Long-Term and Behavioral Health Committee
Division Recommendation
Psychiatric Inpatient Bed Need Methodologies
in the 2022 State 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 psychiatric inpatient bed need methodology was incorporated into the SMFP in 1983. Only minor substantive changes have been made since then[1]. This 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 Psychiatric Inpatient Bed Inventory in the State

Not all licensed behavioral health beds are subject to the CON law. Table 1 outlines the bed licensure categories in the North Carolina Administrative Code (NCAC) and the number of beds in each. The Acute and Home Care Licensure Section licenses beds under 10A NCAC.5200; the Mental Health Licensure Section licenses all other beds. As of December 1, 2019, 91% (1,977) of the adult beds (age 18 and older) require a CON, as do 22% (386) of the child/adolescent beds. However, not all licensed beds are operational (i.e., staffed and ready to accept patients). In acute care hospitals, approximately 18% of licensed psychiatric beds were not operational as of September 30, 2018[2]. The number of operational versus licensed beds is not available for private psychiatric hospitals.

[1] Two minor changes have been made: the target occupancy rate was reduced from 85% to 75% in 1996; and the 20% reduction in projected days of care (DOC) for children/adolescents was eliminated in 2016.

[2] No data exists on the specific reasons, but common reasons include lack of staff and in-process renovations. The number of non-operational beds comes from the Hospital License Renewal Application, as of 9/30/2018.

Table 1: Mental Health Disorder/Psychiatric Beds (December 2019)

License Category	Description	Child/Adolescent Beds	Adult Beds
.1300	Residential, max. 12 beds, often single-family dwelling, mental health	326	
.1700	Residential, max. 12 beds, often single-family dwelling, mental health and SUD	633	
.1800	Residential, staff secure, max. 12 beds, often single-family dwelling, mental health and SUD	24	
.1900	Psychiatric, institutional, mental health and SUD	313	
.5000	Crisis services, mental health and SUD	87*	192
*.6000***	Mental health hospital (10A NCAC 27G)	*224*	*444*
*.5200***	Acute care hospital (10A NCAC 13B)	*162*	*1,533*
Total		**1,769**	**2,169**

* 87 beds are either for the child/adolescent population only or for both all age groups.
** CON required. Beds are in SMFP.

Until recently, it was possible to apply for a CON to transfer beds from state facilities to community-based facilities pursuant to Policy PSY-1 in the SMFP. However, upon the opening of the new Broughton Hospital in 2019, the Division of State Operated Healthcare Facilities (DSOHF) determined that no more than 134 beds could be transferred to a community-based facility pursuant to Policy PSY-1 [3]. DSOHF received requests from 10 facilities and approved the transfer of 134 beds to 8 of those facilities across the state. These facilities must obtain a CON before the beds can be transferred, but a need determination in the SMFP is not required. Once licensed, these beds will become part of the planning inventory in the SMFP.

In 2015, the General Assembly authorized use of the Dorothea Dix Hospital Property Fund to develop additional inpatient behavioral health beds. No CON is required. Information obtained so far indicates that most of these beds will probably be for adults. A condition of this funding is that at least 50% of the beds must be available to serve patients who are indigent. Once developed, these beds will become part of the SMFP planning inventory. In addition, two hospitals plan to use funds to convert existing acute care beds to psychiatric/substance use disorder (SUD) treatment beds. Altogether, these initiatives may add approximately 257 additional beds to the inventory, almost all for adults.

Inpatient Psychiatric Bed Need Methodologies in the SMFP

The SMFP methodology projects bed need using the number of licensed beds, Local management Entity-Managed Care Organization (LME-MCO) population, and days of care (DOC) for the reporting year. It tacitly assumes that, at implementation of the methodology in 1983, the number of beds was adequate and only needs to be adjusted as utilization and population change over time. This assumption alone calls into question the validity of the methodology.

[3] Policy PSY-1 will remain in the SMFP until all beds approved by DSOHF have been transferred.

There are separate calculations for child/adolescent beds and adult beds. The methodology assumes that "full" utilization is 75% of total capacity. That is, when an LME-MCO's beds reach 75% of total capacity, the SMFP should include a need determination.

Over the past six years, applications submitted in response to need determinations for adult beds have been primarily in urban areas (see Table 2). The only application for child/adolescent beds was also in an urban area (Alliance LME-MCO), despite need determinations in quite a few other LME-MCOs. Anecdotal evidence indicates that low reimbursement is the major barrier to developing new beds, rather than the requirement for a CON. Urban areas may be the most likely places to be able to secure sufficient utilization and staff for a new or expanded facility to be viable.

Table 2. Inpatient Psychiatric Bed Need Determinations, 2015-2021

SMFP	Adult Beds		Child/ Adolescent Beds	
	SMFP Need Determination	Beds for which CON Application was Received	SMFP Need Determination	Beds for which CON Application was Received
2015	43-Alliance 26-CoastalCare*	43 20	46	0
2016	32-Alliance 4-Sandhills	32 0	35	0
2017	25-Alliance 15-Sandhills	25 0	106	0
2018	0	----	47	0
2019	0	----	48	0
2020	2	0	89	11
2021	12	0	56	**

Source: SMFP, 2015-2021

* Brunswick, Carteret, New Hanover, Onslow, Pender counties.

** No applications for 14 of the 56 beds. Due dates have not yet passed for the remaining 42 beds.

Bed transfers pursuant to Policy PSY-1 have resulted in 480 new beds in community-based facilities since 2009, about 83% of which are for adults. The standard need determination methodology is unlikely to have generated this large a number of beds. This experience may indicate that the pattern of Policy PSY-1 CON applications could be similar to the pattern of development of beds in the absence of a methodology.

Public Comments and Staff Analysis

Ten comments were received as a result of the public comment period in the Spring of 2020. Five commenters recommended elimination of the methodology. Two commenters favored revisiting

the methodology after further review of the issues involved. The remainder of the comments primarily addressed the general need to make changes that facilitate treatment access.

Ability of the current methodology to project a sufficient number of beds. Examination of data from the National Survey of Drug Use and Health shows that NC currently may need up to about 400 additional beds, based on the degree and severity of mental illness disorders in the state and the average length of stay in inpatient treatment. The current methodology is not likely to achieve adequate need determinations. Note that the SMFP can only result in need determinations. It cannot guarantee their development nor that they will be accessible to all types of patients.

Ability of a revised methodology to facilitate the development of beds outside population centers. Commenters discussed the need for a better distribution of beds and for the ability to have beds closer to patients' county of residence. Currently, psychiatric inpatient beds exist in 40 counties. Most LME-MCOs have greater than 50% outmigration of its residents to other LME-MCOs for treatment.

Overall, the state has 24 adult beds and 17 child/adolescent beds per capita (100,000 population). Adult beds are fairly well distributed by LME-MCO. Child/adolescent beds are not well distributed. This maldistribution is not surprising considering that the SMFP includes only 386 beds statewide. Changes to or elimination of the methodology may maintain a similar per capita distribution. However, within a service area (however defined), beds may be concentrated in urban areas, as they are now.

Options to Current Methodology

Staff offered two general options to the current methodology based on the comments. Staff ran the methodology with these changes, but they yielded little change in need determinations for adult beds. They did, however, substantially increase the need for child/adolescent beds.

- Change the service area from LME-MCOs to the six Health Service Areas (HSA) used in the SMFP. The rationale is that the HSAs are defined geographic regions consisting of contiguous counties. On the other hand, the LME-MCOs are not well-defined geographic regions. Also, the HSAs do not change, but the LME-MCOs do.
- Use the service area population as the basis for determining need rather than the population in the county of patient residence.

Commenters indicated that neither of the options was considered viable unless other factors were considered in the need projection calculations. After the LTBH Committee voted to look into the methodology revision further, staff examined the following factors that commenters suggested for inclusion:

- Payer mix
- Waiting time in hospital emergency departments

- Local outpatient resources
- Exclusion of non-operational beds from calculations
- Exclusion of underutilized facilities from calculations

Payer mix. This data is available for all facilities. However, the purpose of including it in a methodology is unclear. Statewide, the payer mix does not vary substantially across types of facilities, but staff did not analyze data separately by service area. Staff, therefore, concluded that inclusion of payer mix probably would not have a measurable impact on calculations.

Waiting time in emergency departments. This data exists but obtaining it is cost prohibitive. The hospital discharge files at the Cecil G. Sheps Center at UNC-Chapel Hill contain raw data that could be used to provide this information. However, the Division's contract with the Sheps Center would have to be substantially increased to cover the additional work. In addition, the service areas are large enough that the hospitals in a single area may have a large variation in wait times. If so, data aggregation could neutralize the impact of this factor on the need determination calculations.

Local outpatient resources. It is unclear how the commenters would suggest including this factor in a methodology. Moreover, Healthcare Planning has no access to whatever data may exist.

Exclusion of non-operational beds. All bed need methodologies in the SMFP include only licensed beds. Theoretically, any non-operational licensed bed should be able to be made operational on short notice. On that basis, it makes sense to use licensed rather than operational beds in any methodology. By definition, though, exclusion of non-operational beds would produce higher need determinations than the current methodology.

Exclusion of underutilized facilities. Similar to the above point, exclusion of underutilized facilities would also produce higher need determinations than the current methodology. The rationale for excluding underutilized facilities is that facilities with low utilization suppress need, and thus hamper the ability for other providers in the service area to expand or for a new facility to be developed. For the current test, we defined an underutilized facility as one that had been in operation for at least three years and had less than 40% utilization for the past two years. All the underutilized facilities were acute care hospitals. This test used the six HSAa as the service areas, as suggested by several of the commenters.

Table 3 shows the results of this test. As expected, the large need determinations are in areas with a large proportion of underutilized facilities. Of interest, most of the underutilized facilities reported that all or almost all beds were operational[4]. Given this observation, it may be questionable whether anyone would choose to expand capacity in these areas.

[4] The operational status of beds in acute care hospitals is reported by the hospitals on their annual License Renewal Applications. Healthcare Planning has no data on the operational status of beds in private psychiatric facilities. The test assumes assumed that 100% are operational.

Table 3. Adult Psychiatric Bed Need Determination Option: No Underutilized Facilities, Health Service Areas

Health Service Area	Bed Need	Bed Surplus
I		31
II		128
III	10	
IV		47
V	25	
VI	47	
TOTAL	**82**	**206**

A need determination applies to the entire service area. Thus, a CON application could propose to develop or expand a facility anywhere in the HSA. Commenters expressed the need for wider distributions of beds. Neither the current nor this proposed methodology would guarantee that beds would be developed in areas where they do not currently exist. In addition, the large surpluses projected in some HSAs may be difficult to overcome.

Finally, when the market is competitive, elimination of underutilized facilities may be advantageous to new entities seeking to develop beds. However, an examination of CON data since the 1980s found no applications for psychiatric inpatient beds in which two different applicants sought to develop beds pursuant to the same need determination.

Conclusions and Division Recommendations

The Division recommends removal of the need determination methodology for child/adolescent and adult psychiatric beds. Experience indicates that removal of this methodology is highly unlikely to result in unnecessary duplication of services. People who wish to develop additional psychiatric 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 include inventory and utilization data in the SMFP.
- 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 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 because the methodology projects need separately for the two age groups. If the 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 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 psychiatric beds.

Qualified Applicants. It is possible to set parameters for eligibility to file a CON application. However, 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 people who are privately insured to obtain psychiatric inpatient 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 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 medically underserved patients.

The Division further recommends that CON applicants for new beds be required to reserve 15% of the new 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 to examine whether changes may be warranted. The Division recommends annual review of the approved changes for the first two years of implementation.