North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Adam Sholar
Legislative Counsel
Director of Government Affairs

December 8, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 1026, Legislative Building
Raleigh, NC 27603

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 307A, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Mark W. Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

Dear Senator Hise and Representatives Burr and Hollo:

Session Law 2014-100, Section 12F.4, requires the North Carolina Department of Health and Human Services to submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the budget shortfalls within the Department as a result of liabilities associated with (i) the provision of community services for the treatment of mental illness, developmental disabilities, and substance abuse disorders and (ii) the State operated health care facilities under the jurisdiction of the Department. As required by the session law, the report includes detailed explanations of the following:

(1) A history of the annual budget shortfalls since 2008 and all the contributing factors.
(2) An explanation of actions taken by the Department and the Office of State Budget and Management to address these budget shortfalls.
(3) A plan for eliminating these budget shortfalls.

Please contact Dale Armstrong, Director of the NC Division of State Operated Healthcare Facilities, should you have any questions regarding this report. Mr. Armstrong can be contacted at (919) 855-4700.

Sincerely,

Adam Sholar

cc:

Dave Richard	Matt McKillip
Denise Thomas	Rod Davis
Jim Slate	Patricia Porter
Dale Armstrong	Sarah Riser
Brandon Greife	Susan Jacobs
Theresa Matula	Joyce Jones
Pam Kilpatrick	reports@ncleg.net

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SENT VIA ELECTRONIC MAIL

Mark Trogdon, Director
Fiscal Research Division
Legislative Office Building
300 North Salisbury Street, Suite 619
Raleigh, NC 27603-5925

Dear Director Trogdon:

Session Law 2014-100, Section 12F.4, requires the North Carolina Department of Health and Human Services to submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the budget shortfalls within the Department as a result of liabilities associated with (i) the provision of community services for the treatment of mental illness, developmental disabilities, and substance abuse disorders and (ii) the State operated health care facilities under the jurisdiction of the Department. As required by the session law, the report includes detailed explanations of the following:

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REPORT AND PLAN REGARDING BUDGET SHORTFALLS WITHIN THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

SESSION LAW 2014-100, SECTION 12F.4

REPORT TO THE
JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES
AND
THE FISCAL RESEARCH DIVISION

BY

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

December 2014

Session Law 2014-100 Section 12F.4 requires the Department of Health and Human Services to provide a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the budget shortfalls within the Department as a result of liabilities associated with (i) the provision of community services for the treatment of mental illness, developmental disabilities, and substance abuse disorders and (ii) the State-operated health care facilities under the jurisdiction of the Department. The report shall include a detailed explanation of all of the following:

(1) A history of the annual budget shortfalls since 2008 and all the contributing factors.
(2) An explanation of actions taken by the Department and the Office of State Budget and Management to address these budget shortfalls.
(3) A plan for eliminating these budget shortfalls.

I. Overview of the Division of Mental Health/Developmental Disabilities/Substance Abuse Services and Division of State Operated Healthcare Facilities Budget

The Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) and the Division of State Operated Healthcare Facilities (DSOHF) share funds within one Budget Code 14460. Budget Code 14460 funding is certified as follows:

Budget Code 14460
Certified Budget
for SFY 14/15

Description	Total Requirements	Budgeted Receipts	General Fund Appropriation
Administration (Central Office & Community)	$ 85.7M	$ 35.8M	$ 49.8M
Community Services (DMH/DD/SAS)	409.6M	71.1M	338.4M
State Operated Healthcare Facilities (DSOHF)	724.5M	432.8M	291.6M
TOTAL BUDGET	**$ 1.21B**	**$ 539.9M**	**$ 680.0M**

Note: Per BD307 Certified Budget. Does not include Disproportionate Share (DSH) Funds in DSOHF.

The above Certified Budget provides funding for all services of the DMH/DD/SAS and DSOHF. Service oversight and budget management is provided through the two Divisions. Cash Management occurs at the Budget Code level with Department of Health and Human Services oversight. Since State Fiscal Year (SFY) 2008/2009, total annual obligations have exceeded total cash from all sources, leaving unpaid invoices at year end. These year-end liabilities are obligations beyond the normal timing of payments, and are rolled into the next SFY to be paid. The year-end liabilities are paid in July from new year appropriations and cash. Therefore, there are no unpaid obligations over 30 days past due as a result of insufficient cash availability.

The history of Budget Code 14460 year-end cash liabilities is as follows:

Budget Code 14460
History of Year-End Liabilities

State Fiscal Year-End	State Fiscal Year Ending Liabilities
SFY 2008/2009	$ 16.0M
SFY 2009/2010	$ 17.6M
SFY 2010/2011	$ 37.8M
SFY 2011/2012	$ 35.6M
SFY 2012/2013	$ 21.8M
SFY 2013/2014	$ 13.5M

The above year-end cash liabilities result from the various factors causing the Division of State Operated Healthcare Facilities to have a budget shortfall at the end of each SFY, beginning in SFY 2007/2008:

Division of State Operated Healthcare Facilities
Year-End Shortfalls
for SFY 2007/2008 through SFY 2013/2014

State Fiscal Year-End	Appropriations Year-End Shortfall
SFY 2007/2008	$ 13,177,149
SFY 2008/2009	$ 25,764,535
SFY 2009/2010	$ 23,468,102
SFY 2010/2011	$ 18,539,605
SFY 2011/2012	$ 13,346,479
SFY 2012/2013	$ 19,580,335
SFY 2013/2014	$ 17,738,493

II. Factors Contributing to the Division of State Operated Healthcare Recurring Shortfall

1. **Survey and Certification Issues in the State Psychiatric Hospitals -** All certified State Operated Healthcare Facilities are subject to regulatory surveys and investigations to ensure compliance with federal Medicare and Medicaid regulations. In 2007, the Centers for Medicare and Medicaid Services (CMS) changed its standards to require North Carolina State operated psychiatric hospitals to be certified as acute care hospitals rather than residential services like mental health group homes.

In the two to three years following this change in survey teams, the State Hospitals had numerous surveys that resulted in the serious citations (Condition Level, Immediate Jeopardy, and Decertification) that threatened Medicare and Medicaid billing. Patient deaths which occurred in the facilities contributed to the Immediate Jeopardy citations.

These changes resulted in the decertification of both Broughton and Cherry Hospitals between 2008 -2009, which required plans of correction (POC). In addition, the POC resulted in the need to increase staffing levels in the hospitals, including for some patients, one staff to one patient supervision and to conduct additional training, monitoring and auditing to ensure sustainability of the approved POC. Shortly after the change in survey teams, Broughton Hospital was decertified. DHHS appealed the decertification, and that appeal was upheld in court, so all Medicare and Medicaid billing was recouped. However, during the period of decertification, appeal, and recoupment, the state had to cover the loss of receipts in the amount of nine million dollars. Cherry Hospital was decertified in 2008 resulting in an $8.8 million loss in reimbursements until it was recertified in 2009. Central Regional Hospital did not lose certification, but did experience numerous Condition Level and Immediate Jeopardy calls. To correct each of these citations, the hospitals developed POC that were approved and subsequently monitored by CMS. Each POC was unique to the specific citations, but typically involved policy revision, focused staff training, increased patient monitoring, and enhanced staffing. These POC resulted in increased staff resources in the hospitals to meet richer staffing levels, provided newly required around-the-clock one staff to one patient supervision (1:1) for some at-risk patients, and conducted additional training, monitoring and auditing to ensure sustainability of the approved POC.

The impact of CMS changing certification requirements and POC on the hospital's costs was significant. Following the decertification, which was later overturned, Broughton Hospital brought on 24 Agency Nurses and two Physician Extenders for the first time in order to meet some of the requirements of their POC. For example, the average daily cost rate for Broughton Hospital increased from $735 to $817, which is an increase of $82 per day, and the average daily cost rate for Cherry Hospital increased from $835 to $1,062, which is an increase of $209 per day. Because of the merger of Dorothea Dix Hospital and John Umstead Hospital into Central Regional Hospital during this general period, it is difficult to attribute changes in the daily cost rate solely to POC. However, the POC for many survey citations included increasing staffing for around-the-clock 1:1 coverage for some patients, enhanced staffing on units with the most aggressive patients, and other actions which increased hospital costs.

2. **Delayed Closure of Dorothea Dix Hospital** – Central Regional Hospital in Butner opened in July 2008. John Umstead Hospital closed during this same SFY. However, due to various legal delays, the majority of the Dorothea Dix Hospital patients were not moved until December 2010. In addition, the State maintained a forensic unit at Dorothea Dix Hospital until August 2012.

   Over the course of SFYs 2007/2008 and 2008/2009 recurring funding for Dorothea Dix Hospital was completely eliminated. Only $6 million of non-recurring funding was appropriated to offset the delayed closure of Dorothea Dix Hospital in SFY 2009/2010 and no funding was appropriated for SFY 2010/2011.

Although funding was appropriated to Central Regional Hospital for the merger of the hospitals, it was not enough to cover running two hospitals. The shortage of funding to operate Dorothea Dix Hospital during this period of time significantly impacted each SFY's bottom line.

3. **Patient/Resident Increased Acuity** – All facilities have experienced an increase in the medical, behavioral and psychiatric acuity of their patient/resident populations, which has led to an increase in medical and staffing costs. For example, the majority of the residents residing at the Neuro-Medical Treatment Centers are elderly or medically fragile and have numerous health-related and physical challenges, as well as having an intellectual disability. In the past few years, there has been an increase in medical services such as IV treatment and tracheotomy care and a significant increase in the number of individuals that have been diagnosed with Alzheimer's or other related dementias, often resulting in a rapid and progressive health decline for these residents and increased needs for significant clinical support services.

   The needs of individuals served in state psychiatric hospitals are complicated and multi-faceted. Since 2008, there has been a marked increase in admissions to the state-operated psychiatric facilities of individuals who typically have chronic, severe, and treatment refractory illnesses, and community hospitals consistently make clinical decisions that they cannot provide the care needed by the individual. Often individuals in State hospitals have needs that are high risk and high cost for community settings. The concentration of patients with significant SPMI who are often aggressive and require longer term hospitalization requires the hospitals to have higher levels of staffing than if they served a less acute population. This also makes discharge planning more challenging as the services needed are not always available and/or service definition restrictions prevent wrapping the services the person needs. All of these factors combine to increase both cost and average length of stay. Two groups of people have unique barriers that impact length of stay and cost.

   Incapacity to Proceed: Incapacity to Proceed (ITP) is a court order for individuals whose mental illness impacts their ability to understand their charges, understand the court process, and assist with their defense. ITP admissions to State hospitals are increasing year to year. The length of stay for an individual on ITP status averaged three times that of an individual not on ITP in SFY 2013/2014. In SFY 2006/2007 the percentage of ITP individuals in the State hospitals was two percent. The percentage is currently averaging 28%, as follows:

   Broughton Hospital: 81 out of 251 patients
   Cherry Hospital: 64 out of 169 patients
   Central Regional Hospital: 48 out of 257 patients

Individuals on ITP status need individual intervention, group intervention, court specific case management, ongoing assessment, and intense monitoring while in the State hospitals. In addition to the need for staff with specialized training and skills, the hospital must staff the units with health care technicians and nurses to meet monitoring requirements and safety needs.

The increased costs for staffing coverage are represented by the increase in the amount spent for overtime, agency, and temp staffing costs, as follows:

Division of State Operated Healthcare Facilities

Analysis of Overtime, Agency & Temp Costs

for SFY 2007/2008 through SFY 2013/2014

Description	SFY 07/08	SFY 08/09	SFY 09/10	SFY 10/11	SFY 11/12	SFY 12/13	SFY 13/14
Overtime Pay	$ 17,879,379	$22,051,630	$17,998,745	$19,638,153	$18,852,042	$21,205,943	$20,472,248
Agency Staffing - Physicians	3,777,084	-	5,552,450	5,330,340	5,866,845	5,857,558	8,481,878
Agency Staffing - Nurses	14,309,042	-	24,546,281	20,437,682	18,542,913	17,490,620	15,123,502
Temporary Staffing	8,436,151	12,198,241	11,424,045	13,228,671	12,507,271	11,826,593	13,909,127
TOTAL	**$ 44,401,656**	**$34,249,871**	**$59,521,520**	**$58,634,846**	**$55,769,070**	**$56,380,715**	**$57,986,755**
			*	*			

** Increased amounts in SFY 09/10 and SFY 10/11 due to the delayed closure of Dorothea Dix Hospital. Additional staff needed to operate two facilities was provided by Agency & Temp Staffing, as well as some Overtime.*

4. **Lack of Inflationary Increases Within the State Operated Healthcare Facilities -** For several bienniums, the facilities have not received inflationary increases. Since the facilities spend over $50 million annually on line items, specifically for food, drugs, medical supplies, and utilities, lack of inflation increases has a significant impact on the facilities' bottom line. Continued lack of inflationary funding will result in the budget shortfall continuing to grow at the rate of inflation rate which has averaged 2% for all line items except drugs. Pharmaceutical drugs have an inflationary increase of approximately 7% annually.

5. **Changes in Payor Mix** – Facility budgets are supported by a combination of patient receipts and state appropriations.

Division of State Operated Healthcare Facilities

Certified Budget for Facilities

Facility Type Description	* Requirements SFY 2014/2015	* Receipts SFY 2014/2015	Appropriation SFY 2014/2015
Hospitals & Schools	$ 336,777,604	$ 89,649,839	$ 247,127,765
Neuro-Medical Treatment Centers	110,020,208	104,693,581	5,326,627
Developmental Centers	236,912,515	233,736,818	3,175,697
Alcohol & Drug Abuse Treatment Centers	40,875,972	4,808,020	36,067,952
	$ 724,586,299	**$ 432,888,258**	**$ 291,698,041**
		**	

** Disproportionate Share (DSH) Funds are not included.*

*** The majority of Receipts within the Facilities are Patient Receipts.*

Patient receipts are generated by billing Medicaid, Medicare, and third-party payors for those patients who are eligible. In addition, a small portion of revenue is obtained from individuals who can afford to pay directly.

Over time, the mix of patients in the facilities has changed to the point that the facilities are no longer able to generate sufficient patient revenue. This has a negative impact on the facilities' bottom line.

III. A. Completed DHHS/DSOHF Projects to Address Budget Shortfalls

1. **Group Purchasing Organization (GPO)** Contract (HB1088) results in savings via volume incentives and product standardization. The GPO saves the facilities approximately two to three million dollars annually.
2. **Lab Regionalization** – The facilities have downsized to three regional labs. With the closure of three small labs across the state, and regionalization of all lab functions, DSOHF has saved $462,027 annually in expenditures ($145,581 in State Appropriations).
3. **Transcription Consolidation** – Transcription services were researched, and it was determined that the implemented transcription consolidation across all facilities saved $522,769 annually in expenditures ($280,220 in State Appropriations).
4. **Agency Staffing RFP and Negotiated Rates** - Having centralized contracts result in a lower per hour cost; this is primarily beneficial to the smaller facilities, as the larger scale helps lower their per hour fee. The centralized contracts save the facilities approximately $600,000 annually.
5. **Conversion of Whitaker School to PRTF** – During SFY 2010/2011, Whitaker School was converted to a Psychiatric Residential Treatment Facility (PRTF). This conversion resulted in additional Medicaid Receipts, thus saving DHHS $1,938,465 in State Appropriations. Refer to SFY 2010/2011 Conference Report Item #8.
6. **Pharmacy Initiatives** – Cumulative Savings of approximately ten million dollars annually –
    a. **Generic Medication Utilization** – The facilities were directed to transition from brand-name medications to generics unless contra-indicated for a particular patient/resident. Generics cost approximately one-tenth of the equivalent brand name medication.

b. **Drug Wholesaler/Contract Pricing** – All DSOHF pharmacies have converted to the same available drug contract pricing. By purchasing under the same account, the entire division saves.
c. **Automated Tablet Counting (ATC) Machines** prepare medications in "unit of use" packaging. Additional ATC machines have been purchased to allow pharmacies to purchase medications in bulk, as opposed to "unit of use" from the manufacturer – which is more expensive.
d. **Medicare Part D** – This program was initiated in SFY 2007 and continues to be a focus for DSOHF and DHHS Central Billing Office. In SFY 2013, receipts were $7.3million; estimated annual expenses are $300,000.

III. B. Office of State Budget and Management (OSBM) Efforts

1. **Budget Realignment for Current Year Liabilities** – OSBM approved the realignment of budgetary resources to address the one-time accumulation of unpaid liabilities.
2. **Budget Realignment to Address On-going Structural Issue**
   a. OSBM supported the department's effort to pursue cost containment and revenue maximization strategies.
   b. OSBM approved the realignment existing resources across facilities to adjust to the changing facilities' financials and better match facilities and resources.
   c. The Governor's 2014-15 Recommended Budget proposed redirection of administrative savings to address structural gap in the state psychiatric facilities

IV. Plans to Eliminate Budget Shortfall

1. **Regionalization of Purchasing** – DSOHF is in the process of setting up three regional offices to handle the purchasing functions for the facilities. Currently, each facility handles all purchasing internally. By regionalizing, DSOHF anticipates efficiency savings, as well as better accountability and processes for a total expenditure savings of $290,274.

2. **Timekeeping System Implementation** – DHHS-DSOHF is in the process of implementing a Timekeeping System within the Division of State Operated Healthcare Facilities. Given the fact that staffing is 85% of the facilities' total cost, the expectation is that savings will be realized through efficiencies, as well as elimination of time reporting errors. As such, DSOHF anticipates an annual savings of $5.8 million in payroll expenditures.

3. **Reduction in Motor Fleet Vehicles** – DHHS Property and Construction is working closely with DSOHF to assure that each facility maintains the appropriate number of motor fleet vehicles (both leased and owned). Given the current reported total, there is an expectation that a number of vehicles can be reassigned or surplused to Motor Fleet Management, for a total savings of $85,530.

4. **Labor Standards Study/Workforce Management** – DSOHF is working with an outside vendor to evaluate staffing levels across the three psychiatric hospitals. The goal is to staff the hospitals

more efficiently, while not negatively impacting patient care. Additionally, each hospital has identified one position as a Management Engineer to evaluate staffing on an on-going basis. This is critical to assure that staffing does not remain stagnant moving forward and to assure that the facilities can adapt to changing populations, acuity, etc.

Note: *While this initiative currently focuses on the hospitals, DSOHF does anticipate being able to utilize the tool to expand to the other facility types.*

5. **Financial Management Reporting System (FMRS)** – The FMRS is financial reporting software which captures multiple data sets and automates the process of generating consolidated financial reports for DSOHF. The overall goal is to provide management with a tool to efficiently examine, analyze, and report complex financial trends in operations, to identify problems in a timely manner, and to initiate corrective measures. The FMRS has proven to be a useful and resourceful tool in management's planning. With the implementation of the Timekeeping System, the expectation is that time and staff cost data per unit will aid the facilities in cutting costs.

   Note: *Since the majority of Agency, Temp & Overtime Costs are within the three State psychiatric hospitals; the expectation is that hospital facility management will utilize these two tools (Workforce Management and the Financial Management Reporting System) to save a cumulative amount of $6.8 million annually. Savings will be realized with the most efficient use of existing resources (staff).*

6. **Evaluation of Various Services Across Facilities to Achieve Additional Savings** – Cumulative Savings of Approximately $2.8 million annually –
   a. **Radiology and Laboratory Service Consolidation** – Review these Departments in several facilities for consolidation.
   b. **Reduction of Positions** – Due to various program changes within the Developmental Centers and Neuro-Medical Treatment Centers, there are a number of positions which will no longer be needed and will be eliminated.
   c. **Certified Nursing Assistant Program Fee** - As a recruitment tool, an in-house training program has been offered, and a fee will be charged to cover the cost of the class.
   d. **Increase Fee for Respite Stays** - Increase payment from $8 per day to $40 per day in each of the Developmental Centers for Respite Services for those without institutional respite.

Division of State Operated Healthcare Facilities

Summarized List of Reduction Proposals
as of October 30, 2014

Description	Requirements	Receipts	Appropriations
Regionalization of Purchasing	$ (290,274)	$ (195,435)	$ (94,839)
Automated Timekeeping System	(5,800,000)	(3,905,004)	(1,894,996)
Motor Fleet Vehicles - State-Owned & Leased	(85,530)	(57,585)	(27,945)
Increase Rate for Cardinal	-	1,500,000	(1,500,000)
Hospital Reduction (Workforce Mgmt, FMRS, etc.)	(6,824,176)	(1,217,929)	(5,606,247)
Radiology Service Consolidation	(194,240)	(184,039)	(10,201)
Laboratory Service Consolidation	(151,174)	(132,937)	(18,237)
Certified Nursing Assistant Training Prgm Fee	(34,545)	(30,619)	(3,926)
Eliminate Massage Therapy	(19,100)	(18,310)	(790)
Position Eliminations Due to Program Changes	(2,016,584)	(1,933,940)	(82,644)
Medical/Hospital Visit - Sitter Coverage	(173,607)	(168,581)	(5,026)
Eliminate Physician Coverage for Week Nights	(106,631)	(105,268)	(1,363)
Discontinue TADPOLE program	(6,100)	(6,022)	(78)
Increase Fee for Respite Stays	(32,728)	(20,289)	(12,439)
EE Program (Small Animals)	(81,933)	(78,546)	(3,387)
GRAND TOTAL	**$ (15,816,622)**	**$ (6,554,503)**	**$ (9,262,119)**

State Savings in SFY14/15	**$ (317,947)**
State Savings Beginning SFY15/16	**$ (9,262,119)**

Note: Purchasing, Timekeeping & Motor Fleet Projects impact all Facilities.
The remaining reductions are specific to one facility, or several facilities, but not all facilities.

V. Conclusion

The Division of State Operated Healthcare Facilities has experienced ongoing budget shortfalls due to a wide variety of budget, operationa,l and population-driven causes. DSOHF's primary goal is to provide high quality service and care every day for over 3,000 individuals with significant disabilities and increasingly high acuity levels, and to provide quality service utilizing sound business model principles to achieve cost effective, efficient service delivery.

DSOHF has worked to create a culture of safety for patients and residents and to restore the confidence of the citizens of North Carolina in the care and treatment provided by the facilities. As DSOHF continues to identify methods to reduce and eliminate the ongoing shortfall, it is important that all projects and initiatives be implemented while maintaining safety and quality care. Adherence to compliance standards with key service provision areas, along with thoughtful planning is critical to sustaining both federal funding and the trust that has been restored.