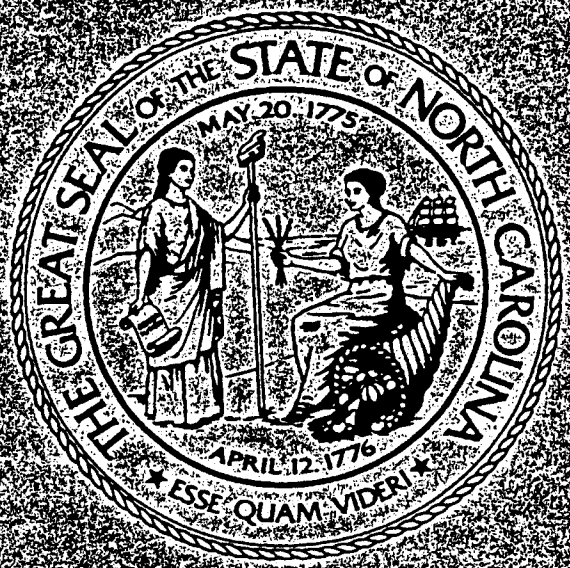
Interim Report
of the

MENTAL HEALTH STUDY COMMISSION



to the

1995 GENERAL ASSEMBLY
OF NORTH CAROLINA

1996 Regular Session

North Carolina

MENTAL HEALTH STUDY COMMISSION

Interim Report and Recommendations
to the 1995 General Assembly
- 1996 Regular Session -

Senator Leslie J. Winner, Co-Chair
Representative Charlotte A. Gardner, Co-Chair

Senator Robert C. Carpenter
Senator J. Richard Conder
Senator Charles S. Dannelly
Senator Jeanne H. Lucas
Senator Robert L. Martin
Senator William N. Martin
Senator Marvin Ward
Representative Martha B. Alexander
Representative Cherie K. Berry
Representative James W. Crawford, Jr.
Representative Julia C. Howard
Representative Cynthia B. Watson
Representative W. Eugene Wilson
Ms. Clara M. Boswell
Dr. Don Everhart
Ms. Mary Gay
Ms. Eula Miller
Mr. Rhett A. Raynor
Mr. David Stewart
Mr. J. Luckey Welsh, Jr.
Ms. Lou Wilson
Ms. Mazie Woodruff

May 1996

State of North Carolina
Mental Health Study Commission

ALBEMARLE BUILDING - ROOM 687
TELEPHONE: (919) 733-6077

COURIER 56-20-24

325 N. SALISBURY STREET
RALEIGH, NC 27603

May 15, 1996

Dear Members of the 1995 General Assembly and
Citizens Interested in the Delivery of Mental Health, Developmental Disabilities, and Substance Abuse Services,

This document includes the 1996 interim report and recommendations of the North Carolina Mental Health Study Commission. As co-chairs, we would like to sincerely thank the members of the Commission for their many hours of thoughtful deliberation.

The reports of the Governance and Accountability Subcommittee and the Financing Subcommittee reflect the hard work and tough decisions that each committee faced in addressing the overall issue of improving the efficient delivery of services and ensuring appropriate accountability for State and federal appropriations.

We would also like to acknowledge the many advocates, family members, professionals, and area directors who took time from their work and families to participate in the subcommittee discussions and lend valuable insight to the issues before us.

On behalf of all who participated so actively in the development of these recommendations, we urge each reader's support.

Sincerely yours,

Leslie Winner

Leslie J. Winner
Senate Co-Chair

Charlotte Gardner

Charlotte A. Gardner
House Co-Chair

MENTAL HEALTH STUDY COMMISSION
Interim Report to the
1995 GENERAL ASSEMBLY

TABLE OF CONTENTS

350 copies of this public document were printed at a cost of $661.33 or $1.89 per copy.

MENTAL HEALTH STUDY COMMISSION

Overview of the Process

DESCRIPTION

The Mental Health Study Commission was established by resolution of the General Assembly in 1973 to serve as the focal point for examining and recommending legislation on mental health, developmental disabilities, and substance abuse service needs. The Commission has been reauthorized to continue every two years since its inception.

One of the major accomplishments of the Commission has been the development of seven long-range plans designed to improve the quality of services for North Carolinians who have mental illness, developmental disabilities, or substance abuse, that were subsequently adopted by the General Assembly as policy guidance for the State. The plans contained detailed policy directions, program goals, and implementation strategies developed through an extensive public planning process. These plans, and the dates of their development, are as follows:

1985 A Comprehensive System of Child Mental Health Services
1987 NC Long-Range Plan for Persons with Severe and Persistent Mental Illness
1989 Adult Substance Abuse Planning Committee Report
1989 MH/DD/SA Services in Jails
1991 Child and Adolescent Alcohol and Other Drug Abuse Plan
1991 A Comprehensive Plan for Services and Supports for Persons with Developmental Disabilities
1992 Quality Improvement Plan

CHARGE FOR THE 1995-97 BIENNIUM

The Mental Health Study Commission was asked to undertake the following activities during 1995-97, as delineated in H.B. 898, Part XIII:

"(1) Conduct research and develop recommendations regarding the response of the public system to the changing health care environment. These recommendations shall address issues of governance, accountability, data collection, and collaboration between public and private sectors.
(2) Analyze and develop recommendations regarding the current system of funding services to evaluate maximum use of funds.
(3) Oversee the Mental Health Study Commission 10-year Disability Plans that have been endorsed by the General Assembly.
(4) Evaluate quality improvement initiatives and develop recommendations regarding accountability, performance standards, and client outcomes.

(5) Monitor and evaluate to new initiatives, including crisis services, Carolina Alternatives, and domiciliary care, developed by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and consider whether to recommend their possible expansion.
(6) Review major initiatives for children for integration with the Child Mental Health Plan.
(7) Develop a business initiative to increase public/private partnerships to enhance current services for those individuals with mental illness, developmental disabilities, and substance abuse problems.
(8) Carry out any other evaluations the Commission considers necessary to perform its mandate."

Additionally, the Commission was directed to "study the issue of how the mandate for a single portal of entry and exit for developmental disabilities services of area mental health authorities should be funded" and include the results of the study in its interim report (H.B. 230, Sec. 23.24).

The Secretary of the Department of Human Resources was directed to establish a task force to determine a minimum reimbursement rate for Adult Developmental Activity Programs (ADAP) and review the current funding stream to ensure that it is the most effective way to provide day services to adults with developmental disabilities, including which Division within the Department is most appropriate for this program. The results of this study were to be reported to the Mental Health Study Commission in time to be included in its interim report (S.B. 776).

PROCESS

The Mental Health Study Commission's first three meetings attempted to provide an overview of where the mental health, developmental disabilities, and substance abuse system is and identify the key issues that are confronting the system today. The Commission learned:

- how the current system has evolved through various federal, State and local initiatives;
- how sporadically and unequally the resources have been developed across the State;
- that there is a strong emphasis on local control, which has its strengths as well as weaknesses;
- what the outcomes have been in the State's first attempt to implement managed care, through Carolina Alternatives; and
- what steps the Department has been able to take in tightening fiscal accountability, as well as some suggestions for further consideration.

The Co-Chairs decided to focus on the two most critical issues facing the Commission: (1) how to address the potential need for Medicaid cuts and to what extent

should the State implement managed care in this system? and (2) how to improve fiscal accountability and quality of services and what are the implications of such improvements for the structure and governance of area programs? It was then decided to break into subcommittees to focus on each issue and develop recommendations for the full Mental Health Study Commission. Three subcommittees were formed:

Governance and Accountability - To come up with solutions and recommendations around: size and structure of area programs, balance between local and State authority, uniformity of administrative procedures, fiscal accountability, client outcomes, and service quality.

Financing - To come up with solutions and recommendations around: potential Medicaid cuts, implementing managed care, equalization of services, and maximization of funding.

Thomas S. Plan Oversight - Upon recommendation from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, this subcommittee was charged with reviewing the progress in implementing the Thomas S. Comprehensive Plan and providing guidance to the Division concerning its continued efforts to serve Thomas S. class members.

Each subcommittee was composed of only Commission members, but the proceedings were completely open for public attendance and participation in discussions.

INTERIM RECOMMENDATIONS

After a series of meetings, the Governance and Accountability Subcommittee and the Financing Subcommittee reported their interim findings and recommendations to the full Mental Health Study Commission for review and discussion. A summary of Commission recommendations is provided on the following page. A complete report from each subcommittee, as approved by the Commission, is included in this report (see Sections II and III).

MENTAL HEALTH STUDY COMMISSION

Interim Recommendations for 1996 Regular Session

A summary of recommendations supported by the Mental Health Study Commission for the 1996 Regular Session is as follows:

1. Require that counties allow area programs to maintain fund balances under the authority of area boards. (Section II)
2. Require that the Director of the Division of MH/DD/SAS (or designee) serve on all area program director search committees. (Section II)
3. Prohibit area board vacancies from remaining open for an extended period of time. (Section II)
4. Eliminate one of the two licensed physicians on the area board. (Section II)
5. Combine the area board representation of drug and alcohol abuse into substance abuse, for both consumer and family representatives, and require consumer to be openly in recovery. (Section II)
6. Add a representative to the area board with financial expertise. (Section II)
7. Require boards of county commissioners to declare vacant the seat of an area board member who accumulates 3 unexcused absences within a 12 month period. (Section II)
8. Require all area boards to have finance committees. (Section II)
9. Mandate training for all members of an area authority's governing body. (Section II)
10. Grant the Division of MH/DD/SAS authority to use withheld funds to contract for services directly. (Section II)
11. Grant the Division of MH/DD/SAS authority to take over a service area or area program when it is necessary in order to ensure clients are appropriately served. (Section II)
12. Prohibit imposition of county freezes on State personnel positions. (Section II)
13. Adopt the Division of MH/DD/SAS' "Incentive Method" for the purposes of allocating new State expansion funds to area mental health programs, effective FY 1996-97. (Section III)

14. Distribute new State expansion funds for FY 1996-97 continue to be allocated across disabilities based upon the one-third formula utilized during FY 1995-96. (Section III)

15. Create a task force, with appropriate representation of all stakeholders, which would work in conjunction with the Division of MH/DD/SAS to develop a needs based approach to funding. (Section III)

16. Expand the managed care program Carolina Alternatives to include additional area programs under the child waiver and full implementation of the adult waiver, within certain guiding principles identified by the Commission. (Section III)

17. Allow the Commission to continue studying the funding of the developmental disabilities single portal mandate and report back to the 1997 General Assembly. (Section I)

18. Extend the reporting date for the Department of Human Resources on the results of its ADAP reimbursement rates study to the Commission to in time for the results to be included in the Commission's report to the 1997 General Assembly. (Section I)

Full details for each recommendation are included in the section referenced after each recommendation. Any legislation necessary to support these recommendations is included in Section IV of this report.

MENTAL HEALTH STUDY COMMISSION
MEMBERSHIP
1995-1997

Co-Chairs

Sen. Leslie Winner
2120 Greenway Avenue
Charlotte, NC 28204
(704) 376-8201

Rep. Charlotte A. Gardner
1500 W. Colonial Dr.
Salisbury, NC 28144-2200
(704) 636-5775

Rep. Martha Alexander
1625 Myers Park Dr.
Charlotte, NC 28207
(704) 365-1003

Rep. Cherie K. Berry
PO Box 456
Maiden, NC 28650
(704) 428-3672

Clara M. Boswell
3622 Rocky Hock Rd.
Edenton, NC 27932
(919) 221-4659

Sen. Robert C. Carpenter
180 Georgia Rd.
Franklin, NC 28734
(704) 524-5009

Sen. Richard Conder
PO Box 1627
Rockingham, NC 28379
(910) 997-5551

Rep. James W. Crawford, Jr.
943L West Andrews Ave.
Henderson, NC 27536
(919) 492-0184

Sen. Charles Smith Dannelly
3167 Dawnshire Ave.
Charlotte, NC 28216
(704) 392-1227

Dr. Don Everhart
PO Box 1378
Morehead City, NC 28557
(919) 247-6483

Mary Gay
2304 Coley Forest Pl.
Raleigh, NC 27612
(919) 787-2596

Rep. Julia C. Howard
330 S. Salisbury St.
Mocksville, NC 27028
(704) 634-3538

Sen. Jeanne Hopkins Lucas
4504 Glenn Rd.
Durham, NC 27704
(919) 688-2838

Sen. Robert L. Martin
126 Nelson St.
Bethel, NC 27812
(919) 825-4361

Sen. William N. Martin
PO Box 21325
Greensboro, NC 27420-1325
(910) 373-1530

Eula Miller
3862 Somerset Dr.
Durham, NC 27707
(919) 489-5649

Rhett A. Raynor
PO Box 458
Dunn, NC 28335
(910) 892-4266

David Stewart
1421 Promise View Acres
Newton, NC 28658
(704) 464-4673

Sen. Marvin Ward
641 Yorkshire Dr.
Winston-Salem, NC 27106
(910) 724-9104

Rep. Cynthia B. Watson
121 Ezra Moore Rd.
Rose Hill, NC 28458
(910) 289-2977

J. Luckey Welsh, Jr.
Southeastern Reg. Medical Center
PO Box 1408
Lumberton, NC 28359
(910) 671-5089

Rep. Gene Wilson
881 Queen St.
Boone, NC 28607
(704) 264-5365

Lou Wilson
NCALTCF
4010 Barrett Dr., Ste. 102
Raleigh, NC 27609
(910) 495-7000 (W)
(919) 787-3560 (Raleigh Office)

Mazie Woodruff
420 Bacon Street
Winston-Salem, NC 27105
(910) 727-8187

Will Lindsay, Ex Officio (temp.)
Department of Human Resources
Adams Building
101 Blair Dr.
Raleigh, NC 27603
(919) 733-4534

Rose Mary Mims, Staff
Mental Health Study Commission
325 N. Salisbury St.
Raleigh, NC 27603
(919) 733-6077

Rennie Honeycutt, Secretary
Mental Health Study Commission
325 N. Salisbury St.
Raleigh, NC 27603
(919) 733-6077

Interim Staff

Karen Hammonds-Blanks
Fiscal Analyst
NC General Assembly
Room 619 Legislative Office Building
Raleigh, NC 27603-5925
(919) 733-4910

Lee Wood
Legislative Liaison
Division of MH/DD/SAS
325 N. Salisbury St.
Raleigh, NC 27603
(919) 733-7011

SECTION I

MENTAL HEALTH STUDY COMMISSION

DELIBERATIONS

MENTAL HEALTH STUDY COMMISSION

Senator Leslie J. Winner
Representative Charlotte A. Gardner
Co-Chairs

October 25, 1995

After Rose Mary Mims explained the responsibilities delegated to the Commission for 1995-97, Sen. Winner emphasized that the Commission priorities include issues of governance, an analysis of fiscal accountability and quality of services in the mental health system and the development of recommendations if changes are required. Changes the federal government may require for Medicaid also must be considered in context with the Commission's study. Sen. Winner stated that the meeting would be divided into two parts with the first two speakers giving background information on the system and the last two speakers providing information on the effects the national changes may have on the state level.

Mark Botts, Assistant Professor of Public Law and Government at the Institute of Government, presented the historical perspective on the evolution of government responsibility for mental health, developmental disabilities, and substance abuse services in North Carolina (see Attachment A of this Section). He focused his comments on two areas: 1) the division of state and local government responsibilities and in more recent years the partnership the two have formed, and 2) how the North Carolina system has developed in response to cultural, political, economic, and social forces. Senator Winner asked if there were any indications that our system is still responding to federal laws that we need to be aware of. Mr. Botts responded that North Carolina is less restricted today by federal law and many requirements are no longer in place.

Sen. Harris gave a brief explanation as to why the Mental Health Study Commission was established in 1973, emphasizing that the Commission has historically served as a forum to resolve difficult problems within the system.

Mike Pedneau, Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse, spoke on the organizational structure of the mental health system in North Carolina. He provided formal definitions of mental illness, developmental disabilities and substance abuse along with statistics of those North Carolinians affected.

Mr. Pedneau reviewed the mission of the Division, stating that the agency is responsible for:

- administering federal and state funds designated for MH/DD/SA services,
- operating the state institutions,

- ensuring that area programs meet the funding requirements for state and federal aid, and
- ensuring state standards for facility operations and licensing.

Ms. Miller asked for figures of money being spent in area authorities and a breakdown of each one. Pedneau responded that $525 million is provided by the state. Rep. Gardner was interested in knowing how money designated for substance abuse could be traced to demonstrate that the area authority is using it as designated. Pedneau stated under state law the area program must retain a private CPA firm to conduct an audit. The Division then uses these findings to ensure that funds are spent according to budget ordinances. Rep. Gardner asked for a detailed budget of her area program.

To provide a national perspective of managed care initiatives, Sen. Winner then introduced Dr. Mary Fraser of the UNC Chapel Hill School of Social Work. Dr. Fraser is Project Coordinator for the Managed Care Technical Assistance Project. Dr. Fraser focused on three main areas: 1) why managed care is being discussed, 2) what is meant by managed care, and 3) what other states are doing in terms of their programs for managed care in MH/DD/SA. She stated that managed care is a set of strategies used to assure that the most appropriate clinical care is provided in a cost-efficient manner. She explained that states can choose to have public mental health programs become managed care organizations to manage the waiver amount or they can choose to contract with a private managed care corporation.

Mrs. Woodruff asked who oversees the process of contracts to ensure that the patient is receiving the care they need. Dr. Fraser stated that in some cases it's the Division of Mental Health, in some cases it's the Division of Medical Assistance or their counterpart in the state. Usually a state agency has the responsibility of monitoring. Mr. Raynor asked if there were any states which provided waivers for developmental disabilities. Dr. Fraser said there were no states with implemented plans at this time. Sen. Winner asked about the incentives for providers under a capitated system to provide adequate services rather than underserving everyone. Dr. Fraser responded that the provider is responsible for providing all of the patients' care which translates into increased hospital costs if adequate outpatient care is not available. Expenses are paid from one budget. An Oversight Committee would monitor complaints if hospitalization is refused. Rep. Gardner expressed concern about whether the state has the expertise to develop a contract with all the necessary safeguards. In closing, Dr. Fraser said most states found that waivers were the best way to use Medicaid money efficiently.

Senator Winner adjourned the meeting for lunch. The meeting reconvened with an examination of the status of managed care in North Carolina by Dr. John Baggett, Deputy Director on the Division of Mental Health, Developmental Disabilities and Substance Abuse. Dr. Baggett said managed care growth in North Carolina has been slower than the national level, but an economist predicts within 3-5 years most covered individuals will be in managed care. Mr. Welsh asked if the definition of managed care included the discounted fee for services or simply HMO/PPO. Dr. Baggett concluded that it is an enrolled population and does not discount fees. He continued by giving a brief history and description of Carolina Alternatives. Sen. Bill Martin inquired as to the percentage of eligibles that needed

services. Dr. Baggett estimated that approximately 20,000 needed services. Sen. Martin asked if the 10 programs have projections regarding the percentage of eligibles requiring services. Lynn Stelle of Financial Initiatives responded that 10-15% of children are estimated to need services at any one time. The Medicaid population is higher. Dr. Baggett went over pending federal changes and options for North Carolina. Sen. Winner asked for the number of people who are Medicaid eligible. Dr. Baggett responded that 32.89% are served through Medicaid funds.

Sen. Bill Martin asked what plans the department has to ensure that risks are being addressed. Barbara Matula was recognized and responded that it is very difficult to plan at this point, given the uncertainties of actions Washington may take. Rep. Gardner asked if she thought we have the expertise at the local level to implement managed care. Ms. Matula explained that managing someone's care reduces the randomness of people entering the system, and she did believe we have the talent throughout the state to manage care.

Mr. Raynor pointed out that "Managed care" as used in this meeting is applied to manage available resources, and since we may not have the same resources in the future, isn't the key question one of who will assume the risk. Sen. Winner agreed that this is a key question the Commission would implicitly or explicitly need to answer.

December 7, 1995

Following approval of the minutes, Rep. Charlotte Gardner recognized Lynn Stelle, Division of MH/DD/SAS, to provide a profile of the North Carolina mental health system. Stelle reviewed a document developed for the Commission entitled "Trends in Resources, Clients and Services." The document included numerous charts including: tables representing community program revenues by source, trends in persons served over a five year period by disability category in the community and in each of the institutions under the purview of the public mental health system from 1990 to 1995.

Mike Pedneau, Director of the Division of MH/DD/SA Services, provided an explanation of funding sources for the MH/DD/SAS system. The presentation included a summary of area program resources by disability and funding source for fiscal year 1994 - 1995 (see Attachment B of this Section). The information was compiled to answer questions from the previous meeting regarding the actual distribution of the value of services by each of the major disability groups.

Marty Knisley, Senior Consultant, Technical Assistance Collaborative, Boston, MA, provided a perspective on the experiences of various states regarding Medicaid, managed care and other public managed care systems around the country. She gave experiences of other states, summarized lessons learned from those experiences, and gave viewpoints as to what is occurring now. Knisley provided examples of Medicaid waiver experiences in Iowa, Arizona, Utah, and Tennessee. Implications of these experiences suggest: dividing systems by funding sources and requirements may add costs, reduced service capacity, and increased cost shifting. Other experiences indicate that the acute care industry/model does not translate

well to managing care for persons with long term and/or complex needs if purchased wholesale or without major refinements; integrated funding and management with mainstream health care is probably not achievable in the short term; many newly formed authorities and behavioral health organizations have oversold capacity capabilities, contracting, network development and utilization management; and most states have underestimated the complexities of these changes. Rep. Gardner informed members that the Commission would hear opinions from other speakers with national experiences as the process continues.

Sen. Winner asked about the pros and cons of private care verses public management of the system. Knisley explained that the issue was very complex. The public system can buy services and retain a presence in the community. She stated that where public presence is maintained and allowed to grow, there is support from the private sector.

Rep. Gardner adjourned the meeting for lunch. The meeting reconvened with representatives across the State discussing their perspectives on problems, benefits, and recommendations concerning Carolina Alternatives. Judy Holland, Branch Head of Carolina Alternatives, began by giving an overview of the program (see Attachment C of this Section). Holland explained that Carolina Alternatives is a Medicaid waiver implemented in ~~ten~~ area programs responsible for serving children in 32 counties. The goals of Carolina Alternatives include: expanding availability to child mental health services in communities; increasing the flexibility of services and expanding individualized services to children in their homes, communities and schools; increasing the coordination of mental health services with other child-serving organizations; increasing treatment plans centered around the client's needs; and increasing the involvement of family members in treatment planning.

Other speakers included: Angela Harris, Director, Department of Social Services, Franklin County; Laura Thomas, Group Vice President of Behavioral Health, Carolina Medical Center, Charlotte, N.C.; Dale Armstrong, CEO, Brynn Marr Behavioral Health Care, N.C. Hospital Association; Greg Brannan, Regional Director of Public Sector Development, Charter Behavioral Health System of N.C.; and Ron Morton, Area Director, Forsyth-Stokes Mental Health Center.

Problems identified by these presenters included: delays in payments and rates of reimbursement to providers; capitated rates causing concern in regard to patients receiving appropriate placement and care; restrictive criteria; funds to utilize services for children and staff paid with Carolina Alternative funds need close evaluation; mishandling of Carolina Alternatives could lead to a class action suit; and little experience with business partnerships within health care.

Benefits included: focus on patient treatment; area programs pay for most appropriate treatment without artificial restrictions; local clients managed by local professionals who are familiar with client needs; and expanded non-hospital services.

Recommendations included: need to have consistent guidelines for implementation of Carolina Alternatives; Carolina Alternatives must continue to be controlled by the public sector; link small area programs with others to establish large base to operate capitated

managed care program; continued communication between the Division of MH/DD/SAS, local area mental health authorities and providers on implementation of Medicaid managed care.

January 24, 1996

Sen. Winner opened the meeting with several announcements. She informed the Commission that Rose Mary Mims, Director of the Mental Health Study Commission, was taking extended medical leave. In her absence, Lee Wood, Legislative Liaison with MH/DD/SAS and Karen Hammonds-Blanks from Fiscal Research, will assume her duties. Jim Barbour has resigned, and the Governor has appointed Mary Gay, Board member of the NC Alliance for the Mentally Ill, to fill his seat. Barry Stanback, Ex Officio member for the Department of Human Resources, has resigned and will temporarily be replaced by Will Lindsay from Budget and Analysis with the Department.

Mark Botts, Assistant Professor of Public Law and Government at the Institute of Government, provided a summary of the composition of the governing bodies for area mental health, developmental disabilities, and substance abuse authorities (area boards) and the legal responsibilities of those boards. Area board members are appointed by the county commissioners, serve 4 year terms (except commissioner member terms are concurrent with their term as county commissioner), and are removable without cause. He explained that the area board is the entity which is responsible for those powers and duties conferred on the area authority by the General Assembly of North Carolina, which he grouped into the following five areas:

Client Services
- determine needs
- provide services
- coordinate with the State
- assure services meet State standards
- assure highest possible quality

Finance (see Attachment D of this Section)
- adopt an annual budget
- complete an annual independent audit
- prepare fee schedules for services
- enter into an annual memorandum of agreement with the State
- establish dispute resolution procedures

Personnel
- appoint an area director
- appoint a budget officer (if multi-county area program)
- establish a salary plan
- adopt a professional reimbursement policy

Contracts

- enter in to contracts for services
- obtain contract for insurance
- acquire personal property
- lease real property

Client Rights

- establish client rights policies
- establish client rights committees

Mr. Botts explained the requirements for audits according to the General Statutes. Botts stated the financial audit and the compliance audit together form the single audit the area authority must have completed each year.

Ralph Campbell, State Auditor, explained to the Commission that the State Auditor's Office has historically had little involvement with the operations of local area mental health centers. However, after several requests to perform audits of the Tri-County and Southeastern Mental Health Centers, it was determined that there is a need for additional reviews of these services with an eye towards identifying any issues which might have statewide implications.

Sam Newman, Performance Audit Manager of the State Auditor's Office, reviewed the authority of the local board, Department of Human Resources, and the Local Government Commission. He suggested the Legislature needs to clearly establish expectations for administration of area mental health centers by identifying roles of the local authority, DHR, and the Local Government Commission. He also suggested the need for a periodic financial/administrative review to determine that the responsibilities set forth by the three entities are being executed properly. Newman explained that a performance audit was performed, which is more comprehensive than a traditional financial compliance audit. Board issues suggested were: limiting terms, adding a board member with financial background, and board training. Newman also discussed accounting/administrative issues and concerns at Tri-County and Southeastern mental health centers.

Jim Edgerton, Assistant Secretary for Budget and Management for the Department of Human Resources, gave a brief history of the audit function in DHR and a response from DHR to the Auditor's recommendations. The Department agreed with the recommendations of the State Auditor's Office. In response to board issues, the Department felt that some flexibility may be needed in consideration of the availability within the catchment area of some of the categories of mandated representation on the area board. In the area of accounting/administrative issues, Edgerton reviewed several actions implemented by DMH/DD/SAS in accordance with amendments to the General Statutes made during the 1995 Legislative Session.

Sen. Winner emphasized to Commission members that today's meeting was primarily directed at gathering information to ensure that problems such as those experienced in Tri-County and Southeastern are detected early and dealt with promptly.

Diane Foster, Chairman of Tri-County Mental Health Board; Bill Burgin, Vice Chair; and Bob Dirks, Area Director, were recognized and explained how the Tri-County situation is being addressed. Foster emphasized to the Commission the Board's commitment to an efficient delivery of mental health services in Tri-County. Burgin suggested board training, a standard accounting practice, a standardized write-off policy, and to recognize red flags promptly. Dirks explained that positions had been cut and programs cut in order to rejuvenate the revenue and have a balanced budget in place.

Following the lunch break, Sen. Winner recognized Susan White, Section Chief of Thomas S. Services. White gave a historical viewpoint of how the lawsuit came about. She then gave an overview of the steps the State was taking, at the mandate of the General Assembly, to get out from under the lawsuit including the recently filed motion to federal court to dismiss the Thomas S. court action. As an assistance to resolve the Thomas S. lawsuit, Ms. White requested that the Mental Health Study Commission consider monitoring the implementation of the Comprehensive Plan for Thomas S. services. Sen. Winner said that decision would be deferred to the discussion on future plans.

Marci White, Chief of Willie M. Services highlighted plans that are being developed to achieve compliance. She provided background information and a profile of the Willie M. population. White stated primary focus has been on staff training, the development of additional secure treatment services, and outcome analysis.

Sen. Winner reminded members that the legislative charge to the Commission included: conducting research and developing recommendations regarding the response of the public system to the changing health care environment including addressing issues of governance, accountability, data collection, and collaboration between public and private sectors; analyzing and developing recommendations regarding the current system of funding services to evaluate maximum use of funds; and overseeing the 10-year plans and other initiatives.

Sen. Winner stated, in accordance with the Commission's charge, it had been determined that a need for two subcommittees existed. One on Governance and Accountability with a focus on the size and structure of the area program, the relationship between the local program and the State, fiscal accountability, and quality service and client access to service accountability. The other subcommittee, Financing, would look at Medicaid, Medicaid cuts, implementation of managed care, equalization of services between area mental health authorities and maximization of outside funding sources.

Sen. Winner further suggested that an additional subcommittee be established to oversee the Comprehensive Plan for the Thomas S. Services. Sen. Carpenter moved that the Commission create an oversight subcommittee for Thomas S. The motion passed.

Sen. Winner stated that Commission members would divide into three subcommittees and that members should state their preferred committee. The first meeting of the subcommittees will be on February 12 and run through April 1. The subcommittees will then make their interim recommendations to the Commission in April with final reports on October 1.

April 19, 1996

Rose Mary Mims announced that she had accepted a position as Human Rights Coordinator with the Division of MH/DD/SAS in the Quality Improvement Section beginning May 1. She expressed her gratitude to everyone for the help and support she has received over the past nine years.

Rep. Gardner, Chair of the Governance and Accountability Subcommittee and Lee Wood, Division of Mental Health, Developmental Disabilities, and Substance Abuse, reviewed the recommendations of the Subcommittee. Each recommendation was discussed and voted upon individually. The recommendations, as amended by the Commission appear in Section II.

Following a lunch break, Allyn Guffey, DHR Budget and Analysis, presented an interim report from the Department of Human Resources on ADAP reimbursement rates. He indicated that in order to accurately assess the extent of any problems in the current reimbursement process, the Task Force intended to survey each of the area programs and that would require additional time. Sen. Carpenter moved that a final report be submitted to the Commission by December 1, 1996, and that the Commission request permission to report the results in its final report in 1997. Commission members approved the motion.

Sen. Leslie Winner presented the report from the Financing Subcommittee with recommendations concerning a new equalization formula to be applied to any expansion money for mental health, developmental disabilities, and substance abuse services and whether to expand Carolina Alternatives to the other area authorities for Medicaid eligible children and Medicaid eligible adults. Both recommendations were adopted by the Commission, and they appear in Section III.

Lee Wood asked for a recommendation to the General Assembly allowing the issue of funding for the DD Single Portal Mandate to be studied after the Short Session and report back in the Long Session in January of 1997. She explained that this study was simply overlooked as part of the Commission's work load for this year. Sen. Lucas made a motion requesting to delay this report until the Long Session. The recommendation passed with a favorable vote.

Next, Dr. Pat Porter, Section Chief, Developmental Disabilities, reviewed the report of the Downsizing and Human Rights Subcommittee. She explained how the recommendations were addressed and in reviewing the Addendum to the report, explained the Division of MH/DD/SAS actions on the recommendations. Dr. Porter recommended the acceptance of the report and to continue the monitoring visits which would report to the Mental Health Study Commission. Rep. Wilson made a motion in favor of the recommendation. The recommendation passed with a favorable vote.

Evolution of Government Responsibility for Mental Health, Developmental Disabilities, and Substance Abuse Services in North Carolina

I. 1785 - 1856: Local government takes de facto role

- long-term confinement of persons with mental disabilities
- concern for public safety, protection of property, and care of those incapable of self-care
- fear of the mentally disabled
- county government takes a de facto role

II. 1856 - 1915: State assumes responsibility

- national reform movement premised on treatment in sound environment
- documentation of neglect at the local level
- government role:
  - -state hospitals, built at state expense, provide mental health care
  - -counties financially responsible for patient care
  - -continued custodial confinement at county level
- segregation of "mental defectives"

1856: State Hospital for the Insane opens at Dix Hill
1869: Board of Public Charities created
1872-73: Board and hospital reports to legislature call for expansion of state facilities
1874: General Assembly authorizes construction of Goldsboro and Morganton hospitals
1914: Caswell Training School opens for white "feeble-minded" children

III. 1915 - 1945: Prevention and community interest

- North Carolina Mental Hygiene Society (and its national counterpart) focuses public attention on mental health care and advocates locally-based systems capable of intervening with preventive care
- eugenics movement; sterilization
- lack of community resources
- community demonstration clinics
- continued custodial confinement on local level

1917: county welfare boards authorized by statute
1921: Bureau of Mental Health and Hygiene (education, volunteer services) created within the State Board of Public Charities and Public Welfare

IV. 1945 - 1963: Beginning of federal involvement

- World War II influences national identity and reveals mental disabilities
- federal government invests in community clinics
- local and state governments slow to respond
- growth in state-operated facilities
- growing aversion to large institutional care

1946: National Mental Health Act--federal grants for pilot community mental health clinics
1949: NC General Assembly authorizes the State Board of Health to administer federal matching grants
1955: federal Mental Health Study Act
1960: MHSA commission report

V. 1963 - Present: Emphasis on community-based services

- psychotropic medications
- civil liberties
- civic engagement and optimism

1963: Community Mental Health Services Act--federal appropriations for construction of community mental health centers (psychiatric hospitals without walls)

- five essential services: outpatient, inpatient, emergency, partial hospitalization, consultation/education
- single state agency: state plan for establishing community centers, operational standards, services to those unable to pay

1963: NC Department of Mental Health (DMH) created to develop, promote, and administer state plan for establishing CMHC's; to administer federal funds; and to set standards for clinic maintenance and operations

- DMH given responsibility for administering state facilities and licensing public and private facilities
- "Local mental health authorities" authorized by the General Assembly to represent the community served by CMHC's; joint undertaking

1965-1981: CMHCA amendments--federal funds for personnel, children's services, federally-defined poverty areas, construction and staffing of facilities for treatment of alcoholism and narcotic addiction,

1965: General Assembly authorizes three state-operated alcoholic rehabilitation centers (ARC's)

1967: General Assembly establishes within the DMH a division on alcoholism to coordinate alcoholic rehabilitation programs on the local level

1971: DMH authorized to establish community-based drug abuse programs

1971: General Assembly authorizes "area mental health programs" covering one or more counties

- comprehensive MH, MR, and SA services
- only counties could establish
- separate governing board established by county commissioners

1977: revision and consolidation of state statutes to authorize "area mental health authorities"

- counties, singly or jointly, required to establish area authorities comprehensive services--mental disorder, mental retardation, substance abuse
- joint undertaking
- substantially similar to the current system

ACTUAL SUMMARY OF AREA PROGRAM REVENUE BY SOURCE
FISCAL YEAR 1994-95

AREA PROGRAM	(1) DIVISION ALLOCATIONS	(2) COUNTY GENERAL FUNDS	(3) FEES FOR SERVICE	(4) OTHER FUNDS	(5) TOTAL REVENUE
BLUERIDGE	$ 20,463,631	$ 660,000	$ 7,167,320	$ 1,062,933	$ 29,353,884
CATAWBA	$ 4,484,802	$ 1,019,674	$ 1,807,438	$ 223,939	$ 7,535,853
CLEVELAND	$ 3,802,402	$ 844,533	$ 1,313,433	$ 296,642	$ 6,257,010
FOOTHILLS	$ 15,015,827	$ 411,790	$ 5,514,302	$ 889,974	$ 21,831,893
GASTON-LINCOLN	$ 15,365,674	$ 1,157,324	$ 5,179,205	$ 3,968,321	$ 25,670,524
MECKLENBURG	$ 21,783,147	$ 15,909,887	$ 4,842,379	$ 837,729	$ 43,373,142
NEW RIVER	$ 7,447,934	$ 625,765	$ 4,258,312	$ 882,201	$ 13,214,212
PIEDMONT	$ 11,313,000	$ 940,221	$ 5,266,426	$ 1,519,921	$ 19,039,568
RUTHERFORD-POLK	$ 3,931,667	$ 332,141	$ 1,623,507	$ 482,083	$ 6,369,398
SMOKY MOUNTAIN	$ 11,314,350	$ 445,518	$ 5,124,255	$ 2,135,901	$ 19,020,024
TREND	$ 8,963,656	$ 361,044	$ 7,742,543	$ 171,186	$ 17,238,429
TRICOUNTY	$ 9,811,772	$ 647,955	$ 2,041,387	$ 287,494	$ 12,788,608
ALAMANCE-CASWELL	$ 7,449,317	$ 1,776,180	$ 1,572,336	$ 1,201,642	$ 11,999,475
DURHAM	$ 9,452,950	$ 6,296,530	$ 1,320,834	$ 88,907	$ 17,159,221
FORSYTH-STOKES	$ 14,742,347	$ 5,211,862	$ 2,734,683	$ 1,387,520	$ 24,076,412
GUILFORD	$ 15,255,434	$ 6,417,410	$ 4,221,759	$ 988,072	$ 26,882,675
OPC	$ 12,797,296	$ 1,786,221	$ 4,280,088	$ 873,941	$ 19,737,546
ROCKINGHAM	$ 4,454,893	$ 960,591	$ 865,852	$ 525,748	$ 6,807,084
SURRY-YADKIN	$ 4,803,289	$ 253,200	$ 1,096,922	$ 279,555	$ 6,432,966
VWGF	$ 10,945,516	$ 320,633	$ 5,613,049	$ 950,317	$ 17,829,515
CUMBERLAND	$ 8,979,986	$ 3,834,684	$ 3,704,220	$ 115,560	$ 16,634,450
DAVIDSON	$ 4,985,172	$ 324,000	$ 1,216,017	$ 45,701	$ 6,570,890
JOHNSTON	$ 3,454,850	$ 1,090,105	$ 1,724,749	$ 179,175	$ 6,448,879
LEE-HARNETT	$ 24,125,909	$ 274,197	$ 724,221	$ 931,432	$ 26,055,759
RANDOLPH	$ 6,174,123	$ 466,731	$ 843,028	$ 353,148	$ 7,837,030
SANDHILLS	$ 8,658,887	$ 381,109	$ 2,602,270	$ 1,577,624	$ 13,219,890
SOUTHEASTERN REG.	$ 11,043,962	$ 349,677	$ 2,012,582	$ 1,706,441	$ 15,112,662
WAKE	$ 29,217,053	$ 8,322,837	$ 7,557,826	$ 1,187,984	$ 46,285,700
ALBEMARLE	$ 3,895,695	$ 96,971	$ 1,498,634	$ 131,715	$ 5,623,015
DUPLIN-SAMPSON	$ 3,607,795	$ 226,000	$ 806,609	$ 387,639	$ 5,028,043
EDGECOMBE-NASH	$ 5,761,273	$ 1,021,792	$ 1,796,859	$ 353,706	$ 8,933,630
HALIFAX	$ 3,893,236	$ 440,056	$ 1,851,170	$ 525,695	$ 6,710,157
LENOIR	$ 3,205,580	$ 527,842	$ 798,396	$ 309,190	$ 4,841,008
NEUSE	$ 7,102,658	$ 625,967	$ 2,642,112	$ 1,162,268	$ 11,533,005
ONSLOW	$ 4,827,285	$ –	$ 1,006,483	$ 619,763	$ 6,453,531
PITT	$ 7,979,240	$ 1,516,672	$ 2,276,438	$ 361,310	$ 12,133,660
ROANOKE-CHOWAN	$ 3,710,666	$ 187,814	$ 1,027,196	$ 514,413	$ 5,440,089
SOUTHEASTERN AREA	$ 19,202,362	$ 1,238,764	$ 3,269,494	$ 563,593	$ 24,274,213
TIDELAND	$ 5,623,604	$ 401,685	$ 993,186	$ 331,514	$ 7,349,985
WAYNE	$ 4,185,365	–	$ 595,065	$ 276,793	$ 5,057,223
WILSON-GREENE	$ 4,293,946	$ 292,334	$ 1,073,345	$ 212,975	$ 5,872,600
TOTAL	$ 387,527,551	$ 67,997,716	$ 113,605,930	$ 30,901,665	$ 600,032,862

Data Sources by Column:

(1) Data based on Division payment records.

(2) Data based on County General Fund data submitted by area programs.

(3) & (4) Data based on information from Area Program Fiscal Monitoring Reports as submitted by area programs.

Area Program Resources by Disability and Funding Source
FY 1994-95

Area Program	Mental Illness					Developmental Disabilities					Substance Abuse					TOTAL REQUIREMENTS
	Allocated Requirements	Division State	Division Federal	Medicaid	All Other	Allocated Requirements	Division State	Division Federal	Medicaid Incl CAP MR	All Other	Allocated Requirements	Division State	Division Federal	Medicaid	All Other	
EASTERN																
Albemarle	2,060,893	693,038	218,145	427,546	722,165	2,509,083	1,519,541	139,835	327,453	522,254	684,127	418,073	126,292	9,574	130,188	5,254,104
Duplin-Sampson	1,728,350	997,649	76,048	427,337	227,316	2,202,506	1,253,552	189,931	54,500	704,523	494,180	278,571	179,002	11,314	25,293	4,425,036
Edgecombe-Nash	3,648,915	1,836,705	315,771	475,909	1,020,530	2,070,176	1,367,862	257,744	444,050	520	1,505,492	567,438	271,670	44,406	621,978	7,224,583
Halifax	1,659,446	708,751	113,038	252,800	584,858	3,342,276	1,156,948	115,036	290,412	1,779,880	816,412	390,810	144,210	36,097	245,295	5,818,134
Lenoir	761,251	321,689	84,437	325,550	29,575	2,289,902	1,124,863	108,506	147,323	909,210	886,574	335,733	463,838	59,222	27,782	3,937,727
Neuse	3,833,152	1,656,586	153,962	720,070	1,302,534	4,757,606	2,296,467	319,873	727,923	1,413,343	1,162,265	478,606	342,551	104,488	236,621	9,753,023
Onslow	1,142,406	760,862	64,069	302,276	15,200	2,547,730	1,715,521	231,882	213,052	387,274	1,343,684	791,079	509,358	43,094	53	5,033,720
Pitt	3,552,495	1,404,948	586,537	542,104	1,018,907	2,128,437	1,333,411	103,706	509,508	181,812	3,917,256	758,913	1,490,861	200,821	1,466,661	9,598,188
Roanoke-Chowan	1,850,548	974,122	92,637	315,479	468,310	1,939,133	969,562	129,255	338,778	501,538	1,028,639	549,500	425,584	22,105	31,451	4,818,321
Southeastern Area	4,806,736	1,146,432	358,222	1,269,296	2,032,785	4,523,314	1,785,416	210,209	647,389	1,880,300	5,485,207	1,094,525	1,864,765	109,401	2,416,517	14,815,257
Tideland	1,764,615	589,753	100,486	323,213	751,163	3,242,388	2,563,619	245,807	270,123	162,838	961,057	536,369	370,291	28,982	25,415	5,968,060
Wayne	1,188,968	942,956	68,506	120,582	56,924	1,503,972	1,061,692	172,435	111,922	157,923	929,758	484,393	336,298	18,614	90,454	3,622,699
Wilson-Greene	2,001,500	988,334	108,360	304,338	600,468	2,283,144	1,429,422	155,907	380,322	317,492	559,848	360,864	136,665	21,795	40,525	4,844,492
EASTERN TOTAL	**29,999,277**	**13,021,825**	**2,340,218**	**5,806,499**	**8,830,735**	**35,339,666**	**19,577,876**	**2,380,126**	**4,462,757**	**8,918,907**	**19,774,401**	**7,044,874**	**6,661,385**	**709,910**	**5,358,232**	**85,113,344**
NORTH CENTRAL																
Alamance-Caswell	2,541,445	1,698,508	228,091	347,296	267,549	6,516,407	2,758,559	211,495	23,495	3,522,858	813,417	405,360	372,346	28,625	7,086	9,871,269
Durham	5,427,043	2,126,855	181,813	473,832	2,644,543	5,274,453	2,368,118	220,122	462,961	2,223,252	4,490,943	939,898	1,016,961	110,172	2,423,912	15,192,438
Forsyth-Stokes	6,846,169	2,589,166	391,028	2,043,019	1,822,956	7,491,399	2,587,022	212,797	685,846	4,005,733	6,997,545	1,633,145	1,463,602	203,156	3,697,643	21,335,113
Guilford	7,824,887	3,032,243	292,486	1,249,811	3,250,348	7,060,896	4,109,473	197,465	226,802	2,527,157	6,158,461	1,421,666	1,628,499	205,346	2,902,951	21,044,245
Orange-Person-Chatha	6,470,305	2,053,702	161,779	2,166,374	2,088,449	7,148,624	3,021,625	199,088	538,148	3,389,764	1,651,181	793,539	633,245	48,108	176,289	15,270,110
Rockingham	953,424	468,018	74,191	186,922	224,292	2,939,457	1,797,902	126,872	390,452	624,231	474,739	249,291	174,615	14,683	36,150	4,367,619
Surry-Yadkin	1,987,589	1,124,067	163,385	423,782	276,356	2,025,602	1,214,950	173,796	321,745	315,111	504,745	189,316	270,064	31,246	14,119	4,517,937
VGFW	4,774,425	761,783	493,723	2,331,244	1,187,674	4,217,311	2,214,200	125,656	415,570	1,461,885	1,787,506	463,275	450,448	59,828	813,954	10,779,241
N. CENTRAL TOTAL	**36,825,286**	**13,854,342**	**1,986,496**	**9,222,281**	**11,762,167**	**42,674,149**	**20,071,849**	**1,467,291**	**3,065,018**	**18,069,990**	**22,878,537**	**6,095,490**	**6,009,780**	**701,163**	**10,072,104**	**102,377,972**
SOUTH CENTRAL																
Cumberland	6,534,282	3,017,240	189,584	1,077,172	2,250,285	3,837,439	1,640,990	355,958	134,059	1,706,432	3,297,522	1,046,061	500,658	107,756	1,643,047	13,669,243
Davidson	2,207,997	1,572,111	23,574	209,940	402,372	1,765,504	998,453	270,044	268,826	228,181	1,129,418	549,678	179,832	26,695	373,213	5,102,919
Johnston	2,436,627	1,428,481	21,377	279,762	707,007	1,880,514	1,037,296	233,336	358,333	251,549	1,725,659	331,954	188,696	719,281	485,729	6,042,800
Lee-Harnett	2,965,220	1,890,213	28,491	256,879	789,637	2,195,468	1,605,012	158,889	60,200	371,367	1,193,478	497,825	648,561	16,920	30,171	6,354,166
Randolph	2,104,148	1,657,115	29,634	304,811	112,587	1,636,430	1,009,083	160,572	179,293	287,482	1,406,632	719,345	257,033	43,726	386,528	5,147,209
Sandhills	4,800,609	2,701,850	66,295	1,020,972	1,011,493	4,708,160	2,590,998	224,902	768,943	1,123,317	2,062,923	730,040	827,771	46,629	458,484	11,571,693
Southeastern Regional	5,049,550	2,919,885	267,500	882,102	980,063	4,310,012	3,114,388	275,643	413,353	506,628	1,700,548	674,546	851,568	77,515	96,919	11,060,110
Wake	13,092,734	4,001,642	726,668	6,385,058	1,979,366	10,071,774	4,215,690	391,761	1,704,532	3,759,791	8,306,761	1,771,539	1,577,406	186,575	4,771,241	31,471,268
S. CENTRAL TOTAL	**39,191,166**	**19,188,537**	**1,353,123**	**10,416,695**	**8,232,811**	**30,405,301**	**16,211,910**	**2,071,105**	**3,887,540**	**8,234,746**	**20,822,941**	**6,320,988**	**5,031,525**	**1,225,097**	**8,245,331**	**$90,419,408**
WESTERN																
Blue Ridge	9,434,481	1,894,457	282,432	5,175,626	2,081,966	7,207,135	2,712,422	365,244	1,027,612	3,101,858	4,755,639	2,296,785	1,395,904	119,641	943,310	$ 20,437,186
Catawba	3,300,664	1,350,285	137,491	572,208	1,240,680	2,163,453	1,121,607	190,443	345,397	506,007	1,222,553	407,056	341,704	19,619	454,174	$ 6,471,130
Cleveland	1,830,483	1,174,941	167,380	353,187	134,975	2,755,773	788,546	123,189	511,502	1,332,536	1,185,037	309,132	276,642	26,302	572,961	$ 5,563,279
Foothills	6,885,589	2,104,367	384,090	3,692,412	704,720	4,749,715	2,298,484	182,633	805,675	1,462,923	1,478,949	914,411	295,581	19,991	248,965	$ 12,036,895
Gaston-Lincoln	5,782,012	1,879,157	74,733	1,399,098	2,429,024	12,148,514	4,248,370	276,446	1,551,404	6,072,294	1,298,290	783,034	349,672	103,969	61,615	$ 17,478,321
Mecklenburg	21,529,279	6,011,432	614,092	1,262,840	13,640,915	12,731,928	5,176,135	395,413	2,808,083	4,352,297	9,148,821	1,960,496	1,704,264	268,658	5,215,402	$ 39,186,768
New River	5,050,181	2,853,758	215,227	1,902,628	78,568	5,904,604	1,963,496	267,051	928,724	2,745,333	1,348,640	816,483	281,661	52,863	197,633	$ 11,475,205
Piedmont	4,269,383	2,173,098	307,929	641,664	1,146,692	6,582,108	3,085,852	294,260	1,642,945	1,559,051	2,444,450	764,467	734,220	74,753	871,010	$ 12,555,511
Rutherford-Polk	2,164,476	1,388,713	89,713	563,944	122,106	2,119,529	1,213,875	132,033	171,364	602,257	681,157	332,914	143,369	11,014	193,860	$ 5,380,134
Smoky Mountain	4,488,287	2,479,906	139,291	985,060	884,030	4,672,256	1,946,340	342,903	750,891	1,632,122	1,564,609	748,976	393,385	54,785	367,464	$ 11,672,782
Trend	5,013,932	1,109,805	105,278	1,157,117	2,641,732	2,552,104	1,546,161	173,726	770,766	61,452	956,905	318,027	175,730	18,257	444,891	$ 10,359,393
Tri-County	4,302,509	2,458,312	194,547	486,860	1,162,790	4,189,085	2,612,319	224,233	545,325	807,208	1,926,445	806,035	537,105	39,209	544,096	$ 10,754,194
WESTERN TOTAL	**74,051,276**	**26,878,231**	**2,712,203**	**18,192,644**	**26,268,198**	**67,776,205**	**28,713,607**	**2,967,574**	**11,859,687**	**24,235,337**	**28,011,495**	**10,457,818**	**6,629,237**	**809,061**	**10,115,381**	**183,370,798**
GRAND TOTALS	**180,067,005**	**72,942,935**	**8,392,040**	**43,638,120**	**55,093,911**	**176,195,321**	**84,575,242**	**8,886,096**	**23,275,003**	**59,458,980**	**91,487,374**	**29,919,168**	**24,331,927**	**3,445,232**	**33,791,048**	**441,281,522**

Notes: Total Requirements are based on the Fiscal Monitoring Report, with Thomas S. and Willie M. excluded. Requirements are allocated to disabilities based on value of reported services.
Medicaid includes CAP MR/DD, Carolina Alternatives and MH Plan Medicaid payments to area programs, with paymewnts to Thomas S. and Willie M. clients excluded.

CAROLINA ALTERNATIVES

Presentation to the Mental Health Study Commission
December 7, 1995

WHAT IS CAROLINA ALTERNATIVES?

- Carolina Alternatives is a Medicaid 1915(b) waiver administered by the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

- The waiver is currently implemented in ten area programs responsible for serving children in 32 counties (list attached).

- Carolina Alternatives was developed:
  - to address increasing costs of inpatient care for children through better management of access to inpatient services,
  - to develop community services to better serve children in their homes and communities

- Carolina Alternatives supports the goals of the Child Mental Health Plan:
  - to expand availability of child mental health services in communities,
  - to increase the flexibility of services and expand individualized services to children in their homes, schools and communities,
  - to increase the coordination of mental health services with other child-serving organizations,
  - to increase treatment plans that are centered around the client's needs, and
  - to increase the involvement of parents and family members in treatment planning

- The Carolina Alternatives capitation model places both treatment and financial responsibility for clients with the area programs. This model supports an individualized and proactive approach to serving clients.

SCOPE

- Child program serves children aged 0-17 years who receive Medicaid services in participating counties and who need mental health and/or substance abuse services.

- Adult program will serve persons aged 18-64 who receive Medicaid services in the Disabled and Other eligibility categories and who need mental health and/or substance abuse services.

- The current program provides an entitlement to medically necessary services included in the State Medicaid Mental Health Plan, using community based delivery systems including both in-house and contract providers.

OUTCOMES

- Since January 1994, over 127,000 children have been eligible for Medicaid services, including Carolina Alternatives, in participating counties.

- Access to mental health and/or substance abuse services has increased.
  - The number of children served increased by 44% from 1992 to 1994.
  - The number of children served in the first six months of 1995 is 47% higher than the number served in the first six months of 1994.
  - The percentage of children served is now almost 10% of the total eligible population, up from 6.9% in 1992.

- The average inpatient days per client dropped from 44.4 days in 1992 to 23.6 days in the first six months of 1995.

- Funding for outpatient services to eligible children increased over 529% from 1992. The proportion of dollars spent on outpatient services increased from 33% of total dollars spent in 1992 to almost 80% in 1994.

CHALLENGES

- Outpatient services grew more than anticipated and state appropriations had not been budgeted to maintain this level of financing the state share.
  Responded by:
  - changing reimbursement to area programs
  - reducing local funds available to pay to contract providers
  - growth containment through area program assumption of full financial risk for outpatient services in January 1996.

- Concerns about area program readiness to handle challenges of managing resources through this capitation method.
  Responded by:
  - developing readiness criteria to help area programs prepare for implementation of the waiver program

- making site visits to each area program using the readiness criteria to make judgments about area program readiness and needs for future technical assistance and training.

- Start-up issues, such as late payment of bills, variations in contract management across area programs, and varied responses to treatment planning for clients.

  Responded by:

  - working with area programs to develop a standard contract to use with providers (in process),
  - monitoring claims payment process through site visits and through meetings with provider groups (ongoing),
  - discussions with area programs on ways to standardize credentialing and privileging providers, including use of a centralized organization (in process),
  - development of standardized levels of care criteria to guide area program staff in making treatment decisions based on medical necessity (in process).

- Early policy development and governance structures did not adequately include input from consumers, advocates and providers.

  Responded by:

  - seeking input from these groups on proposed contracts, levels of care criteria, and expansion of waiver to adult services.

FUTURE PLANS

- The State has submitted an application to the federal Health Care Financing Administration to:
  - to continue the current waiver past December 1995,
  - to expand the child program statewide by December 1997 and,
  - to include adults statewide by July 1998.

- Participating area programs will be at full financial risk for covered services, both inpatient and outpatient, for eligible children beginning in January 1996. Area programs who join Carolina Alternatives will do so at full risk.

For more information, please contact:
Judy Holland, Head
Carolina Alternatives Branch
919 733-0598

CAROLINA ALTERNATIVES

AREA PROGRAM	COUNTY	CODE
Blue Ridge Area Program 356 Biltmore Avenue Asheville, North Carolina 28801 704-258-3500	Buncombe Madison Mitchell Yancey	11 57 61 100
Foothills Area Program 306 South King Street Morganton, North Carolina 28655 704-438-6230	Alexander Burke Caldwell McDowell	2 12 14 59
Forsyth Stokes Area Program 725 Highland Avenue Winston Salem, North Carolina 27101 910-725-7777	Forsyth Stokes	34 85
Gaston Lincoln Area Program 401 North Highland Street Gastonia, North Carolina 28052 704-867-2361	Gaston Lincoln	36 55
OPC Area Program 101 East Weaver Street Carrboro, North Carolina 27510 919-918-1116	Orange Person Chatham	68 73 19
Smoky Mountain Area Program PO Box 280 Dillsboro, North Carolina 28725 704-586-5501	Cherokee Clay Graham Haywood Jackson Macon Swain	20 22 38 44 50 56 87
Southeastern Area Program 2023 South Seventeenth Street Wilmington, North Carolina 28401 910-251-6440	Brunswick New Hanover Pender	10 65 71
Trend Area Program 800 Flemming Street Hendersonville, North Carolina 28739 704-692-5741	Henderson Transylvania	45 88
VGFW Area Program 125 Emergency Road Henderson, North Carolina 27536 919-492-4011	Franklin Granville Vance Warren	35 39 91 93
Wake Area Program 401 East Whitaker Mill Road Raleigh, North Carolina 27608 919-856-5260	Wake	92

Mental Health Study Commission
Area Board Fiscal Responsibilities
January 24, 1996

All funding for mental health, developmental disabilities, and substance abuse programs or related services must be allocated, received, and used in accordance with the requirements of the General Statutes, state rules and regulations, and any area authority agreements with DHR. Failure to comply with these requirements could lead to delay, reduction, or denial of funds administered by the Division.[1] These requirements impose the following fiscal responsibilities on the area board:

- Develop and maintain an ***annual budget*** in accordance with the Local Government Budget and Fiscal Control Act;
- Undergo an ***annual independent audit*** and submit audited financial statements and compliance audit reports to the Local Government Commission in accordance with the Local Government Budget and Fiscal Control Act;
- Prepare ***fee schedules*** for services and make every reasonable effort to collect appropriate reimbursement for the cost of services;
- Prepare and enter into an ***annual memorandum of agreement*** with DHR that establishes how the area authority will earn state dollars;
- Establish ***dispute resolution procedures*** for persons challenging the planning and budget processes or any reduction in funding for services;
- Submit to the Division ***quarterly reports*** of receipts and expenditures by major types of funds received and expended during the quarter and during the fiscal year to date; and
- Comply with federal requirements as a condition of receipt of ***federal grants***.[2]

A single-county area authority is a department of the county for purposes of budget and fiscal control. A multicounty area authority area authority is considered a "public authority" for purposes of the budget law. All local governments and public authorities must operate under a balanced annual budget ordinance.[3]

---

1 G.S. 122C-141(b).

2 G.S. 122C-146 (fee schedules for services); G.S. 122C-143.2 (annual memorandum of agreement); 122C -151.3 (dispute resolution procedures); 122C-117(a)(4) and -144.1(a) (annual budget); G.S. 122C-144.1(b) (quarterly reports); G.S. 122C-144.1(c) (annual independent audit); and G.S. 122C-117(a)(6) (federal grant requirements). Although G.S. 122C-144.1(b) states only that the Division "may require periodic reports of receipts and expenditures," according to Commission rules, quarterly reports are "required" from all area authorities receiving state-administered funds. N.C. ADMIN. CODE tit. 10, ch. 14C § .1004.

3 G.S. 159-8(a).

SECTION II

GOVERNANCE AND ACCOUNTABILITY

SUBCOMMITTEE REPORT

MENTAL HEALTH STUDY COMMISSION

GOVERNANCE & ACCOUNTABILITY SUBCOMMITTEE

CHAIR: Representative Charlotte A. Gardner

Representative Martha Alexander
Ms. Clara Boswell
Senator Richard Conder
Senator Jeanne Lucas
Senator Robert L. Martin
Ms. Eula Miller
Mr. Rhett Raynor
Senator Marvin Ward
Representative Cynthia Watson

GOVERNANCE AND ACCOUNTABILITY SUBCOMMITTEE

Representative Charlotte A. Gardner
Chair

Charge to the Subcommittee

The main focus of the Governance and Accountability Subcommittee is how to improve fiscal accountability and quality of services and what are the implications of any necessary improvements for the structure of area programs, as well as how they relate to the State. In particular, the subcommittee was asked to look at: appropriate number/size of area programs, the balance between local flexibility and State standards, uniformity of administrative procedures/documentation, and client outcomes.

Discussion

February 14, 1996

At this first meeting of the Subcommittee, Representative Gardner began by reviewing why the governance and accountability issues need to be addressed as priorities now. She explained that:

- The delivery of health care, including mh/dd/sa, is changing
- MHSC laid out a vision for the State in its plans.
  - → A policy was established, as a result, for growing and improving the system of care. Initiatives were undertaken to expand available resources to implement those plans.
  - → Coalition 2001 was successful in advocating for additional State resources, and the Division was successful in improving the participation of Medicaid resources in achieving those objectives.
- But, with serious restrictions on growth of expansion resources, it is important to look at how we're going to continue to address the needs of these populations and do so in a cost effective manner.
  - → Providers often say they could produce quality of care if they had more resources. The legislature has expressed concerns that, if it is to find additional resources there needs to be greater accountability for what's being spent.
  - → The real challenge is how to assure quality of care to more people in a cost efficient manner, and to be good stewards of public dollars while also being responsive to the needs of the people.

- Questions have been raised again and again in public hearings, correspondence with the MHSC, and conversations across the State -- are the area programs accountable, for fiscal operations and quality of services. Are there adequate safeguards for advocacy concerns and fiscal soundness?
  - ➔ We saw a vivid example of how these issues can come to life at our last meeting with the Tri-County audit report.

- Very closely associated with the accountability issue, is the issue of whether the current structure of area programs (their size, county relationships, and State relationships) is adequate to meet this challenge of quality of service and cost efficiency.

The meeting was then opened up to the Subcommittee members to express their concerns and questions around these issues. Items brought up for discussion included: the need for 41 area programs; current structures of programs (size, county relationship, state relationship, are they adequate to meet the challenge); differences between single county programs and multi-county programs; lack of uniformity in procedures; client satisfaction; self-examination from DHR; composition of area boards; lack of education for boards and commissioners; what are we getting for the money spent; and how to evaluate the administration of area programs.

The discussion was opened up to the audience, and they expressed concerns related to: unevenness of money spent between mental health, developmental disabilities, and substance abuse; single counties struggling with managed care changes; outcome study; no system established for peer reporting; ownership of area boards in responsibilities; making sure money spent best way; possible state involvement in consortiums; managed care - economies of scale; administrative services organizations (ASO); credibility of system; and experiences from other states may be helpful.

After lunch, John Baggett, Deputy Director with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, provided a presentation developed at the request of the MHSC Co-Chairs on concerns, objectives, and options for area program governance.

Concerns related to governance included:

- Lack of ability of State under current governance structure to intervene in area program operations, except to withhold funds.
- Inefficiencies and problems resulting from operating with different single county, multi-county and large single county systems (Mecklenburg).
- Difficulty of providers and advocacy groups in dealing with the wide range of differences between local programs.
- Inefficiencies and costs resulting from the need for 41 separate administrative operations.

The following objectives for improving governance were given:

- Optimize economies of scale in administrative functions: personnel, contracts, information systems, service authorization, data processing, quality assurance and fiscal viability.
- Standardize and simplify administrative and operational processes in order to reduce costs to private providers and strengthen responsiveness to advocacy concerns.
- Clarify and strengthen accountability for administrative and fiscal operations, professional practice, client access, clinical outcomes and consumer satisfaction
- Standardize county policies and procedures in order to simplify administrative and operational processes while maintaining local government support, stakeholder policy participation, and achievement of state policy objectives
- Minimize administrative overhead in order to maximize services within available resources

Dr. Baggett then presented three options for restructuring area programs, and spoke to the strengths and weaknesses of each. Those options were:

Option #1: Do not restructure local programs; keep the historic 41 programs.

Option #2: Reorganize into approximately 20 area programs with an average of 5 counties each. All counties would be multi-county programs and operate under the same rules. Each area would be configured so as to have more than a minimum and less than a maximum population, except that geographical distance and population sparsity would be considered.

Option #3: Reorganize into approximately 10 area programs with an average of 10 counties each. All counties would be multi-county programs and operate under the same rules. Each area would be configured so as to have more than a minimum and less than a maximum population, except that geographical distance and population sparsity would be considered.

Each of the three options included the following recommendations:

- Support the Administrative Service Organization (ASO) strategy to address these objectives:
  - assist the Area Mental Health Programs in effectively implementing managed care approach to service delivery in NC
  - functions: standardized contracts, communication, technical assistance, claims management, quality assurance, utilization management, financial forecasting, review, support, and stop-loss fund management
  - provide leverage and flexibility in purchasing and contracting
- Grant Division of MH/DD/SAS greater statutory authority to address accountability issues:

  - ability not only to withhold funds but to use those funds to contract for services directly
  - ability to take over a service or a program when it is necessary in order to insure clients are appropriately served
- Provide in statute for a person with local government budget officer experience on the Area Board and require finance committees with appropriate representation.
- Require that counties allow Area Programs to maintain fund balances under authority of Area Boards and prohibit imposition of county freezes on state positions.
- Require that Division Director (or designee) be on all Area Program Director Search Committees and Division Director approve selection of Area Director and Finance Officer.

Response to Dr. Baggett's presentation included questions of ASO involvement; need for intervention in area program operation; controversy of Division Director serving on area director search committees. It was suggested that the Commission for MH/DD/SAS approve selection. Other comments included: concern that area directors have no personnel protection; need to negotiate small programs coming together voluntarily; education of board and commission members; and establishing criteria to appoint board members.

February 22, 1996

This meeting began with a review of the three options for governance and the related proposals from the last meeting. Dr. John Baggett reviewed the governance options, which included a lengthy discussion on each one. It was decided to postpone further discussion until another meeting, in order to move on.

After much discussion on State and local relationships, the Subcommittee asked the staff to draft statutory language that would implement the following recommendations: grant the Division of MH/DD/SAS greater authority to address accountability issues (ability not only to withhold funds, but to use these funds to contract for services directly & ability to take over a service or area program when it is necessary in order to ensure clients are appropriately served); require that counties allow Area Programs to maintain fund balances under authority of Area Boards and prohibit imposition of county freezes on State positions; and require that the Division Director (or designee) be on all Area Program Director search committees.

After lunch, Allan Spader, NC Council of Area Programs, made a presentation on the various opportunities for training that are available to area board members. Based on a response to a survey of area board members, the Area Board Forum was created to provide training, technical support and information to help board members become more knowledgeable and effective. Committee members viewed a portion of a training video tape used in acquainting area board members with their legal responsibilities. Staff was asked to make recommendations on statutory language to mandate training for all board members.

Lee Wood, DMH/DD/SAS, presented a brief overview of the differences between single- and multi-county area boards, as detailed below.

	Single-County	Multi-County
Authority	Local political subdivision of the State, except for purposes of budget and fiscal control in G.S. 159. [*G.S. 122C-116*] • must present its budget for approval of the county commissioners. • financial operations must follow the budget set by the county commissioners. • the county has responsibility for fiscal management of the area authority and may require all disbursements, receipts, and financial management of the area authority to be handled by the county's finance officer (can designate a deputy finance officer who is area employee). • part of the county's audit.	Local political subdivision of the State. [*G.S. 122C-116*] • responsible for their own budgeting, disbursing, accounting, and financial management. • required to appoint a budget officer and a finance officer to assume the duties outlined in the budget and fiscal control act. • must contract for their own audit to be completed.
Membership of Area Board	Board of county commissioners determines the size of the area board [*G.S. 122C-118(a)*] and appoints the members of the area board, who may be removed with or without cause. [*G.S. 122C-118(b)*] In counties with a population in excess of 425,000, the board of county commissioners may become the governing body for the area authority. [*G.S. 153A-77*]	Each board of county commissioners must jointly agree on the size of the area board [*G.S. 122C-118(a)*] and appoints one commissioner as a member of the area board and these members appoint the other members of the area board, who may be removed with or without cause by the group authorized to make the initial appointment. [*G.S. 122C-118(c)*]

	Single-County	Multi-County
Personnel	Area employees are subject to the provisions of Chapter 126 of the General Statutes (State Personnel Act). [*G.S. 122C-154*]	(same)
	County may pursue statutory options to bring the personnel administration within the county personnel system - if deemed "substantially equivalent" by the State Personnel Commission. [*G.S. 126-11(a1)*]	The area authority, with the approval of each board of county commissioners, may pursue statutory options to bring the personnel administration within the county personnel system - if deemed "substantially equivalent" by the State Personnel Commission. [*G.S. 126-11(a1)*]
	The board of county commissioners may prescribe for area employees rules governing annual leave, sick leave, hours of work, holidays, and the administration of the pay plan, if these rules are adopted for county employees generally. [*G.S. 126-9(a)*]	Each board of county commissioners may jointly prescribe for area employees rules governing annual leave, sick leave, hours of work, holidays, and the administra-tion of the pay plan, if these rules are adopted for each county's employees generally. [*G.S. 126-9(c)*]

In reviewing the composition of area boards as directed by statute, it was determined several changes to the structure needed to be made in order to open additional space for members from the community. Recommended changes included: combining drug abuse and alcoholism into one category under substance abuse (a client presently in recovery or a member of a citizens' organization); one licensed physician instead of two (if possible, one who has completed a residency in psychiatry); three "family consumers" representing the three disability groups; eliminate the attorney slot, and include a person with local government budget officer experience. There was some discussion around requiring area boards to have finance committees. Staff was asked to draft legislation that would implement the various recommendations, with the intention of discussing and voting on the proposals at a later meeting.

March 6, 1996

The first half of this meeting was devoted to gaining some insight from the experiences of other states in struggling to make system improvements. The Subcommittee heard from Arizona, South Carolina, and Georgia.

Sue Davis, board member of the National Alliance for the Mentally Ill from Arizona, stated that Arizona never had a Medicaid program but rather a managed care system was established in 1982. Problems she focused on included: the system is primarily an acute care model; a reduced quality of care due to lack of funds to deliver services; managed care requires advocacy; and the system is funded on capitation basis. Positive aspects included: the elimination of fraud; the elimination of duplicated services; consolidation of services; and maximization of resources through integrated funding. She expressed concern that clinicians needed to dictate care and not businessmen. Lessons learned included: family members and consumers on all regional area authority boards should be involved in planning and fiduciary responsibility; meeting the eligibility criteria is the key to accessing the system; and fear that the system is moving to an indigent only care system. Issues raised by Commission members included: accessibility for rural population, additional information needed on developmental disabilities in managed care, and concern that managed care would not work in 41 area programs.

The next presentation was by David Mahrer, Quality Improvement and Advocacy, of the South Carolina Department of Mental Health. He explained that the South Carolina system is different in that they are not answerable to the Governor but rather to a 7 member commission (citizen board) comprised of 1 person at-large, and 1 person from each of the legislative districts. The system is a wholly owned State mental health system. There are 17 mental health centers (with local boards) with the same budgeting system for all, which generates a monthly budget forecast, and the Department of Mental Health incurs any debt as part of their overall budget. They have the same 30 plus services available in all of the centers. He stated that 53% of all revenues are from Medicaid, with the rest coming from the State and a small amount from the county. The fee for service system has encouraged South Carolina financially to develop more services, therefore they do not foresee a need for managed care at this time. Questions were raised concerning: how they handle DiSH moneys, the level of county support, the level of equalization for funding, and the authority of the counties in the system.

Rep. Gardner then introduced Susan Twardowski of the United Cerebral Palsy Associations from Georgia. Ms. Twardowski discussed the restructuring of the Georgia MHMRSA service delivery, as well as the shortcomings before restructuring. Unlike North Carolina, Georgia has a free standing Medicaid agency in which federal money goes to the Department of Human Resources and then disbursed. She reviewed the organizing principles, the planning boards and their responsibilities, and the composition of regional and community service boards. Ways of improving the system included: consumer and family choice; a single system of service entry and coordination; local community decision-making; a single point of accountability; separation of planning and service delivery; and a client-centered service system.

After lunch, Rep. Gardner asked the Committee members to consider the draft legislation that staff had prepared on the recommendations from the last meeting. She requested that they review the document and make comments or changes before the next meeting.

Charles T. Grubb, Ph.D., Chief, Quality Improvement Section of the Department of Mental Health, Developmental Disabilities, and Substance Abuse Services made a presentation on the Division's current approach to outcomes and accreditation. He referenced the Mental Health Study Commission Plan for Quality adopted by the General Assembly as policy guidance for the Division. The plan instructs the Division to transform management style from one based on quality assurance to one based on quality improvement, reduce rules and procedures, and emphasize client outcomes and client satisfaction. He explained that 700 plus rules had been reduced to less than 190, with the number of rules being reduced by 74% and the pages of rules reduced by 47%. Dr. Grubb mentioned the biggest advantage of the new rules was that they clarify and specify responsibility for administrative and clinical operations. He also emphasized the importance of the development of client outcomes and the new accreditation process. Accreditation is defined as "the authorization granted to an area program by the Department of Human Resources, as a result of demonstrated compliance with the standards established in the Rules, to provide specific services." The Division can recommend a 1-3 year accreditation for area programs or, for those which are especially good, recommend a 4-5 year accreditation with the approval of the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services. If there are dramatic changes in the area program, the Division can come back and conduct another assessment at any time. The purpose of the accreditation process includes:

- assurance and enhancement of system integrity,
- constant improvement of area programs and the services they provide,
- provide a process and mechanism for recognition of area programs that provide services at a level of excellence,
- identify opportunities for systemic improvements that will enhance efficacy and efficiency of service delivery,
- assure that services are provided at recognized levels of competence and in accord with applicable rules,
- identify opportunities for development of individual service provider skills,
- protect the health, safety and welfare of our clients, and
- identify service providers that would benefit from technical assistance and training.

The basic accreditation process would include:

1. Self-study by the area program based upon Division rules and standards of practice.
2. Review of the self-study by the Accreditation Team.
3. On-site visit by the Accreditation Team.
4. Team identifies strengths and areas for improvement.
5. Area program develops improvement implementation plan.
6. Team recommends duration of Accreditation.
7. Division accredits area program.

Dr. Grubb stated that the first statewide consumer satisfaction surveys were conducted in November, and results from them should be available by mid-April. Questions were raised concerning: cost of such an approach, accrediting the whole program vs. by service, and whether announced reviews would skew the results.

Maria Spaulding, Director of Human Services for Wake County made a presentation on the Wake County governance proposal. The proposal was generated by the County Commissioners Board which was interested in a greater integration of program services and a revival of quality service at a reduced cost. Wake County proposes to integrate the Social Services Dept., Public Health Dept., Mental Health Dept., Child Support Agency, and the Job Training Agency into one Human Services organization.

Recommendations from Wake's Human Services Policy Board to the County Commissioners included: a single policy making board; a single human service agency, with one executive director; and the savings received from the changes would be reinvested in the services. Legislation is needed to allow the county to operate with a single board and director. Concerns expressed by Commission members included: who's ultimately accountable, net loss of representation on board, authority of the Division in new arrangement, how to access the system for a specialized need, expected cost savings, authority of new board to set policy vs. advise, and ability to track specific funding initiatives.

March 20, 1996

Each of the recommendations generated thus far were reviewed and discussed thoroughly with consideration given to recommended language changes and suggestions submitted by various parties.

Sen. Ward asked the Department to prepare a response after lunch regarding: how the changes being made now would prevent occurrences such as Tri-County and Southeastern in the future; how will the Department be affected with the proposals being considered as far as additional personnel; and will these changes impact services for the people of North Carolina.

After lunch, John Baggett, Deputy Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse, responded to Sen. Ward's concerns. In regard to the first concern, he stated that regulations would have been in place allowing for financial receipts to be closely monitored and a complete administrative and program review to have occurred. Secondly, additional personnel would not be needed unless there were multi-counties having difficulty or if the Department were to experience downsizing. In that case, contract services could be used to attain additional staff if deemed necessary. Last, Dr. Baggett assured Sen. Ward that the changes being made would not affect services of the local programs.

The Subcommittee then voted on which recommendations to submit to the full MHSC, and those are listed in the following section.

GOVERNANCE & ACCOUNTABILITY SUBCOMMITTEE
RECOMMENDATIONS

Many of the recommendations included here are based on a few broad premises that seemed to emerge from the Subcommittee's deliberations. Those underlying themes are:

- With the State allocating approximately 65% of the funds for mental health, developmental disabilities, and substance abuse services, the State has a strong vested interest in the financial accountability of and quality of services provided by the area programs.
- As the system moves toward a managed care model of service delivery, the role and function of the area board not only changes, but becomes even more complex and critical.
- With the move to managed care, it is important that all area programs (whether single-county, multi-county or exceptions) are operating as much as possible with the same authorities, as well as responsibilities.

Recommendation #1

Require that counties allow area programs to maintain fund balances under the authority of area boards.

Rationale for change: During presentations to the full MHSC regarding managed care, several comments were made regarding the difficulties many area programs, especially single-county programs, face in managing a system of resources without a financial reserve. Most multi-county area programs operate with a fund balance, and the need was felt to equalize some of the management capacities of single-county programs with those of other area programs. Concerns were raised regarding the ability of the county to determine its level of support for mh/dd/sa services, and it was made clear that they still maintained discretion as long as proposed reductions aren't for the reasons listed in G.S. 122C-115(e).

Legislative language:

Amend G.S. 122C-115 by adding:

(d) The board or boards of county commissioners that establish the area authority shall allow that area authority to maintain an unrestricted fund balance of up to 15% for the provision of mental health, developmental disabilities, and substance abuse services. The fund balance shall continue forward from year to year, in accordance with the rules of the Secretary.

(e) Counties may not reduce county appropriations and expenditures for area authorities due to the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area authority.

and amend G.S. 122C-117 by inserting:

(5) Maintain an unrestricted fund balance of up to 15% in accordance with the rules of the Secretary, allocations from which are solely within the authority of the area authority.

Recommendation #2

Require that the Director of the Division of MH/DD/SAS (or designee) serve on all area program director search committees.

Rationale for change: In analyzing the role of the State in ensuring an area program's financial stability and accountability, it was felt that, with the responsibility that the area director has, the perspective and input of the Division Director would be a valuable addition to the process of selecting an area director. Concerns were raised about mandating this consultation, but it was felt that those who most needed the assistance wouldn't ask for it otherwise.

Legislative language:

Amend G.S. 122C-117(a)(7) as follows:

~~(7)~~(8) Appoint an area ~~director.~~ director, chosen through a search committee on which the Secretary of the Department of Human Resources or his designee serves as an ex-officio, non-voting member.

Recommendation #3

Prohibit area board vacancies from remaining open for an extended period of time.

Rationale for change: Concerns were raised over reports that sometimes seats on an area board are vacant for an extensive period of time, and with the importance the board plays or must play in managing the complex finances of an area authority, appointing members to this board must be a high priority.

Legislative language:

Amend G.S. 122C-118 by adding a new section as follows:

(d1) Whenever a vacancy occurs on the board, it shall be filled within one hundred and twenty days.

Recommendation #4

Eliminate one of the two licensed physicians on the area board.

Rationale for change: It was felt that there was a need to open the board up for greater "non-designated" representation from the community, and that one physician was adequate,

especially for rural areas, where it might be more difficult to fill both of these slots on the board. This is still just a minimum requirement and could be exceeded if desired.

Legislative language:
Amend G.S. 122C-118(e)(2) as follows:

(2) At least ~~two physicians~~ one physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina ~~and~~ who, when possible, ~~one of these physicians should be~~ is certified as having completed a residency in psychiatry;

Recommendation #5

Combine the area board representation of drug and alcohol abuse into substance abuse, for both client and family representatives.

Rationale for change: This recommendation sprung from the desire to put representation for substance abuse needs in parity with the other two disabilities, as well as encourage stronger advocacy on behalf of substance abuse services. Again, this would only be the minimum requirement and additional representatives could always be appointed.

Legislative language:
Amend G.S. 122C-118(e)(4.1) and (5) as follows:

(4.1) At least one primary consumer ~~each~~ presently and openly in recovery ~~and~~ representing the interests of individuals suffering from the disease of alcoholism or other drug abuse. ~~with:~~
~~a. Alcoholism; and~~
~~b. Drug abuse.~~

(5) At least one family consumer each representing the interest of individuals with:
a. Mental illness;
b. Developmental disabilities; and
c. ~~Alcoholism; and~~ Alcoholism or other drug abuse in the family.
~~d. Drug abuse.~~

Recommendation #6

Add a representative to the area board with financial expertise

Rationale for change: This recommendation originated with the State Auditor's presentation to the full MHSC on the state-wide implications of the Tri-County Area Program Audit. With the complex nature of area program financing, it was thought that someone who could interpret figures and ask appropriate questions was a critical addition to the board.

Legislative language:
Amend G.S. 122C-118(e) by adding a new subsection (7) as follows:

(7) At least one member who has experience in financial areas to the extent that he or she can understand and interpret audits and other financial reports accurately.

Recommendation #7

Require boards of county commissioners to declare vacant the seat of an area board member who accumulates 3 unexcused absences within a 12 month period..

Rationale for change: This recommendation came from the full Commission as a substitute to the Subcommittees recommendation for term limits for area board members (which also originated with the State Auditor's presentation to the full MHSC on the state-wide implications of the Tri-County Area Program Audit). It was felt that the real issue was not how long a person serves on the board, but whether or not they are an active participant who takes the responsibilities of their office seriously. The Commission expressed desire to have the Subcommittee look at additional areas the State can provide guidance in to assure a level of quality among area board members, when they reconvene after the short sessison.

Legislative language:

Amend G.S. 122C-118 by adding a new subsection as follows:

(c1) The group of county commissioners authorized to make appointments to the area board shall declare vacant the office of a member of the area board who does not attend three scheduled meetings without justifiable excuse within a twelve month period.

Recommendation #8

Require all area boards to have finance committees.

Rationale for change: As a means of ensuring that problem areas could be identified early, it was felt that some board members needed to be continually examining the financial data that area programs generate monthly. While many area programs currently have finance committees, not all do, as it is up to the discretion of the board.

Legislative language:

Amend G.S. 122C-119 by adding a new section (d) as follows:

(d) The area board shall establish a finance committee that shall meet at least six times per year to review the financial strength of the area program. The finance committee shall have a minimum of three members, two of whom have experience in budgeting and fiscal control. If the area board so chooses, the entire area board may function as the finance committee; however, its required meetings as a finance committee shall be distinct from its meetings as an area board.

Recommendation #9

Mandate training for all members of an area authority's governing body.

Rationale for change: Because an area authority has ultimate responsibility for planning and operating mental health, developmental disabilities, and substance abuse services, it was felt that it was important for each board member to have a thorough understanding of their responsibilities as well as the intricacies of delivering these services. This recommendation also extends this training requirement to all folks who serve on a governing body, even if there is no area board (i.e. Mecklenburg model). The State Auditor also mentioned the need for greater board training in his remarks.

Legislative language:

Amend G.S. 122C-119.1 as follows:

All members of the governing body for an area ~~authority's board of directors~~ authority shall receive initial orientation on board members' responsibilities and training provided by the ~~Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Secretary of the~~ Department ~~of Human Resources~~ in fiscal management, budget development, and fiscal accountability. A member's refusal to be trained ~~may~~ shall be grounds for removal from the board.

Recommendation #10

Grant Division of MH/DD/SAS authority to use withheld funds to contract for services directly.

Rationale for change: During the last few legislative sessions, the Division has received authority to withhold administrative funds from an area program for failure to provide timely services or financial failure. Unfortunately, exercising this option could impact services to clients. In order to ensure that services aren't interrupted, it was felt the Division needed the ability to contract for those services directly.

Legislative language:

Amend G.S. 122C-124 by inserting a new section (b) as follows:

(b) If the Secretary determines that an area authority is not providing minimally adequate services, in accordance with its annual service plan, to persons in need in a timely manner, or fails to demonstrate reasonable efforts to do so, the Secretary, after providing written notification of his or her intent to the area board and after giving the area authority an opportunity to be heard, may withhold funding for the particular service or services in question from the area authority and insure the provision of these services through contracts with public or private agencies or by direct operation by the Department.

Recommendation #11

Grant Division of MH/DD/SAS authority to take over a service area or area program when it is necessary in order to ensure clients are appropriately served.

Rationale for change: As the Division moves to an accreditation model of reviewing area programs, there needs to be a mechanism to allow for direct action by the State, when all existing avenues have failed, to ensure the delivery of quality services to persons in need.

Legislative language:
Add a new G.S. 122C-125.1 that reads as follows:

§ 122C-125.1. Area Authority failure to provide services; State assumption of service delivery.

At any time that the Secretary determines that an area authority is not providing minimally adequate services, in accordance with its annual service plan, to persons in need in a timely manner, or fails to demonstrate reasonable efforts to do so, the Secretary, after providing written notification of his or her intent to the area board and after giving the area authority an opportunity to be heard, may assume control of the particular service in question or of the area authority and appoint an administrator to exercise the powers assumed. This assumption of control shall have the effect of divesting the area authority of its powers in G.S. 122C-117 and all other service delivery powers conferred in the area authority by law as they pertain to this service. County funding of the area authority shall continue when the State has assumed control of a service area or of the area authority. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area authority.

Upon assumption of control of service delivery, the Department shall, in conjunction with the area authority, develop and implement a corrective plan of action and provide notification to the area authority's board of directors of the plan. The Department shall also keep the county board of commissioners and the area authority's board of directors informed of any ongoing concerns or problems with the area authority's delivery of services.

Recommendation #12

Prohibit imposition of county freezes on State personnel positions.

Rationale for change: During discussions around county participation in mental health, developmental disabilities, and substance abuse services, it was discovered that a few single county programs have effected hiring freezes on the area program in order to force reversions to the county general fund. This has a direct impact on the area program's ability to provide quality services, as well as representing another way that single-county programs are hampered in their ability to manage the services they're directed to provide.

Legislative language:
Amend G.S. 122C-154 as follows:

Employees under the direct supervision of the area authority are employees of the area authority. For the purposes of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. The area authority shall have the sole authority to determine, subject to the policies and procedures established by the State Personnel Commission, the establishment of positions, the hiring of positions, and the setting of salaries within a salary plan established according to G.S. 122C-156 for any position which is partially or wholly funded by federal dollars, state appropriations or fees.

GOVERNANCE & ACCOUNTABILITY SUBCOMMITTEE
FUTURE WORK

Many questions were raised during the Subcommittee deliberations that weren't addressed during this round of recommendations. It was expressed that these were some of the issues the Subcommittee wanted to return to when it began meeting after the 1996 Legislative Session. These issues included:

- Do we need 41 area programs?
- How can we know what we are getting for our money?
- Current statutes restrain initiative (like Carolina East).
- What have been the outcomes of the Mecklenburg experience in consolidating Human Resource boards?
- Is there any way to predict administrative costs of various governance models?
- System changes should be driven by something other than savings, especially administrative savings.
- How long do you allow an area program to continue to perform poorly before acting?
- There's no mechanism for peer reporting (as prevention).
- Need economies of scale (ASO can provide).
- Area directors have no personnel protection (unlike DSS & Public Health).
- When combining area programs, look at county financial participation - be careful that it won't result in a net loss of county support.
- Should provide some guidance/criteria to county commissioners for appointing board members so that you can get the best people on board.
- Area authority should have final authority over all budget amendments and transfers within its approved budget.
- Area authority finance director (in single county programs) should have the same authority/responsibility for the area program regarding G.S. 159 (Budget and Fiscal Control Act) as is currently designated to the county finance officer.
- Look at need to reform the State Personnel System, specifically its classification and compensation provisions.
- Need to allow single county area boards to obtain "substantial equivalency" for personnel without county commissioner approval - as multi-county area boards can.
- What additional measures can the State take to ensure the quality of members serving on area boards?

The only issue remaining to be addressed from the State Auditor's recommendations is:

- The Legislature needs to clearly establish its expectations for administration of area mental health centers by more clearly identifying the respective roles of the local authority, the Department of Human Resources, and the Local Government Commission.

SECTION III

FINANCING

SUBCOMMITTEE REPORT

MENTAL HEALTH STUDY COMMISSION

FINANCING SUBCOMMITTEE

CHAIR: Senator Leslie J. Winner

Representative Jim Crawford
Senator Bob Carpenter
Senator Charlie Dannelly
Dr. Don Everhart
Ms. Mary Gay
Mr. Will Lindsay
Mr. David Stewart
Mr. Luckey Welsh

FINANCING SUBCOMMITTEE

Senator Leslie J. Winner
Chair

The Mental Health Study Commission Subcommittee on Financing met a total of four (4) times. Below is a summary of each meeting. Minutes of the meetings, including handouts distributed to the Subcommittee, are available in the Commission Office in Room 687 - Albemarle Building.

February 14, 1996

The initial meeting of the Subcommittee began with a discussion, led by Senator Leslie Winner, Chair, of the items to be considered by the Subcommittee: (1) Medicaid as it applies to mental health; (2) managed care - expansion of Carolina Alternatives; (3) equalization of funding for area mental health programs; and (4) maximization of funds in mental health. Staff from the Department of Human Resources, Division of Mental Health (DMH) and the Fiscal Research Division of the N.C. General Assembly made presentations on each of the items under the Subcommittee's charge.

The Subcommittee directed staff to provide further information regarding Equalization and Managed Care and agreed to defer further discussion of the Medicaid issue pending action from the U.S. Congress.

March 1, 1996

The second meeting was devoted to a discussion of Equalization of funding for area mental health programs. The Division of Mental Health provided a brief history of various strategies used by the state to address the issue of equalization. The Division also reviewed various methodologies for equalization of funding including the current formula for equalization (70% of new state dollars for expansion and 30% for equalization) and methodologies which factored in division funds, state institution usage, value of service, county appropriations and fee collections.

The Subcommittee heard from representatives of the various disability groups as well as several area mental health program directors regarding their views on equalization. Most representatives agreed that system wide funding is insufficient and that the concept is difficult to define given the nature of mental health services and the diversity of North

Carolina geographically and economically. Representatives concluded their comments with expressions of support for the Subcommittee's charge to review the issue of equalization.

The Subcommittee deferred a vote on this issue until further information could be provided by the Division. Consequently, the Subcommittee directed the Division to bring back charts which depict equalization of all state funds (which include state general funds, federal funds administered by the state and costs for state facility usage) and county ability-to-pay (defined as all county appropriations and fee collections).

March 21, 1996

The purpose of this meeting was to review the Carolina Alternatives program comprehensively in order to develop a recommendation regarding future expansion of the Program. The Department of Human Resources was asked to present its position on the future of Carolina Alternatives (CA) regarding expanding the program statewide to include adults and children (who are Medicaid eligible) who require mental health and substance abuse services and to address the issue of cost as it relates to not fully implementing Carolina Alternatives.

In response to these questions, the Division indicated that the cost of not implementing a managed care approach in mental health and substance abuse services would exceed the cost of fully implementing Carolina Alternatives statewide. The Division pointed out that the dramatic growth in Medicaid eligibles as well as the demand for mental health services under the regular or "fee-for-service" model is projected to increase at significant levels consistent with past years experience, thus making Carolina Alternatives a financially viable alternative.

Given this assumption, the Division of Mental Health indicated that DHR fully supports Carolina Alternatives. However, the Office of State Budget and the Governor have not yet taken a formal position regarding expansion pending an analysis of available funding within the Medicaid budget.

In addition to the issue of cost, the Subcommittee reviewed the issue of quality of care under CA. A variety of individuals were invited to present their perspectives on the issue. Two independent researchers from Duke University presented their findings based upon a two-pronged evaluation of the Carolina Alternatives program. The evaluation focused on provider satisfaction (including public agencies such as local departments of social services) as well as client/family satisfaction. The evaluators indicated generally positive feedback from respondents.

Members of the various disability groups as well as area mental health program directors provided feedback which ranged from caution to support of CA. Most agreed that policy makers should emphasize services under a managed care approach as opposed to cost containment only. In conclusion, the Subcommittee heard from the parent of a child

currently receiving care under CA. This individual commended CA on its staff and quality of services provided to her and her entire family.

The discussion of Carolina Alternatives concluded with several members of the Subcommittee giving "tentative" support of CA with certain provisos to be included in the final report to the full Mental Health Study Commission. The Subcommittee deferred a final vote on the matter until its April 19, 1996 meeting.

The Subcommittee resumed its discussion (from the March 1, 1996 meeting) of Equalization of funding for area mental health programs. The Division of Mental Health provided a chart titled "Incentive Method" which illustrated how future expansion funds would be allocated to area mental health programs. Under this methodology, new state expansion funds would be allocated as follows: 50% per capita and 40% "catch up" based upon all Division funds and State institution usage (which is aimed at bringing all area programs to the statewide per capita mean). The remaining 10% would constitute "incentive funds" for area programs demonstrating actual increased county appropriations and fee collections. Incentive funds would be allocated on the basis of percent of growth as compared to a previous fiscal year. In order for area programs to be eligible for incentive funds, counties would have to pay 100% of the amount of county general funds budgeted.

The Subcommittee agreed to take a final position on the issue at its April 19, 1996 meeting pending a revision in the Incentive Method which would reflect allocation of the 10% incentive funding on a per capita basis.

The meeting concluded with a committee discussion of the idea of modifying the current policy of distributing new state expansion funds based upon a one-third distribution across disabilities. Using the long range disability plans as a basis, the Division provided updated needs estimates. Members of the audience expressed concerns regarding data used in the development of the plans. Since the Subcommittee did not take a position on this issue, the issue will be considered again during the April 19, 1996 meeting.

April 19, 1996

The Subcommittee met briefly to formally vote on its recommendations to the MHSC regarding the issues of Equalization of funding and future expansion of Carolina Alternatives.

FINANCING SUBCOMMITTEE RECOMMENDATIONS

The Subcommittee on Financing made the following recommendations:

Recommendation #1: Equalization

The Mental Health Study Commission recommends adoption of the Department of Human Resources, Division of Mental Health's "Incentive Method" for the purposes of allocating new state expansion funds to area mental health programs, effective FY1996/97 (see Attachment A of this Section.). Additionally, it is recommended that the distribution of new state expansion funds for FY1996/97 continue to be allocated across disabilities based upon the one-third formula utilized during FY1995/96.

The Subcommittee on Financing recognizes the need to begin the process of distributing new funding for MH/DD/SAS between the disability groups on the basis of need. However, much work needs to be completed to develop a system which would accurately and appropriately assess the needs for all disability groups. In further recognition of this need, *the Subcommittee recommends the creation of a task force, with appropriate representation of all stakeholders, which would work in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to develop a needs based approach to funding.*

Recommendation #2: Carolina Alternatives

The Mental Health Study Commission recommends future expansion of the managed care program Carolina Alternatives to include additional area programs under the child waiver and full implementation of the adult waiver.

In recognition of the tremendous work already completed and future work needed to implement the above recommendation, the Subcommittee provides the following concerns/guiding principles:

1. The Mental Health Study Commission's endorsement of the expansion of Carolina Alternatives is contingent upon capitation rates which are sufficient to provide for appropriate, quality services.

2. MH/DD/SAS Medicaid funds under the control of the Division of Mental Health should be adjusted for changes in number of eligible recipients and inflation using the same continuation budget methodology as is currently applied to other Medicaid funds in the Department of Human Resources.

3. The Department of Human Resources, Division of Mental Health and the Fiscal Research Division of the N.C. General Assembly should review the Carolina Alternatives program periodically to evaluate the cost effectiveness of the program.

4. A finding of "readiness" should formally be made by the Department of Human Resources, Division of Mental Health for each area mental health authority prior to expansion of the current waiver to adults in the ten pilot area programs and prior to implementation of Carolina Alternatives in additional area programs. This finding should address readiness issues such as (a) adequate community services, (b) administrative support, (c) fiscal stability and accountability, (d) Area Board of Directors support, and (e) quality assurance.

5. Financial savings realized by the state or area mental health authority/program as a result of the implementation of managed care, should be re-invested in the local mental health system for the purpose of creating or expanding appropriate community based mental health services.

6. The system of care management should be provided by appropriately trained and competent mental health professionals and should be client/family centered, based upon individual needs and should provide for the most appropriate services.

7. Definitive client outcome measures should be implemented in the current pilot programs and in place prior to further expansion of Carolina Alternatives.

8. Future expansion of Carolina Alternatives should aim to ameliorate problems created by a public "two tiered" system of mental health services based upon client eligibility status.

9. Planning for future expansion of Carolina Alternatives should be deliberate, methodical and provide for inclusion of all stakeholders including clients, families, state and local governmental agencies, providers, advocacy groups and other interested parties.

10. Future expansion of Carolina Alternatives should aim to minimize cost shifting at any various levels of state and local governmental agencies (such as human services and criminal justice), within disability areas in area programs, public and private providers, and clients and their families.

11. In the capacity of the Managed Care Organization (MCO), area programs should maintain emphasis on high quality, appropriate services to mental health clients while balancing the need to maintain efficient operations.

12. A "user friendly" grievance and appeals system for clients/families which addresses issues such as appropriateness of services should be in place prior to future expansion of Carolina Alternatives. The system should ensure timely

resolution of issues as well as adequate provider and consumer education regarding the system.

13. Future expansion of Carolina Alternatives should include a thorough review of capitation rates. These rates should be evaluated periodically by the Department of Human Resources to assess appropriateness and to address the issue of cost shifting as addressed in #7.

14. State contracts with area programs acting as MCO's, should detail expectations regarding the provision of services, state and local authority and responsibility.

15. Expansion of managed care should not result in the inappropriate shifting of public resources from direct services for mental health clients to area program administration.

16. Future planning and expansion of Carolina Alternatives should emphasize preventative services.

INCENTIVE METHOD (50% per capita, 40% Catch-up based on Division funds + Institution Use and 10% Population Weighted Incentive related to County General/Patient Fees): Recommended requirements for funding from 10% incentive portion and differences between method of presentation and implementation related to County General Funds and Patient Fees.

RECOMMENDED REQUIREMENTS:

1. Counties must pay 100% of the amount of County General Funds budgeted, otherwise, the area program will be ineligible for consideration for any share of the 10% incentive portion, regardless of whether growth in Patient Fees off-set such a reduction in County General funds. (Legislative Special Provision prohibits a reduction in County General payments based on increased fee collections.)

2. If a county decreases its budgeted County General funds from one year to the next, the area program will be ineligible for consideration for any share of the 10% incentive portion, regardless of whether growth in Patient Fees off-set such a reduction in budgeted County General funds. (G.S. 122C-146 prohibits a reduction in the budgeted commitment of local tax revenue due to increases in fee collection.) Allowances will be made for county fund fluctuations for capital projects, etc.

3. An area program must have an overall increase in County General funds plus Patient Fees to be eligible for consideration for incentive funds. If an area program shows an overall decrease in County General funds plus Patient Fees, they will not reflect growth and would therefore be ineligible for any share of the 10% incentive portion.

4. All area programs meeting the requirements of 1thru 3 above would be eligible for funding from the incentive portion based on <u>their percent of growth</u> multiplied by their population compared to the percentage growth, multiplied by population, for all other qualifying programs.

DIFFERENCES BETWEEN PRESENTATION AND IMPLEMENTATION

TABLE PRESENTATION	ACTUAL IMPLEMENTATION
1.County General funds considers payment at 95% of prior year budgeted level.	1. Area programs would not be eligible for incentive funds if counties did not pay 100% of budgeted County General funds.
2. Patient fees compare growth from 1994-95 Actual to 1995-96 Budgeted. At this time, only 1994-95 Actual and 1995-96 Budgeted have been reported on the Fiscal Monitoring Report. If Incentive Method is implemented, Division will be able to compare 94-95 and 95-96 Actual when measuring growth.	2. Patient fees growth will be calculated on a comparison of <u>Actual collections from the 2 most recent years</u>.
3. Excludes Carolina Alternatives and regular Medicaid Plan funds from Patient Fees.	3. Carolina Alternatives and regular Medicaid Plan funds will be added to the Patient Fees portion once CA implementation is uniform.

)DSAS

AGGREGATE: Incentive Method

(10%: % Increase, Population Weighted)

(1) ea Program	(2) Total Division State and Federal Funds*	(3) 4-Year Avg. State Institution Usage**	(4) Total Division Funds Plus Institution Use	(5) Total Div. Per Capita	(6) Total Div. Per Cap Rank	(7) Funds Needed to Mean of $85.62	Distribution			Area Programs
							$1,000,000 50% Per Cap 40% Catch-Up Portion	$1,000,000 10% Incentive Portion	Total 50-40-10 Method	
nd	3,821,637	9,229,963	13,051,600	141.86	1		6,550	2,135	8,685	Tideland
ke-Chowan	2,760,868	7,048,583	9,809,451	134.11	2		5,207	788	5,995	Roanoke-Chowan
	2,146,488	5,372,690	7,519,178	129.78	3		4,124	0	4,124	Lenoir
n-Greene	3,012,734	7,499,456	10,512,190	125.95	4		5,942	1,760	7,702	Wilson-Greene
-W	4,511,776	12,701,829	17,213,605	124.27	5		9,861	441	10,302	V-G-F-W
x	2,439,248	4,232,274	6,671,522	117.18	6		4,053	1,272	5,325	Halifax
m	6,039,409	16,831,000	22,870,409	116.98	7		13,918	172	14,090	Durham
nce-Caswell	5,426,680	10,184,399	15,611,079	116.77	8		9,517	411	9,928	Alamance-Caswell
ombe-Nash	4,071,298	11,669,786	15,741,084	113.06	9		9,911	411	10,322	Edgecombe-Nash
ngham	2,770,769	6,920,583	9,691,352	110.99	10		6,216	0	6,216	Rockingham
n-Sampson	2,941,397	6,645,296	9,586,693	107.47	11		6,350	0	6,350	Duplin-Sampson
rford-Polk	3,214,413	4,594,202	7,808,615	105.41	12		5,274	1,128	6,402	Rutherford-Polk
arle	3,056,398	7,680,030	10,736,428	102.73	13		7,440	5,512	12,952	Albemarle
	6,154,344	11,794,660	17,949,004	101.73	14		12,560	1,393	13,953	O-P-C
	3,710,874	8,182,910	11,893,784	101.33	15		8,355	0	8,355	Pitt
Ridge	6,820,281	15,011,397	21,831,678	94.47	16		16,451	10,431	26,882	Blue Ridge
and	2,743,738	5,392,696	8,136,434	93.62	17		6,187	5,033	11,220	Cleveland
rd	10,095,371	23,581,394	33,676,765	93.06	18		25,763	0	25,763	Guilford
lls	5,794,383	14,289,548	20,083,931	92.96	19		15,381	963	16,344	Foothills
eastern	5,554,757	14,349,769	19,904,526	89.90	20		15,762	1,061	16,823	Southeastern
ills	6,189,861	9,825,006	16,014,867	89.29	21		12,768	4,282	17,050	Sandhills
	4,667,351	10,117,992	14,785,343	89.02	22		11,823	6,495	18,318	Neuse
h-Stokes	8,016,866	19,690,109	27,706,975	87.96	23		22,425	7,965	30,390	Forsyth-Stokes
Yadkin	2,990,139	5,164,500	8,154,639	85.23	24	37,226	7,068	2,296	9,364	Surry-Yadkin
arnett	4,542,345	5,210,115	9,752,460	83.89	25	201,379	9,666	3,484	13,150	Lee-Harnett
	2,971,757	6,202,816	9,174,573	83.85	26	194,224	9,130	0	9,130	Wayne
iver	5,950,529	6,259,479	12,210,008	83.15	27	362,518	12,956	1,865	14,821	New River
lph	3,681,137	5,541,145	9,222,282	81.43	28	474,782	11,340	1,836	13,176	Randolph
on	3,062,998	4,133,365	7,196,363	80.84	29	425,872	9,277	2,390	11,667	Johnston
Mountain	5,672,491	6,200,352	11,872,843	79.80	30	865,529	16,566	3,807	20,373	Smoky Mountain
eastern Reg.	6,847,540	10,639,484	17,487,024	78.58	31	1,566,166	26,653	3,720	30,373	Southeastern Reg.
	3,105,789	4,699,162	7,804,951	77.13	32	858,937	13,133	0	13,133	Trend
n-Lincoln	5,814,357	12,032,442	17,846,799	75.86	33	2,296,762	32,603	6,498	39,101	Gaston-Lincoln
	11,432,796	23,923,723	35,356,519	72.73	34	6,268,329	77,879	0	77,879	Wake
unty	5,953,317	11,385,215	17,338,532	70.75	35	3,644,447	42,604	10,985	53,589	Tri-County
ba	3,248,214	5,397,794	8,646,008	69.37	36	2,025,155	22,852	2,638	25,490	Catawba
on	3,526,709	5,676,944	9,203,653	68.34	37	2,327,221	25,652	0	25,652	Davidson
ont	6,859,303	8,851,149	15,710,452	62.17	38	5,925,722	58,894	8,828	67,722	Piedmont
enburg	14,541,458	18,368,612	32,910,070	58.55	39	15,219,415	145,076	0	145,076	Mecklenburg
erland	6,196,908	8,654,071	14,850,979	51.35	40	9,909,041	88,989	0	88,989	Cumberland
	3,286,895	4,532,341	7,819,236	50.86	41	5,343,127	47,827	0	47,827	Onslow
S	205,645,623	395,718,281	601,363,904	85.62	N/A	57,945,851	900,000	100,000	1,000,000	
				Total Below Mean:			658,165	48,347	706,512	

ludes Willie M., Thomas S., Cross Area Service Program, One-Time Funds and Carryover Funds.

ear average days usage at current rates adjusted to FY 95 utilization level. Excludes leave days and days from specialty units.

DMHDDSAS

MENTAL HEALTH: Incentive Method
(10%: % Increase, Population Weighted)

(1) Area Program	(2) Total MH Division State & Federal*	(3) 4-Year Psy. Hospital Institution Usage**	(4) Division MH Funds Plus Psyh. Hosp. Use	(5) MH Per Capita	(6) MH Per Cap Rank	(7) Funds Needed to Mean of $36.51	Distribution: $1,000,000 50% Per Cap 40% Catch-Up Portion	Distribution: $1,000,000 10% Incentive Portion	Distribution: Total 50-40-10 Method	Area Programs
Durham	2,031,093	10,091,545	12,122,638	62.01	1		13,918	172	14,090	Durham
Roanoke-Chowan	1,046,750	2,744,016	3,790,766	51.83	2		5,207	788	5,995	Roanoke-Chowan
Wilson-Greene	975,586	3,322,986	4,298,572	51.50	3		5,942	1,760	7,702	Wilson-Greene
Alamance-Caswell	1,774,861	4,948,984	6,723,845	50.30	4		9,517	411	9,928	Alamance-Caswell
Rutherford-Polk	1,427,612	2,075,854	3,503,466	47.29	5		5,274	1,128	6,402	Rutherford-Polk
Edgecombe-Nash	1,674,160	4,869,185	6,543,345	47.00	6		9,911	411	10,322	Edgecombe-Nash
Lee-Harnett	1,797,296	3,461,548	5,258,844	45.24	7		8,276	3,484	11,760	Lee-Harnett
V-G-F-W	1,563,680	4,671,853	6,235,533	45.02	8		9,861	441	10,302	V-G-F-W
Wake	4,467,649	17,091,488	21,559,137	44.35	9		34,609	0	34,609	Wake
Duplin-Sampson	1,066,684	2,862,785	3,929,469	44.05	10		6,350	0	6,350	Duplin-Sampson
Tideland	680,185	3,325,232	4,005,417	43.54	11		6,550	2,135	8,685	Tideland
Johnston	1,433,112	2,435,677	3,868,789	43.46	12		6,337	2,390	8,727	Johnston
Halifax	765,357	1,702,967	2,468,324	43.35	13		4,053	1,272	5,325	Halifax
Rockingham	575,822	3,172,177	3,747,999	42.92	14		6,216	0	6,216	Rockingham
Foothills	2,370,842	6,759,698	9,130,540	42.26	15		15,381	963	16,344	Foothills
Randolph	1,621,124	3,142,781	4,763,905	42.06	16		8,063	1,836	9,899	Randolph
Pitt	1,606,751	3,324,524	4,931,275	42.01	17		8,355	0	8,355	Pitt
O-P-C	2,215,599	5,172,907	7,388,506	41.88	18		12,560	1,393	13,953	O-P-C
Sandhills	2,560,761	4,941,140	7,501,901	41.83	19		12,768	4,282	17,050	Sandhills
Wayne	965,736	3,560,143	4,525,879	41.36	20		7,790	0	7,790	Wayne
New River	2,700,722	3,185,953	5,886,675	40.09	21		10,453	1,865	12,318	New River
Guilford	3,120,713	10,845,982	13,966,695	38.59	22		25,763	0	25,763	Guilford
Cleveland	1,284,185	1,975,349	3,259,534	37.51	23		6,187	5,033	11,220	Cleveland
Albemarle	942,756	2,894,495	3,837,251	36.72	24		7,440	5,512	12,952	Albemarle
Lenoir	479,332	1,638,618	2,117,950	36.56	25		4,124	0	4,124	Lenoir
Forsyth-Stokes	2,785,348	8,653,266	11,438,614	36.31	26	62,401	23,361	7,965	31,326	Forsyth-Stokes
Smoky Mountain	2,523,295	2,846,249	5,369,544	36.09	27	62,341	11,526	3,807	15,333	Smoky Mountain
Southeastern	1,473,358	6,211,172	7,684,530	34.71	28	399,186	21,748	1,061	22,809	Southeastern
Neuse	1,437,768	4,246,313	5,684,081	34.22	29	379,646	17,517	6,495	24,012	Neuse
Trend	1,238,188	2,164,912	3,403,100	33.63	30	291,347	11,573	0	11,573	Trend
Davidson	1,570,119	2,910,092	4,480,211	33.27	31	436,773	16,137	0	16,137	Davidson
Blue Ridge	2,456,167	4,905,950	7,362,117	31.86	32	1,074,942	32,571	10,431	43,002	Blue Ridge
Surry-Yadkin	1,103,302	1,906,479	3,009,781	31.46	33	483,386	14,060	2,296	16,356	Surry-Yadkin
Southeastern Reg.	2,583,620	4,303,995	6,887,615	30.95	34	1,237,028	34,393	3,720	38,113	Southeastern Reg.
Tri-County	1,946,902	4,918,257	6,865,159	28.01	35	2,082,383	48,675	10,985	59,660	Tri-County
Catawba	1,313,811	2,002,788	3,316,599	26.61	36	1,233,788	27,375	2,638	30,013	Catawba
Gaston-Lincoln	1,744,961	4,461,097	6,206,058	26.38	37	2,383,540	52,494	6,498	58,992	Gaston-Lincoln
Piedmont	2,412,799	4,017,060	6,429,859	25.44	38	2,796,218	59,923	8,828	68,751	Piedmont
Mecklenburg	6,072,945	7,390,849	13,463,794	23.95	39	7,059,536	145,887	0	145,887	Mecklenburg
Cumberland	2,805,494	4,101,323	6,906,817	23.88	40	3,651,327	75,345	0	75,345	Cumberland
Onslow	816,958	1,757,185	2,574,143	16.74	41	3,038,539	56,512	0	56,512	Onslow
TOTALS	75,433,403	181,014,874	256,448,277	36.51	N/A	26,672,383	900,000	100,000	1,000,000	
				Amount Below Mean:			649,098	64,724	713,822	

* Excludes Willie M., Thomas S., Cross Area Service Programs, One-Time Funds and Carryover Funds.

** 4-Year average days usage at current rates adjusted to FY 95 utilization level. Excludes leave days, days at specialty units including ICF, SNF, MR, forensic and Carolina Lodge.

DSAS

DEVELOPMENATL DISABILITIES: Incentive Method
(10%: % Increase, Population Weighted)

(1) :a Program	(2) Total DD Division State & Federal*	(3) 4-Year MR Center Institution Usage**	(4) Total DD Division $ Plus MR Center Use	(5) DD Per Capita	(6) DD Per Cap. Rank	(7) Funds Needed to Mean of $40.63	Distribution $1,000,000 50% Per Cap 40% Catch-Up Portion	Distribution $1,000,000 10% Incentive Portion	Distribution Total 50-40-10 Method	Area Programs
ıd	2,696,526	5,636,778	8,333,304	90.58	1		6,550	2,135	8,685	Tideland
	1,181,693	3,534,383	4,716,076	81.40	2		4,124	0	4,124	Lenoir
;e-Chowan	1,070,196	4,243,321	5,313,517	72.64	3		5,207	788	5,995	Roanoke-Chowan
W	2,229,585	7,309,453	9,539,038	68.87	4		9,861	441	10,302	V-G-F-W
-Greene	1,559,619	3,784,286	5,343,905	64.03	5		5,942	1,760	7,702	Wilson-Greene
;	1,148,871	2,429,569	3,578,440	62.85	6		4,053	1,272	5,325	Halifax
nce-Caswell	2,915,271	5,009,981	7,925,252	59.28	7		9,517	411	9,928	Alamance-Caswell
gham	1,726,041	3,283,988	5,010,029	57.38	8		6,216	0	6,216	Rockingham
ımbe-Nash	1,606,024	6,346,994	7,953,018	57.12	9		9,911	411	10,322	Edgecombe-Nash
arle	1,589,277	4,345,099	5,934,376	56.78	10		7,440	5,512	12,952	Albemarle
-Sampson	1,417,140	3,567,141	4,984,281	55.87	11		6,350	0	6,350	Duplin-Sampson
idge	2,719,186	9,464,273	12,183,459	52.72	12		16,451	10,431	26,882	Blue Ridge
	3,051,345	5,938,967	8,990,312	50.96	13		12,560	1,393	13,953	O-P-C
	1,368,788	4,404,791	5,773,579	49.19	14		8,355	0	8,355	Pitt
ford-Polk	1,319,018	2,319,162	3,638,180	49.11	15		5,274	1,128	6,402	Rutherford-Polk
Yadkin	1,368,855	3,207,793	4,576,648	47.83	16		6,811	2,296	9,107	Surry-Yadkin
	2,530,426	5,334,376	7,864,802	47.35	17		11,823	6,495	18,318	Neuse
and	888,779	3,127,709	4,016,488	46.22	18		6,187	5,033	11,220	Cleveland
d	4,188,270	12,039,670	16,227,940	44.84	19		25,763	0	25,763	Guilford
m	2,434,018	6,228,448	8,662,466	44.31	20		13,918	172	14,090	Durham
lls	2,285,196	7,157,564	9,442,760	43.71	21		15,381	963	16,344	Foothills
-Lincoln	3,122,087	7,120,989	10,243,076	43.54	22		16,748	6,498	23,246	Gaston-Lincoln
h-Stokes	2,708,772	10,783,998	13,492,770	42.83	23		22,425	7,965	30,390	Forsyth-Stokes
astern Reg.	3,298,374	6,046,760	9,345,134	41.99	24		15,842	3,720	19,562	Southeastern Reg.
astern	1,929,354	7,037,046	8,966,400	40.50	25	29,529	16,066	1,061	17,127	Southeastern
ills	2,545,061	4,522,640	7,067,701	39.41	26	219,371	15,025	4,282	19,307	Sandhills
	1,435,316	2,203,978	3,639,294	35.96	27	472,056	12,061	0	12,061	Trend
unty	2,663,275	6,115,176	8,778,451	35.82	28	1,178,784	29,576	10,985	40,561	Tri-County
ba	1,243,643	3,176,125	4,419,768	35.46	29	644,111	15,500	2,638	18,138	Catawba
Mountain	2,048,223	2,981,374	5,029,597	33.81	30	1,015,253	21,038	3,807	24,845	Smoky Mountain
iver	2,191,663	2,765,427	4,957,090	33.76	31	1,009,060	20,837	1,865	22,702	New River
	1,205,330	2,426,292	3,631,622	33.19	32	814,234	16,168	0	16,168	Wayne
on	1,109,236	1,677,538	2,786,774	31.30	33	830,271	14,881	2,390	17,271	Johnston
lph	1,113,614	2,230,963	3,344,577	29.53	34	1,257,055	20,998	1,836	22,834	Randolph
ont	3,147,384	4,065,556	7,212,940	28.54	35	3,054,261	49,418	8,828	58,246	Piedmont
on	1,239,080	2,566,164	3,805,244	28.26	36	1,666,601	26,737	0	26,737	Davidson
arnett	1,746,542	1,404,101	3,150,643	27.10	37	1,572,838	24,461	3,484	27,945	Lee-Harnett
enburg	5,429,352	8,989,161	14,418,513	25.65	38	8,420,788	126,667	0	126,667	Mecklenburg
v	1,551,443	2,211,497	3,762,940	24.48	39	2,483,110	36,495	0	36,495	Onslow
	4,467,649	6,538,148	11,005,797	22.64	40	8,746,803	124,614	0	124,614	Wake
erland	1,924,695	4,366,493	6,291,188	21.75	41	5,458,399	76,754	0	76,754	Cumberland
LS	87,414,217	197,943,172	285,357,389	40.63	N/A	38,872,524	900,000	100,000	1,000,000	
				Total Below Mean:			647,294	41,176	688,470	

cludes Willie M., Thomas S., Cross Area Service Programs, One-Time Funds and Carryover Funds.
ear average days usage at current rates adjusted to FY 95 utilization level. Excludes leave days and Alzheimer's Unit.

DMHDDSAS

SUBSTANCE ABUSE: Incentive Method
(10%: % Increase, Population Weighted)

(1) Area Program	(2) Total SA Division State & Federal*	(3) 4-Year Average ADATC Usage**	(4) Total Division Funds Plus ADATC Use	(5) SA Per Capita	(6) SA Per Cap. Rank	(7) Funds Needed to Mean of $8.48	Distribution: $1,000,000 50% Per Cap 40% Catch-Up Portion	Distribution: $1,000,000 10% Incentive Portion	Distribution: Total 50-40-10 Method	Area Programs
Southeastern	2,152,045	1,101,551	3,253,596	14.69	1		15,762	1,061	16,823	Southeastern
Lenoir	485,463	199,689	685,152	11.83	2		4,124	0	4,124	Lenoir
Lee-Harnett	998,507	344,466	1,342,973	11.55	3		8,276	3,484	11,760	Lee-Harnett
Halifax	525,020	99,738	624,758	10.97	4		4,053	1,272	5,325	Halifax
Rockingham	468,906	464,418	933,324	10.69	5		6,216	0	6,216	Rockingham
Durham	1,574,298	511,007	2,085,305	10.67	6		13,918	172	14,090	Durham
Wilson-Greene	477,529	392,184	869,713	10.42	7		5,942	1,760	7,702	Wilson-Greene
V-G-F-W	718,511	720,523	1,439,034	10.39	8		9,861	441	10,302	V-G-F-W
Pitt	735,335	453,595	1,188,930	10.13	9		8,355	0	8,355	Pitt
Smoky Mountain	1,100,973	372,729	1,473,702	9.91	10		10,591	3,807	14,398	Smoky Mountain
Cleveland	570,774	289,638	860,412	9.90	11		6,187	5,033	11,220	Cleveland
Blue Ridge	1,644,928	641,174	2,286,102	9.89	12		16,451	10,431	26,882	Blue Ridge
Randolph	946,399	167,401	1,113,800	9.83	13		8,063	1,836	9,899	Randolph
Onslow	918,494	563,659	1,482,153	9.64	14		10,944	0	10,944	Onslow
Roanoke-Chowan	643,922	61,246	705,168	9.64	15		5,207	788	5,995	Roanoke-Chowan
Guilford	2,786,388	695,742	3,482,130	9.62	16		25,763	0	25,763	Guilford
New River	1,058,144	308,099	1,366,243	9.30	17		10,453	1,865	12,318	New River
Wayne	800,691	216,381	1,017,072	9.29	18		7,790	0	7,790	Wayne
Albemarle	524,365	440,436	964,801	9.23	19		7,440	5,512	12,952	Albemarle
Rutherford-Polk	467,783	199,186	666,969	9.00	20		5,274	1,128	6,402	Rutherford-Polk
Mecklenburg	3,039,161	1,988,602	5,027,763	8.94	21		40,017	0	40,017	Mecklenburg
Edgecombe-Nash	791,114	453,607	1,244,721	8.94	22		9,911	411	10,322	Edgecombe-Nash
O-P-C	887,400	682,786	1,570,186	8.90	23		12,560	1,393	13,953	O-P-C
Forsyth-Stokes	2,522,746	252,845	2,775,591	8.81	24		22,425	7,965	30,390	Forsyth-Stokes
Piedmont	1,299,120	768,533	2,067,653	8.18	25	75,243	23,331	8,828	32,159	Piedmont
Sandhills	1,084,039	361,226	1,445,265	8.06	26	75,640	18,137	4,282	22,419	Sandhills
Tideland	444,926	267,953	712,879	7.75	27	67,306	11,328	2,135	13,463	Tideland
Duplin-Sampson	457,573	215,370	672,943	7.54	28	83,524	12,280	0	12,280	Duplin-Sampson
Trend	432,285	330,272	762,557	7.54	29	95,534	13,986	0	13,986	Trend
Neuse	699,157	537,303	1,236,460	7.44	30	171,932	24,029	6,495	30,524	Neuse
Catawba	690,760	218,881	909,641	7.30	31	147,255	19,326	2,638	21,964	Catawba
Alamance-Caswell	736,548	225,434	961,982	7.20	32	171,675	21,704	411	22,115	Alamance-Caswell
Foothills	1,138,345	372,286	1,510,631	6.99	33	321,524	38,206	963	39,169	Foothills
Tri-County	1,343,140	351,782	1,694,922	6.92	34	383,280	44,655	10,985	55,640	Tri-County
Davidson	717,510	200,688	918,198	6.82	35	223,846	25,478	0	25,478	Davidson
Johnston	520,650	20,150	540,800	6.07	36	214,124	21,538	2,390	23,928	Johnston
Gaston-Lincoln	947,309	450,356	1,397,665	5.94	37	597,399	59,158	6,498	65,656	Gaston-Lincoln
Surry-Yadkin	517,982	50,228	568,210	5.94	38	243,131	24,071	2,296	26,367	Surry-Yadkin
Wake	2,497,498	294,087	2,791,585	5.74	39	1,331,035	129,099	0	129,099	Wake
Cumberland	1,466,719	186,255	1,652,974	5.72	40	799,315	77,330	0	77,330	Cumberland
Southeastern Reg.	965,546	288,729	1,254,275	5.64	41	632,796	60,764	3,720	64,484	Southeastern Reg.
TOTALS	42,798,003	16,760,235	59,558,238	8.48	N/A	5,634,560	900,000	100,000	1,000,000	
				Total Below Mean:			624,420	51,641	676,061	

* Excludes Willie M., Thomas S., Cross Area Service Programs, One-Time Funds and Carryover Funds. Allocations as of March 1, 1995.

** 4-year average days usage at current rates adjusted for FY 95 utilization level. Excludes leave days.

DMHDDSAS

10% Incentive

Population Weighted

AREA PROGRAM	ADJUSTED COUNTY GENERAL FUNDS			PATIENT FEES*			NET INCREASE/ (DECREASE)	PERCENT INCREASE	CENSUS @ 7-1-95	WEIGHTED % INCREASE (x) CENSUS	INCENTIVE FUNDS	AREA PROGRAM
	FY 94-95 BUDGETED	FY 95-96 BUDGETED	INCREASE/ (DECREASE)	FY 94-95 ACTUAL	FY 95-96 BUDGETED	INCREASE/ (DECREASE)						
Alamance-Caswell	2,166,940	2,194,435	27,495	876,144	985,454	109,310	136,805	4.50%	135,940	6,117	411	Alamance-Caswell
Albemarle	117,237	132,049	14,812	970,127	1,799,792	829,665	844,477	77.66%	105,725	82,106	5,512	Albemarle
Blue Ridge	818,400	820,892	2,492	1,871,288	3,632,370	1,761,082	1,763,574	65.57%	237,025	155,417	10,431	Blue Ridge
Catawba	1,131,838	1,189,023	57,185	1,036,789	1,659,771	622,982	680,167	31.36%	125,319	39,300	2,638	Catawba
Cleveland	1,021,885	1,026,489	4,604	709,198	2,172,429	1,463,231	1,467,835	84.79%	88,413	74,965	5,033	Cleveland
Cumberland	4,793,893	5,140,208	346,315	2,681,440	2,589,644	(91,796)	254,519	3.40%	296,709	(1)	(1)	Cumberland
Davidson	375,840	372,082	(3,758)	671,818	832,728	160,910	157,152	15.00%	136,951	(2)	(2)	Davidson
Duplin-Sampson	293,800	287,924	(5,876)	268,412	466,829	198,417	192,541	34.25%	92,450	(2)	(2)	Duplin-Sampson
Durham	6,327,191	6,347,281	20,090	799,387	873,443	74,056	94,146	1.32%	193,954	2,560	172	Durham
Edgecombe-Nash	1,287,458	1,331,960	44,502	895,349	945,938	50,589	95,091	4.36%	140,386	6,121	411	Edgecombe-Nash
Foothills	492,109	492,109	0	1,535,667	1,667,081	131,414	131,414	6.48%	221,433	14,349	963	Foothills
Forsyth-Stokes	5,840,127	6,087,350	247,223	1,654,125	4,192,150	2,538,025	2,785,248	37.17%	319,198	118,646	7,965	Forsyth-Stokes
Gaston-Lincoln	1,380,511	1,391,417	10,906	1,948,523	3,311,394	1,362,871	1,373,777	41.27%	234,519	96,786	6,498	Gaston-Lincoln
Guilford	8,026,259	7,926,131	(100,128)	1,624,935	2,888,938	1,264,003	1,163,875	12.06%	369,821	(1,2)	(1,2)	Guilford
Halifax	382,236	472,600	90,364	624,885	865,850	240,965	331,329	32.90%	57,613	18,955	1,272	Halifax
Johnston	1,319,027	1,350,995	31,968	699,373	1,434,925	735,552	767,520	38.03%	93,608	35,599	2,390	Johnston
Lee-Harnett	334,520	386,786	52,266	322,256	549,562	227,306	279,572	42.57%	121,907	51,896	3,484	Lee-Harnett
Lenoir	885,718	851,218	(34,500)	271,310	309,000	37,690	3,190	0.28%	58,937	(1)	(1)	Lenoir
Mecklenburg	17,643,153	19,871,146	2,227,993	3,134,556	5,243,853	2,109,297	4,337,290	20.87%	573,131	(1)	(1)	Mecklenburg
Neuse	433,560	465,109	31,549	776,759	1,457,650	680,891	712,440	58.86%	164,360	96,742	6,495	Neuse
New River	744,660	756,810	12,150	1,458,496	1,856,664	398,168	410,318	18.62%	149,224	27,786	1,865	New River
O-P-C	1,986,284	2,056,853	70,569	685,693	989,750	304,057	374,626	14.02%	147,986	20,748	1,393	O-P-C
Onslow	231,522	344,546	113,024	293,538	393,587	100,049	213,073	40.58%	180,979	(1)	(1)	Onslow
Piedmont	1,090,656	1,106,489	15,833	2,556,007	4,383,168	1,827,161	1,842,994	50.54%	260,174	131,492	8,828	Piedmont
Pitt	1,804,840	1,726,011	(78,829)	958,491	1,199,384	240,893	162,064	5.86%	117,643	(2)	(2)	Pitt
Randolph	527,406	566,747	39,341	608,256	840,374	232,118	271,459	23.90%	114,402	27,342	1,836	Randolph
Roanoke-Chowan	259,183	265,373	6,190	548,164	671,136	122,972	129,162	16.00%	73,400	11,744	788	Roanoke-Chowan
Rockingham	1,181,527	1,161,305	(20,222)	479,286	1,401,303	922,017	901,795	54.30%	88,067	(2)	(2)	Rockingham
Rutherford-Polk	395,975	404,419	8,444	747,033	996,522	249,489	257,933	22.57%	74,419	16,796	1,128	Rutherford-Polk
Sandhills	499,253	513,211	13,958	941,393	1,421,163	479,770	493,728	34.27%	186,106	63,779	4,282	Sandhills
Smoky Mountain	561,353	574,998	13,645	1,188,176	1,824,001	635,825	649,470	37.12%	152,761	56,705	3,807	Smoky Mountain
Southeastern	1,344,585	1,590,008	245,423	1,035,644	951,834	(83,810)	161,613	6.79%	232,787	15,806	1,061	Southeastern
Southeastern Regional	472,064	476,751	4,687	592,829	848,073	255,244	259,931	24.41%	227,006	55,412	3,720	Southeastern Reg.
Surry-Yadkin	306,372	352,449	46,077	481,826	711,522	229,696	275,773	34.99%	97,731	34,196	2,296	Surry-Yadkin
Tideland	538,763	538,763	0	219,578	476,740	257,162	257,162	33.91%	93,787	31,803	2,135	Tideland
Trend	410,177	363,444	(46,733)	2,158,116	2,716,472	558,356	511,623	19.92%	103,959	(1,2)	(1,2)	Trend
Tri-County	745,148	754,429	9,281	1,125,634	2,340,727	1,215,093	1,224,374	65.45%	249,999	163,624	10,985	Tri-County
V-G-F-W	413,622	425,750	12,128	685,672	725,024	39,352	51,480	4.68%	140,264	6,564	441	V-G-F-W
Wake	9,529,265	7,174,025	(2,355,240)	2,540,095	2,404,733	(135,362)	(2,490,602)	-20.64%	512,944	(1,2,3)	(1,2,3)	Wake
Wayne	480,335	634,887	154,552	404,179	434,000	29,821	184,373	20.84%	110,038	(1)	(1)	Wayne
Wilson-Greene	371,264	386,114	14,850	607,592	897,372	289,780	304,630	31.12%	84,223	26,210	1,760	Wilson-Greene
TOTAL	78,965,956	80,310,586	1,344,630	43,688,039	66,362,350	22,674,311	24,018,941	1151.95%	7,165,298	1,489,567	100,000	TOTAL

* Patient Fees excludes Mental Health Plan Medicaid payments and Carolina Alternatives, to allow for fluctuations due to implementation of the Waiver programs.

NOTES:

1. Ineligible for incentive payment due to County's failure to pay at least 95% of budgeted committement in FY 94-95.
2. Ineligible for incentive payment due to County's reduction in budgeted commitment from FY 94-95 to FY 95-96.

SECTION IV

DRAFT LEGISLATION TO BE PROPOSED

IN THE 1996 SESSION

A BILL TO BE ENTITLED

AN ACT TO STRENGTHEN THE ACCOUNTABILITY OF AREA MENTAL HEALTH AUTHORITIES, EQUALIZE THE AUTHORITY AMONG THEM, AND AUTHORIZE THE STATE TO INTERVENE WHEN NECESSARY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-115 is amended by adding new subsections to read:

"(d) The board or boards of county commissioners that establish the area authority shall allow that area authority to maintain an unrestricted fund balance of up to 15% for the provision of mental health, developmental disabilities, and substance abuse services. The fund balance shall continue forward from year to year, in accordance with the rules of the Secretary.

(e) Counties may not reduce county appropriations and expenditures for area authorities due to the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area authority."

Sec. 2. G.S. 122C-117(a) reads as rewritten:

(a) The area authority shall:

(1) Engage in comprehensive planning, budgeting, implementing, and monitoring of community-based mental health, developmental disabilities, and substance abuse services;

(2) Provide services to clients in the catchment area;

(3) Determine the needs of the area authority's clients and coordinate with the Secretary the provision of services to clients through area and State facilities;

(4) Develop plans and budgets for the area authority subject to the approval of the Secretary;

(5) Maintain an unrestricted fund balance of up to 15% in accordance with the rules of the Secretary, allocations from which are solely within the authority of the area authority.

~~(5)~~(6) Assure that the services provided by the area authority meet the rules of the Commission and Secretary;

~~(6)~~(7) Comply with federal requirements as a condition of receipt of federal grants; and

~~(7)~~(8) Appoint an area ~~director.~~ director, chosen through a search committee on which the Secretary of the Department of Human Resources or his designee serves as an ex-officio, non-voting member."

Sec. 3. (a) G.S. 122C-118 is amended by adding a new subsection to read:

"(c1) The group of county commissioners authorized to make appointments to the area board shall declare vacant the office of a member of the area board who does not attend three scheduled meetings without justifiable excuse within a twelve month period."

(b) G.S. 122C-118 is amended by adding a new subsection to read:

"(d1) Whenever a vacancy occurs on the board, it shall be filled within one hundred and twenty days."

(c) G.S. 122C-118(e) reads as rewritten:

"(e) The area board shall include:

(1) At least one county commissioner from each county in the area except that in a single-county area authority the board of commissioners may instead appoint any resident of the county;

(2) At least ~~two physicians~~ one physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina ~~and~~ who, when possible, ~~one of these physicians should be~~ is certified as having completed a residency in psychiatry;

(3) At least one professional representative from the fields either of psychology, social work, nursing, or religion;

(4) At least one individual each, either a primary consumer or an individual from a citizens' organization, representing the interests of individuals with:

a. Mental illness; and

b. Developmental disabilities.

(4.1) At least one primary consumer ~~each~~ presently and openly in recovery ~~and~~ representing the interests of individuals suffering from the disease of alcoholism or other drug abuse. ~~with:~~

~~a. Alcoholism; and~~

~~b. Drug abuse.~~

(5) At least one family consumer each representing the interest of individuals with:

a. Mental illness;

b. Developmental disabilities; and

c. ~~Alcoholism; and~~ Alcoholism or other drug abuse in the family.

~~d. Drug abuse.~~

(6) At least one attorney licensed to practice in North Carolina.

(7) At least one member who has experience in financial areas to the extent that he or she can understand and interpret audits and other financial reports accurately."

Sec. 4. G.S. 122C-119 is amended by adding a new subsection to read:

"(d) The area board shall establish a finance committee that shall meet at least six times per year to review the financial strength of the area program. The finance committee shall have a minimum of three members, two of whom have experience in budgeting and fiscal control. If the area board so chooses, the entire area board may function as the finance committee; however, its required meetings as a finance committee shall be distinct from its meetings as an area board."

Sec. 5. G.S. 122C-119.1 reads as rewritten:

"**§ 122C-119.1. Area Authority board members' training.**

All members of the governing body for an area ~~authority's board of directors~~ authority shall receive initial orientation on board members' responsibilities and training provided by the ~~Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Secretary of the~~ Department ~~of Human Resources~~ in fiscal management, budget development, and fiscal accountability. A member's refusal to be trained ~~may~~ shall be grounds for removal from the board."

Sec. 6. G.S. 122C-124 reads as rewritten:

"**§ 122C-124. Area Authority funding suspended.**

(a) The Secretary of the Department of Human Resources may suspend funding to any area authority with a revenue or expenditure budget variance of ten percent (10%) or a significant deterioration in the fund balance of the authority's general fund. A significant deterioration of fund balance is defined as a twenty-five percent (25%) decrease in the balance from one fiscal year to the next without the prior approval of the Department. Area authorities shall report any such revenue or expenditure variance or deterioration in fund balance to the Department of Human Resources within 30 days of its occurrence. In the event that funding is suspended, the ~~Department~~ Department, ~~of Human Resources~~ after providing written notification of its intent to the area board and after giving the area authority an opportunity to be heard, may contract with, and make payments of Department funds on an interim basis directly to, a contract provider of the area authority to avoid the disruption of direct services to clients.

(b) If the Secretary determines that an area authority is not providing minimally adequate services, in accordance with its annual service plan, to persons in need in a timely manner, or fails to demonstrate reasonable efforts to do so, the Secretary, after providing written notification of his or her intent to the area board and after giving the area authority an opportunity to be heard, may withhold funding for the particular service or services in question from the area authority and insure the provision of these services through contracts with public or private agencies or by direct operation by the Department.

(c) Upon suspension of funding, the Department shall, in conjunction with the area authority, develop and implement a corrective plan of action and provide notification to the area authority's board of directors of the plan. The Department shall also keep the county board of commissioners and the area authority's board of directors informed of any ongoing concerns or problems with the area authority's ~~finances.~~ finances or delivery of services.

Sec. 7. G.S. 122C-125 reads as rewritten:

"**§ 122C-125. Area Authority financial failure; State assumption of financial control.**

At any time that the Secretary of the Department of Human Resources determines that an area authority is in imminent danger of failing financially and of failing to provide direct services to clients, the Secretary, after providing written notification of his or her intent to the area board and after giving the area authority an opportunity to be heard, may assume control of the financial affairs of the area authority and appoint an administrator to exercise the powers assumed. This assumption of control shall have the effect of divesting the area authority of its powers as to the adoption of budgets, expenditures of money, and all other financial powers conferred in the area authority by law. County funding of the area authority shall continue when the State has assumed control of the financial affairs of the area authority. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area authority. The Secretary shall adopt rules to define imminent danger of failing financially and of failing to provide direct services to clients.

Upon assumption of financial control, the Department shall, in conjunction with the area authority, develop and implement a corrective plan of action and provide notification to the area authority's board of directors of the plan. The Department shall also keep the county board of commissioners and the area authority's board of directors informed of any ongoing concerns or problems with the area authority's finances.

Sec. 8. Part 2 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-125.1. Area Authority failure to provide services; State assumption of service delivery.**

At any time that the Secretary determines that an area authority is not providing minimally adequate services, in accordance with its annual service plan, to persons in need in a timely manner, or fails to demonstrate reasonable efforts to do so, the Secretary, after providing written notification of his or her intent to the area board and after giving the area authority an opportunity to be heard, may assume control of the particular service in question or of the area authority and appoint an administrator to exercise the powers assumed. This assumption of control shall have the effect of divesting the area authority of its powers in G.S. 122C-117 and all other service delivery powers conferred in the area authority by law as they pertain to this service. County funding of the area authority shall continue when the State has assumed control of a service area or of the area authority. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area authority.

Upon assumption of control of service delivery, the Department shall, in conjunction with the area authority, develop and implement a corrective plan of action and provide notification to the area authority's board of directors of the plan. The Department shall also keep the county board of commissioners and the area authority's board of directors informed of any ongoing concerns or problems with the area authority's delivery of services.

Sec. 9. G.S. 122C-126 reads as rewritten:

"**§ 122C-126. Area authority caretakers appointed.**

In the event that an area authority fails to comply with the corrective plan of action required pursuant to G.S. 122C-124 when funding is ~~suspended or~~ suspended, pursuant to G.S. 122C-125 when the State assumes financial control of the area authority, or pursuant to G.S. 122C-125.1 when the State assumes control of service delivery, the ~~Secretary of the Department of Human Resources~~ Secretary, after providing written notification of his or her intent to the area board, shall appoint a caretaker administrator, a caretaker board of directors, or both.

The Secretary may assign any of the powers and duties of the director of the area authority and of the board of directors and the caretaker board to the caretaker administrator as it deems necessary and appropriate to continue to provide direct services to clients, including the powers as to the adoption of budgets, expenditures of money, and all other financial powers conferred on the area authority by law. County funding of the area authority shall continue when the State has assumed control of the financial affairs of the area authority. At no time after the State has assumed this control shall a county withdraw funds previously obligated or appropriated to the area authority. The caretaker administrator and the caretaker board shall perform all of these powers and duties. The Secretary may terminate the contract of any director when it appoints a caretaker administrator. The Administrative Procedure Act shall apply to any such decision. Neither party to any such contract shall be entitled to damages.

After a caretaker board has been appointed, the General Assembly shall consider, at its next regular session, the future governance of the identified area authority."

Sec. 10. G.S. 122C-154 reads as rewritten:

"**§ 122C-154. Personnel.**

Employees under the direct supervision of the area authority are employees of the area authority. For the purposes of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. The area authority shall have the sole authority to determine, subject to the policies and procedures established by the State Personnel Commission, the establishment of positions, the hiring of positions, and the setting of salaries within a salary plan established according to G.S. 122C-156 for any position which is partially or wholly funded by federal dollars, state appropriations or fees."

Sec. 11. This act is effective upon ratification.