**	**$ 4,049,296**	**5,422**	**7.7**
Cardinal	Cone Health Alamance Regional	162	$ 579,000	772	4.8
	Carolinas Healthcare: Charlotte & Davidson	249	$ 1,510,500	2014	8.1
	Halifax Regional Medical Center	149	$ 797,849	1064	7.1
	Novant Health Presbyterian Medical *	301	$ 1,640,100	2161	7.2

LME-MCO	Hospital	Persons Served	Three-Way Contract Dollars Paid	Bed Days	Units Per Person
Cardinal Total		**861**	**$ 4,527,449**	**6,011**	**7.0**
CenterPoint	**Novant Health Forsyth Medical Center**	**499**	**$ 2,367,000**	**3156**	**6.3**
CenterPoint Total		**499**	**$ 2,367,000**	**3,156**	**6.3**
Eastpointe	**Nash Hospitals (Coastal Plain Hospital)**	**522**	**$ 2,897,800**	**3865**	**8.6**
	Southeastern Health	**123**	**$ 502,500**	**670**	**7.4**
	Vidant Duplin Hospital	**143**	**$ 905,550**	**1229**	**5.4**
Eastpointe Total		**788**	**$ 4,305,850**	**5,764**	**7.3**
Partners	**Catawba Valley Medical ***	**726**	**$ 3,101,100**	**4116**	**5.7**
	Davis Regional Med. Center	**235**	**$ 1,191,558**	**1601**	**6.8**
	DLP Frye Regional	**204**	**$ 836,250**	**1115**	**5.5**
	Carolinas Healthcare Sys. Kings Mountain	**403**	**$ 1,644,750**	**2193**	**5.4**
Partners Total		**1,568**	**$ 6,773,658**	**9,025**	**6.0**
Sandhills	**FirstHealth Moore Regional**	**321**	**$ 1,107,750**	**1484**	**4.6**
	Good Hope Hospital	**168**	**$ 1,197,023**	**1602**	**9.5**
	Moses H. Cone Hospital	**418**	**$ 1,797,835**	**2398**	**5.7**
Sandhills Total		**907**	**$ 4,102,608**	**5,484**	**6.1**
Smoky	**Charles A. Cannon Memorial Hospital**	**70**	**$ 312,000**	**416**	**5.9**
	DLP Haywood Regional	**114**	**$ 610,500**	**814**	**7.1**
	Margaret R. Pardee Hosp.	**255**	**$ 1,039,500**	**1386**	**5.4**
	Mission Hospital System	**327**	**$ 1,691,250**	**2255**	**6.9**
	DLP Rutherford Regional	**70**	**$ 418,104**	**558**	**8.0**
Smoky Total		**836**	**$ 4,071,354**	**5,429**	**6.7**
Trillium	**CarolinaEast Health Sys.**	**28**	**$ 131,250**	**175**	**6.3**
	New Hanover Regional	**363**	**$ 1,998,000**	**2665**	**7.3**
	Vidant Beaufort Hospital	**210**	**$ 972,000**	**1296**	**6.2**
	Vidant Medical Center *	**79**	**$ 478,300**	**613**	**7.8**
	Vidant Roanoke- Chowan Hospital	**129**	**$ 617,850**	**824**	**6.4**
Trillium Total		**809**	**$ 4,197,400**	**5,573**	**7.1**

LME-MCO	Hospital	Persons Served	Three-Way Contract Dollars Paid	Bed Days	Units Per Person
Total		**6,979**	**$ 34,394,614**	**45,864**	**7.0**

Source: NCTracks

Data retrieved for claims adjudicated for payment through September 27, 2016 for service dates in SFY 2016.

*Three hospitals have enhanced (higher rate tier: $900/day) three-way beds (code: YP 822), as well as the lower rate tier ($750/day) YP 821 beds (three-way beds). The YP 822 beds have had very little utilization, and thus were combined on this table with the more frequently used lower tier three-way beds (YP 821).

While it may appear that about $6 million of the original contracted total of $40,583,394 was unused, it is important to convey that, in addition to the $34,394,614 paid for service provided in SFY 2016, more than $4 million was paid in SFY 2016 for three-way inpatient services provided in SFY 2015, for claims that were adjudicated after June 30, 2015. This $4+ million in funds was paid from the $40,583,394 in SFY 2016 contract dollars. Further, one of the hospitals, which came under new ownership in January 2016, decided to withhold claims submissions pending negotiations about billing with the former hospital owner. The unintended consequence was that the hospital, under new ownership, has been unable to successfully submit claims for three-way contract care that was provided the last six months in SFY 2016, which may be in the range of $1 million or more.

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

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, eighty-seven percent (87%) of the LME-MCOs used a portion of their generic allocation of state 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. This YP 820 psychiatric inpatient service differs from the three-way 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 pays the hospital for the bed fee, not for the professional services provided by the psychiatrists and other caregivers, which may be separately billed. 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.

Table 3 depicts the expenditures, bed days purchased, persons served, and units per person in State Fiscal Year 2015–2016 per LME-MCO. Seven (7) LME-MCOs paid for psychiatric inpatient services for 2,161 individuals in community hospitals at a cost of $13,071,354. One LME-MCO, Eastpointe Human Services, did not pay for YP 820 inpatient services. The state-wide average was 8.59 bed days (i.e., units per person), with a range across the identified hospitals from an average of 2.6 to 11.0 days.

Table 3. Inpatient Bed Days Purchased (service code YP 820) with Local Management Entities-Managed Care Organizations Allocations of State Appropriations for Services in SFY 2016 in Community Hospitals (as of 9/27/16)

LME-MCO	Hospital	Persons Served	YP 820 Dollars Paid	Bed Days	Units Per Person
Alliance	Holly Hill Hospital	933	$7,919,339	10,286	11.0
Alliance Total		**933**	**$7,919,339**	**10,286**	**11.02**
Cardinal	High Point Regional Health	30	$43,292	93	3.1
	Old Vineyard Behavioral Health	190	$814,228	1,621	8.5
	Holly Hill Hospital	139	$610,142	1,368	9.8
	Rowan Regional Medical Center	88	$206,217	443	5.0
	Stanly Regional Medical Center	41	$105,226	220	5.4
Cardinal Total		**488**	**$1,779,105**	**3,745**	**7.67**
CenterPoint	Novant Health Forsyth Medical Center	1	$1,298	3	3.0
	Moses H. Cone Memorial Hospital	66	$186,083	333	5.0
	North Carolina Baptist Hospital	134	$522,600	804	6.0
	Old Vineyard Behavioral Health	246	$1,358,308	2,132	8.7
CenterPoint Total		**447**	**$2,068,289**	**3,272**	**7.5**
Partners	Carolinas Health Blue Ridge	56	$201,064	433	7.7
	Gaston Memorial Hospital	64	$110,515	238	3.7
Partners Total		**120**	**$311,579**	**671**	**5.59**
Sandhills	High Point Regional Health	72	$112,063	188	2.6
	Moses H. Cone Memorial Hospital	1	$3,098	5	5.0
	Old Vineyard Behavioral Health	48	$222,380	341	7.1
	Holly Hill Hospital	51	$235,582	431	8.5
	Sandhills Regional Medical Center	53	$105,188	237	4.5
Sandhills Total		**225**	**$678,311**	**1,202**	**5.34**
Smoky	Charles A. Cannon, Jr. Memorial Hospital	39	$149,058	234	6.0
	DLP Haywood Regional	54	$270,088	424	7.9
Smoky Total		**93**	**$419,146**	**658**	**7.08**

LME-MCO	Hospital	Persons Served	YP 820 Dollars Paid	Bed Days	Units Per Person
Trillium	Brynn Marr Behavioral Healthcare	4	$17,150	28	7.0
	Holly Hill Hospital	5	$20,180	32	6.4
Trillium Total		**9**	**$37,330**	**60**	**6.67**
Total		**2,315**	**$13,213,099**	**19,894**	**8.59**

Source: NCTracks

Data retrieved for claims adjudicated for payment through September 27, 2016 for service dates in SFY 2016.

III. Beds/Bed Days Purchased with Local Funds

Four LME-MCOs reported to DMHDDSAS that they were able to access local funding to purchase or financially supplement additional psychiatric inpatient services in community hospitals. A total of $9,270,248 was paid to community hospitals for inpatient care. These local funds were reported to have purchased 12,848 bed days and served 1,128 people, with an overall average length of stay of 11.4 days, as reflected in Table 4. 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 3 and 4.

Table 4. Inpatient Bed Days Purchased by Local Management Entities-Managed Care Organization with Local Funds for Services during SFY 2016 in Community Hospitals

LME-MCO	Hospital	Persons Served	Local Dollars Paid	Bed Days	Units Per Person
Alliance	Holly Hill Hospital	961	$8,100,363	11,321	**11.8**
Alliance Total		**961**	**$8,100,363**	**11,321**	**11.8**
Cardinal *	UNC Hospital *		$214,200		
Cardinal Total		**-**	**$214,200**		
CenterPoint	Old Vineyard Behavioral Health	146	$939,827	1,446	9.9
CenterPoint Total		**146**	**$939,827**	**1,446**	**9.9**
Partners	Carolinas Health Blue Ridge	21	$15,858	81	**3.9**
Partners Total		**21**	**$15,858**	**81**	**3.9**
Total		**1,128**	**$9,270,248**	**12,848**	**11.4**

Source: LME-MCOs reports on local funds used for inpatient care

*The annual amount Cardinal Innovations pays to one community hospital using local funds is $214,200. These funds do not pay for actual bed days, but are used to offset the costs of indigent inpatient care.

IV. Selected Measures of Performance for Three-Way Contract Psychiatric Inpatient Care

Admissions, Involuntary Commitment, Length of Stay, and Out of Area Admissions

The three-way contract hospitals have submitted self-report data on a quarterly basis to DMHDDSAS. This data was not tied to the eventual claims that were adjudicated for payment, but was based on the hospitals' admissions and discharge records. The data elements that are reported by the hospitals focus on admissions, persons admitted from within and outside of the LME-MCOs catchment areas, diagnoses, voluntary vs. involuntary admissions, lengths of stay, and discharge referrals. This data have been used for monitoring purposes, not for payment of care, as noted above.

Table 5 depicts four of the multiple data elements that the hospitals reported in SFY 2016. The total number of admissions reported was 10,294; with 50% of the admissions being identified as involuntary; and 24% identified as persons from outside of the LME-MCOs catchment area. The average length of stay was 5.89 days.

Table 5. Three-Way Contract Admissions and Lengths of Stay in SFY 16

Managing LME	Hospital	Admissions	% Involuntary Commitment	Average Length of Stay	% of Admits which are Out of Area Clients *
Alliance	Cape Fear Valley Hosp.	297	27%	5.81	10%
	Duke University Health	118	65%	8.95	12%
	Johnston Health System	287	62%	5.35	13%
	UNC Hosp.-Wake Brook	134	93%	10.53	1%
Alliance Total		**836**	**55%**	**6.85**	**10%**
Cardinal	Cone Health Alamance Regional	335	68%	5.03	8%
	Carolinas Healthcare: Charlotte & Davidson	30	50%	8.37	0%
	Halifax Regional Medical Center	296	47%	7.29	18%
	Novant Health Presbyterian Medical	206	41%	6.04	21%
	Cone Health Alamance Regional	543	43%	5.88	18%
Cardinal Total		**1,410**	**50%**	**6.05**	**16%**
CenterPoint	Novant Health Forsyth Medical Center	635	27%	5.87	32%
CenterPoint Total		**635**	**27%**	**5.87**	**32%**
Eastpointe	Nash Hospitals (Coastal Plain Hospital)	702	59%	5.80	18%
	Southeastern Health	218	75%	5.20	11%
	Vidant Duplin Hospital	264	95%	7.84	28%
Eastpointe Total		**1,166**	**70%**	**6.18**	**18%**

Managing LME	Hospital	Admissions	% Involuntary Commitment	Average Length of Stay	% of Admits which are Out of Area Clients *
Partners	Catawba Valley Medical	992	43%	4.79	48%
	Davis Regional Med. Center	331	83%	6.66	36%
	DLP Frye Regional	540	34%	5.54	42%
	Carolinas Healthcare Sys. Kings Mountain	448	80%	5.45	65%
Partners Total		**2,311**	**54%**	**5.36**	**48%**
Sandhills	FirstHealth Moore Regional	462	35%	3.72	16%
	Good Hope Hospital	223	96%	8.87	75%
	Moses H. Cone Hospital	792	22%	5.35	7%
Sandhills Total		**1,477**	**37%**	**5.37**	**20%**
Smoky	Charles A. Cannon Memorial Hospital	167	51%	5.79	25%
	DLP Haywood Regional	289	49%	6.62	4%
	Margaret R. Pardee Hosp.	353	12%	4.14	21%
	Mission Hospital System	324	35%	6.25	10%
	DLP Rutherford Regional	93	57%	6.81	22%
Smoky Total		**1,226**	**36%**	**5.71**	**15%**
Trillium	CarolinaEast Health Sys.	35	63%	6.34	9%
	New Hanover Regional	565	55%	6.76	5%
	Vidant Beaufort Hospital	239	68%	6.19	15%
	Vidant Medical Center	142	36%	7.73	10%
	Vidant Roanoke- Chowan Hospital	234	100%	6.25	31%
Trillium Total		**1,233**	**64%**	**6.61**	**14%**
Total		**10,294**	50%	**5.89**	24%

Source: Hospital self-report of 3-Way funded admissions. This data is statistical and is not the basis of payment. Retro-active Medicaid coverage can change the payer after the data is reported.

While 50% of all of the reported admissions were for people who were involuntarily committed (IVC) to inpatient hospitalization, there was much variability among the three-way contract hospitals, with a low of 12% to a high of 100%. The reasons for such differences in the percentages of IVC admissions from one hospital to another are unknown to DMHDDSAS. A variety of explanations for the variability in IVC rates are possible.

Higher percentages of IVC admissions may be attributable to:

- A hospital staff's willingness and capacity to admit and serve a higher proportion of the persons who have more complex and acute psychiatric or substance use needs, and/or behavioral challenges;
- Risk averse emergency department (ED) physicians who would rather hospitalize a person with a psychiatric crisis than refer the individual to non-hospital crisis service alternatives (e.g., Facility Based Crisis) or other community based services;

- An unfortunate practice of using IVCs in order to transport persons in the emergency department to an inpatient bed in another hospital;
- Scarce community services for persons who are medically indigent, resulting in pressures to use IVC and inpatient hospitalization as the only recourse in the absence of other community based services;
- Combinations of the aforementioned factors (e.g., scarce community resources and risk averse ED physicians).

At the other end of the continuum, lower percentages of IVC admissions may be attributable to:

- A hospital staff's reluctance and/or lack of resources to serve a higher proportion of the persons who have more complex and acute psychiatric or substance use needs, and/or behavioral challenges;
- Less risk averse ED physicians who may feel comfortable recommending voluntary, rather than involuntary, inpatient care;
- Scarce community services for persons who are medically indigent, resulting in pressures to use inpatient hospitalization as the only mental health and substance use treatment resource;
- Combinations of the aforementioned factors (e.g., scarce community resources and less risk averse ED physicians).

The lengths of stay (LOS) among the 29 hospitals has also varied, though the state-wide LOS has consistently remained under seven days since the data has been reported to and collected by DMHDDSAS. Differences across the 29 hospitals in LOS likely has a variety of possible explanations. Higher LOS would be expected for hospitals that

- have 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;
- are located 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;
- have 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).

Out-of-area admissions is a measure that identifies the extent to which a hospital has accepted persons from outside of the LME-MCO contractor's catchment area for admission. In order to receive three-way contract funds, a hospital must be willing to admit people for psychiatric and substance use inpatient who live both inside and outside of the LME-MCO's catchment area. Of the total number of reported admissions, 10,294, twenty-four percent (24%) were admissions of people from outside of the home LME-MCO contractor's area. As with the other reported measures, much variability was evident (range: 0% to 75%) across the hospitals for this admission measure. A lower percentage of out-of-area admissions is likely to coincide with urban areas, more densely populated counties or areas surrounding the hospital. A lower percentage may also occur in hospitals that prioritize referrals for admission from within its own hospital system, restricting or limiting the number of referrals from other facilities. A relatively smaller number of available beds may also limit the flow of referrals from other areas. Higher percentages of out-of-area admissions may be attributable to a relatively greater number of beds available, and where hospitals are located in proximity to the boundary of an out-of-area LME-MCO that is not the LME-MCO contract partner of the hospital.

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 has begun tracking 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 calendar year 2015, the overall re-admission rate to any community hospital for psychiatric/substance use inpatient care was 10% (see Table 6). Across LME-MCOs the range varied from 9% to 13%, while across hospitals the range was broader, 5% to 17%.

Table 6. Re-admission (Post Discharge from Three-Way Contract Hospital) within 30 Days to Any Community Hospital Psychiatric/Substance Abuse Inpatient Bed in Calendar Year 2015

MANAGING LME	HOSPITAL NAME	DISCHARGES	READMITS	% READMITTED
ALLIANCE	Cape Fear Valley Hosp.	390	35	9%
	Duke University Health	122	19	16%
	Johnston Health System	236	12	5%
	UNC Hosp.-Wake Brook	138	20	14%
ALLIANCE Total		886	86	10%
CARDINAL	Cone Health Alamance Regional	185	13	7%
	Carolinas Healthcare: Charlotte & Davidson	120	20	17%
	Halifax Regional Medical Center	195	22	11%
	Novant Health Presbyterian Medical	384	34	9%
CARDINAL Total		884	89	10%
CENTERPOINT	Novant Health Forsyth Medical Center	627	63	10%
CENTERPOINT Total		627	63	10%
EASTPOINTE	Vidant Duplin Hospital	196	18	9%
	Nash Hospitals (Coastal Plain Hospital)	582	84	14%
	Southeastern Health	5	0	0%
EASTPOINTE Total		783	102	13%
PARTNERS	Catawba Valley Medical	798	85	11%
	Davis Regional Med. Center	239	24	10%
	DLP Frye Regional	423	34	8%
	Carolinas Healthcare Sys. Kings Mountain	448	23	5%
PARTNERS Total		1,908	166	9%
SANDHILLS	FirstHealth Moore Regional	398	44	11%
	Good Hope Hospital	226	31	14%
	Moses H. Cone Hospital	338	28	8%
SANDHILLS Total		962	103	11%

MANAGING LME	HOSPITAL NAME	DISCHARGES	READMITS	% READMITTED
SMOKY	Charles A. Cannon Memorial Hospital	135	14	10%
	DLP Haywood Regional	131	12	9%
	Margaret R. Pardee Hosp.	326	40	12%
	Mission Hospital System	277	34	12%
	DLP Rutherford Regional	97	10	10%
SMOKY Total		966	110	11%
TRILLIUM	Vidant Beaufort Hospital	199	15	8%
	New Hanover Regional	445	55	12%
	Vidant Roanoke- Chowan Hospital	206	14	7%
	Vidant Medical Center	63	8	13%
TRILLIUM Total		913	92	10%
Grand Total		**7,929**	**811**	**10%**

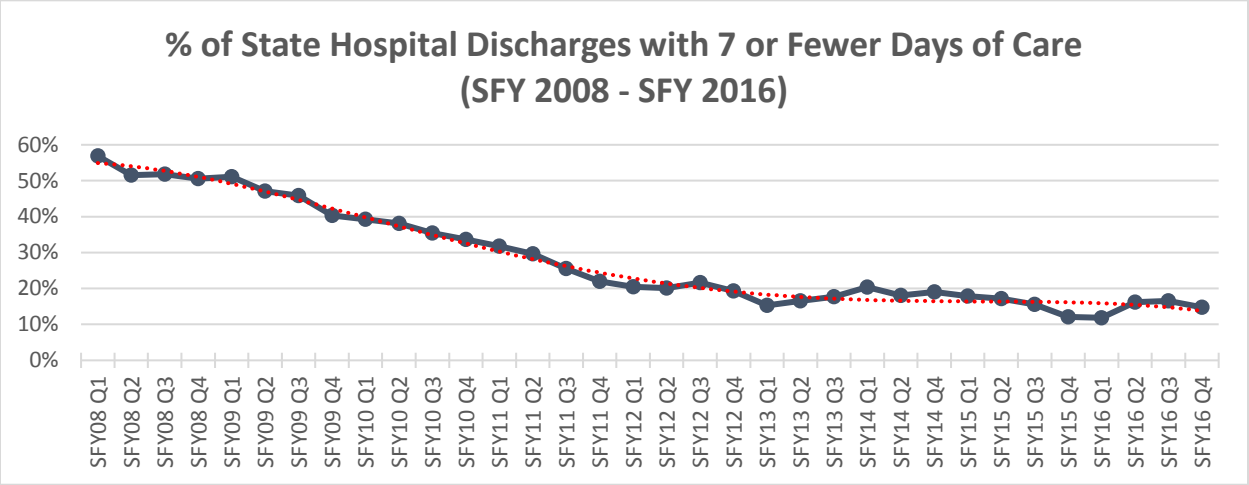
Source: NCTracks claims data. Transfers to other inpatient facilities are excluded.

In order to impact the overall rate of re-admissions to three-way contract inpatient care and consequently the effectiveness of care, it is important to consider that modification and improvement may be needed at multiple levels of the service continuum and within the systems that fund and manages 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 1 below illustrates the downward trend of lengths of stay of seven days or less in the state hospitals since calendar year 2008.

Figure 1. Short-term (7 days or less) Lengths of Stay at State Hospitals: SFY 2008 through SFY 2016



Data Source: State Psychiatric Hospital data in the Client Data Warehouse. Discharges have been filtered to 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.

- Decrease in operational beds in the state hospitals between SFY 2008 and SFY 2010;
- State hospitals having a higher percentage of admission diagnoses of schizophrenia and other major psychiatric disorders and lower percentage of substance use diagnoses (i.e., longer-term inpatient treatment needs), 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 resulted 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 a 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 1, 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 (North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services 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, since there has been an increase of three-way beds available from 113 in 2010 to 178 in 2016, it is reasonable to hypothesize that ED wait times for community hospital beds could have diminished. Further intensive collaborative study would be needed to compare current wait times with the November 2010 data.

Trend of Closure of Community Inpatient Beds

In order to track the number of community hospital psychiatric beds for this report, data from the North Carolina State Medical Facilities Plans (SMFPs) were accessed from 2007 through 2016. https://www2.ncdhhs.gov/dhsr/ncsmfp/index.html The 2007 SMFP reported that there were 1,232 licensed psychiatric beds for adults in the community hospitals. By 2016, the number of licensed psychiatric beds for adults had increased by 451 (37%) to 1,683 (North Carolina Department of Health and Human Services Division of Health Service Regulation, 2007-2016). This data suggests that community hospitals were motivated to apply for Certificates of Need and psychiatric bed licensure since 2007, which indicated a reversal of any downward trend that may have existed prior to 2007. However, the reasons for the increased number of beds are unclear; and because the increase of 451 beds substantially exceeds the number of beds that were identified for three-way contract funding (i.e., 178), the creation of the 451 beds cannot be solely attributed to the three-way contracts.

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.

Increasing Facility Based Crisis Beds

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 emergency departments and inpatient hospitalization for persons who experience crises related to mental health, substance use, or intellectual/developmental disabilities diagnoses.

FBCs are 24-hour residential facilities licensed under Rule 10A NCAC 27G Section .5000 to provide facility-based crisis service as described in Rule 10A NCAC 27G .5001. The state has only 22 adult FBC Service beds, half of which are designated for the treatment of persons who have been involuntarily committed (IVC). Four more sites are in development at present. Smoky Mountain Center LME-MCO and a provider agency in Buncombe county are moving an existing adult FBC and will be opening its co-located BHUC component later in the next month or two and is marketing itself as a regional alternative for surrounding counties. Of interest here is that Mission Hospital is another funder and major partner in this project due to the expectation that ED diversion will be successful. Eastpointe/Robeson is renovating its existing adult FBC to add beds and make it IVC capable and adding a co-located BHUC component. CenterPoint/Forsyth is in the construction phases for a completely new BHUC and FBC combo. Cardinal/Mecklenburg 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.

Behavioral Health Urgent Care Centers with Twenty-Three Hour Observation/Stabilization

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 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 crisis that may resolve with time and observation.

In SFY 2015, there were 152,000 ED visits for individuals with a primary mental health, intellectual/developmental disabilities, and/or substance use (MH/IDD/SUD) diagnosis, across all payer sources. State appropriations for the BHUC clinics with 23-hour observation/stabilization services appear to have made a significant impact on the number of ED admissions when mental health, substance use, or intellectual/developmental disabilities was the primary diagnosis or reason for the ED visit. In SFY 2015, EDs in the six counties (Durham, Wake, Guilford, Cleveland, Iredell, and Onslow) that have BHUCs that are open 24 hours a day/seven days per week experienced 25% fewer ED admissions when MH/SU/IDD was the reason for the visit.

Table 7. Tier IV Behavioral Health Urgent Care and ED Admissions of Persons with Primary MH/SU/IDD Diagnoses in SFY 2015.

ED Admission Rate - Counties with Tier IV BHUC and Those Without

Has BHUC?	Count of County	Population	Admissions	Rate Per 1,000	Rate as % of Total
Yes	6	2,286,058	27,553	12.05	75%
No	94	7,768,134	124,952	16.09	
Total	100	10,054,192	152,505	15.17	

While more analysis is needed to determine the service capacity of BHUCs to impact the local ED admissions, it appears that FBCs or Tier IV BHUCs in low population areas will have more immediate impacts on ED admissions and community hospital inpatient bed use. In higher population areas, it would take a greater number of BHUCS and/or FBCs before we would see a similar reduction of ED visits. Another way of stating this is that ED alternatives have to come closer to meeting the demand before real impact will be felt.

Four more sites are in development, using the state appropriation contributions as well as local investments.

1. Smoky Mountain LME-MCO in Buncombe County is moving an existing adult FBC, creating a co-located BHUC, and creating a child/adolescent FBC. Of particular interest here is that the local hospital system is another funder and major partner in this project due to the expectation that ED and inpatient diversion will be successful.
2. Eastpointe LME-MCO in Robeson County is renovating an existing adult FBC to add beds and make it IVC capable and adding a co-located BHUC component.
3. Cardinal Innovations (formerly CenterPoint LME-MCO) is constructing new co-located BHUC and FBC units in Forsyth County. Again, notably, the local hospital systems are partnering with the LME-MCO.
4. Cardinal Innovations in Mecklenburg County is constructing a new child/adolescent FBC.

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.

Together 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 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.

VI. Discussion and Plan for the Future

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 psychiatric beds has increased since SFY 2008 from 77 to 178 in SFY 2016. For three-way contract inpatient services provided between July 1, 2015 and June 30, 2016, DMHDDSAS has expended approximately $34.4 million, with another $13.2 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 $9.2 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.

During SFY 2016, more than $4 million of the three-way contract appropriation was also used to pay for three-way contract inpatient care that was provided in SFY 2015. For SFY 2016, a total of 9,294 persons were served and paid for by state funds and some of the local funds for both three-way contract inpatient and YP 820 inpatient care. It should be noted that, beyond the scope of this report, LME-MCOs also paid hospitals for inpatient care funded by Medicaid dollars.

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 review the need for this enhanced three-way level of care with the LME-MCOs and community hospitals.

DMHDDSAS has recently received input from LME-MCOs, community hospitals, and DHHS General Counsel on a proposed revision to the three-way contract. The proposed contract substantially improves 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.

In Session Law 2016-94, the NC General Assembly appropriated $18 million for the conversion or construction of new psychiatric inpatient beds in rural areas. That legislation requires that at least 50% of the newly created beds be reserved for purchase with three-way contract funds. It is likely that there will be additional requests from hospitals and their partner LME-MCOs for three-way contracts in the near future.

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