JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

REPORT TO THE 2007 GENERAL ASSEMBLY

Co-Chairs:
Senator Martin Nesbitt
Representative Verla Insko

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JOINT LEGISLATIVE OVERISGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES
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Raleigh, North Carolina 27603

Senator Martin Nesbitt, Co-Chair *Representative Verla Insko, Co-Chair*

MARCH 7, 2007

TO THE MEMBERS OF THE 2007 GENERAL ASSEMBLY (2007 Regular Session):

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services submits to you for your consideration its report pursuant to G.S. 120-231.

Respectfully Submitted,

Rep. Verla Insko, Co-Chair **Sen. Martin Nesbitt, Co-Chair**

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PREFACE

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) is established in Article 27 of Chapter 120 of the General Statutes. The LOC is charged with examining, on a continual basis, the system-wide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and quality of services.

The LOC consists of sixteen members, eight appointed by the President Pro Tempore of the Senate and eight appointed by the Speaker of the House of Representatives. The members appointed by the President Pro Tempore must include all of the following: at least two must be members of the Senate Committee on Appropriations, the chair of the Senate Appropriations Committee on Human Resources, and at least two must be of the minority party. The members appointed by the Speaker of the House of Representatives must include all of the following: at least two members of the House Committee on Appropriations, the cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, and at least two members of the minority party.

The co-chairs for the 2005-2006 Session are Senator Martin Nesbitt and Representative Verla Insko.

COMMITTEE PROCEEDINGS

LEGISLATIVE OVERSIGHT COMMITTEE

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) met on six occasions during the 2006-2007 interim. The LOC also met four times in two days during the 2007 Regular Session. The following is a brief summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

September 6, 2006

The LOC convened its first meeting on Wednesday, September 6, 2006, at 9:30 A.M. in Room 643 of the Legislative Office Building. At this meeting, the LOC heard several updates concerning legislative actions of interest and the proposed LOC work schedule for the coming interim.

The meeting began with a review of legislative actions from the 2006 Session. Andrea Russo, Fiscal Research, provided a description of budget actions and noted $95.8 million dollars was appropriated for the 2006-2007 fiscal year for mental health, developmental disabilities, and substance abuse services. Shawn Parker, Research Division, reviewed procedural and policy changes enacted in H.B. 2077, *Mental Health Reform Changes (S.L. 2006-142)*, H.B. 2120, *Strengthen LOC Oversight Role (S.L. 2006-32),* and S.B. 1741 (S.L. 2006-66), *Modify Appropriations Act of 2005.*

Leza Wainwright, Deputy Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH), discussed how funds appropriated for the 2006-2007 fiscal year would be allocated to community programs. In response to concerns over the disproportionate funding between area programs, Ms. Wainwright indicated results of the Funding Equity Study would be ready in a future meeting. Ms. Wainwright continued her presentation by explaining the role of the two consultants authorized by legislation. The first would assist DHHS and the LMEs with crisis planning and the second would help with State-level strategic planning and technical assistance to the LMEs. She also noted that the report on how Mental Health Trust Fund dollars would be spent would be ready to present at the October 6th meeting.

Ms. Wainwright outlined how DHHS planned to accomplish tasks assigned by the Legislature during the last session. She noted that the total number of

individuals served in State Hospitals and in the community had increased significantly and was asked to provide a statewide count. Ms. Wainwright also addressed the concerns of sheriffs' departments regarding confusion in knowing where to take a person in need of help as well as issues regarding mentally ill people in adult care facilities.

Terry Hatcher, Director, Office of Property and Construction for the Department of Health and Human Services (DHHS), gave an update on the status of capital projects related to the Developmental Centers, the replacement of the Cherry and Broughton psychiatric hospitals, and the funding for each project.

Tara Larson, Assistant Director of Clinical Policy, Division of Medical Assistance (DMA), discussed the transition to Value Options and several factors contributing to the delay in authorization performing utilization review (UR) for Medicaid services. Ms. Larson also explained that DMA monitoring of Value Options began on June 1 and identified problem areas and preliminary actions taken to ensure services would not be disrupted.

Kory Goldsmith, Research Division, reviewed the LOC work plan proposed by the co-chairs for the interim. The work plan covered studying: LME funding allocations, Services Gap and other LME issues. The goal was to review all the topics and make recommendations to the 2007 General Assembly.

Representative Insko explained that she and Representative Earle had met with DHHS to discuss a report that had been submitted to the Commission on Aging on mentally ill residents in Adult Care Homes. It was suggested that a joint subcommittee of the Commission on Aging and the LOC look into the needs of those residents and services offered to mentally ill people in adult care facilities.

Vivian Leon, Mental Health Program Manager with the Best Practice Team, gave an in-depth description of services and supports for the developmentally disabled.

October 4, 2006

The LOC held its second meeting on Wednesday, October 4, 2006, at 9:30 A.M. in Room 643 of the Legislative Office Building.

Kory Goldsmith, Research Division, provided a review of legislation requiring DMH to study the long-term plan for meeting the mental health, developmental disabilities, and substance abuse services needs.

Steve Hairston, Section Chief for Operations Support, DMH, introduced consultant Dr. Christina Thompson, Heart of the Matter Consulting, Inc., who presented the preliminary report on the Long Range Study for MHDDSAS and Service Gaps.

Dr. Thompson explained how the statistical models were created and reviewed some of the components used in the model. Dr. Thompson also provided a preliminary estimate that it would cost $500,000,000 to bring North Carolina up to the national average over a five year period of time.

Committee staff Kory Goldsmith and Andrea Russo reviewed follow-up questions from the September meeting.

Dr. Bonnie Morell, Team Leader for the Best Practice Team, DMH, presented an in-depth description of services for the mentally ill.

Secretary Carmen Hooker Odom, DHHS, addressed the LOC to provide information relating to a shortfall in LME administration funds for fiscal year 2006-07. The Secretary indicated that the new cost model would produce an adequate and appropriate calculation of the amount needed to fund the LME administrative functions.

Leza Wainwright, Deputy Director, DMH, identified eight areas of service funding that would be cut to make up the shortfall in LME administrative funding. Ms. Wainwright also provided the LOC with the proposed spending allocations from the Mental Health Trust Fund.

November 13, 2006

The LOC convened its third meeting on Monday, November 13, 2006, at 9:30 A.M. in Room 643 of the Legislative Office Building.

Leza Wainwright, Deputy Director, DMH, provided the LOC with information regarding the revised cost model for payment of LME administrative functions.

Ms. Wainwright also provided a preliminary report on the Funding Allocation Study. Ms. Wainwright described sources of funding and went on to state that the consultants would present the Finance cost model to the LOC at the December meeting. She said that DMH and the consultants would work with the North Carolina Association of County Commissioners and the North Carolina Council of Community Programs on recommendations related to the finance model and that, following approval of the model, implementation would begin on July 1, 2007.

The audience was recognized for comments regarding a technical amendment to the Medicaid State Plan. Tara Larson, Assistant Director for Clinical Policy, DMA, said that Value Options would not implement the amendment until February 1, 2007.

Patricia Amend, Director of Policy, Planning, and Technology with the North Carolina Housing Finance Agency (NCHFA) and Julia Bick, Housing Coordinator, DHHS, provided an update on the Housing 400 Initiative. The Housing 400 Initiative will be delivered through three programs; the Supportive Housing Development Program 400, the Preservation Loan Program 400, and the Housing Credit Program.

Flo Stein, Chief, Community Policy Program, DMH, offered an in-depth description of substance abuse services.

Kory Goldsmith, Research Division, offered follow-up information from previous meetings.

December 6, 2006

The LOC met for the fourth time on Wednesday, December 6, 2006, at 9:45 A.M. in Room 643 of the Legislative Office Building.

Senator Nesbitt announced that the Service Gaps Study and the Funding Allocation Study would not be heard by the LOC on that day, but the co-chairs and staff would receive the reports on December 15, 2006. Leza Wainwright, Deputy Director, DMH, stated that some of the reports' conclusions were based on faulty data and needed review. Many LOC members expressed serious concerns about the failure of DMH to provide the report. Mike Moseley, Director, DMH, explained that certain items were contracted out because the DMH did not have the capacity to do the work internally, but it was incumbent upon the Division that the product be accurate.

Ms. Wainwright described DMH's progress on tasks outlined in legislation during the 2006 Session and made clarifications with regard to administrative costs for the LMEs.

Dr. Bert Bennett, Program Manager for the Best Practice Team, DMH, delivered a report on the First Level Commitment Pilot Program. The report recommended that the program be expanded statewide.

The LOC then received comments from the audience including several sheriffs.

January 10, 2007

The LOC met on Wednesday, January 10, 2007, at 9:30 A.M. in Room 643 of the Legislative Office Building.

Dr. Allen Dobson, Assistant Secretary for Health Policy and Medical Assistance, DHHS, gave an update on the technical amendment to the CAP-MR/DD waiver and discussed a data exchange pilot program which has enabled three participating LMEs to access the Medicaid database to track what is happening with consumers.

Jeff Weaver, General Assembly Chief of Police, addressed the building evacuation policy.

Representative Insko took a moment to recognize the passing of Representative Howard Hunter and Senator Robert Holloman.

Eddie Caldwell, Executive Vice President and General Counsel to the N.C. Sheriffs' Association, offered information regarding mental health services available for pre-trial detainees in county jails.

Kory Goldsmith, Research Division, reviewed the study provisions related to the consultant's reports.

Dr. Christine Thompson, Heart of the Matter Consulting, Inc., gave her presentation on the final report for the Long Range Plan and Gaps Analysis.

It was suggested that the Funding Allocation Report be presented at the next meeting to allow staff ample time to review the report and to allow further questioning of the Gaps Study Report by the committee.

Dr. Thompson reviewed estimates of funding resources based on recommendations made in the report and stated that the collective impact of the proposed increases would cost $2.7 billion over a 5 year period.

Andrea Russo-Poole, Fiscal Research, offered follow-up information from previous meetings.

The LOC then received comments from the audience.

January 16, 2007

The LOC met on Wednesday, January 16, 2007, at 1:30 P.M. in Room 643 of the Legislative Office Building.

Leza Wainwright, Deputy Director, DMH gave a brief overview of the Funding Allocation Model. Ms. Wainwright then gave several financing recommendations which included: 1) Expand Medicaid eligibility; 2) Pursue Medicaid waivers; 3) Increase cost sharing under Medicaid; 4) Standardize first party payments and third party collection protocols

Senator Nesbitt then recognized LOC staff, who recommended that because neither DMH nor the consultant had provided a methodology for the models, and because the models had produced some unexpected results, the LOC should retain an independent party to forensically deconstruct the models in order to understand the methodology and to verify the models' accuracy.

LOC staff then reviewed possible options for legislation. Committee members discussed each of the seventeen options and offered feedback. The co-chairs directed staff to go back and craft proposals based on the discussions. Senator Nesbitt suggested that the size and speed of building the new State hospitals also be considered.

Senator Nesbitt stated that the LOC would hold a final meeting after session started to review and approve the final report.

March 6-7, 2007

The LOC met on Tuesday, March 6, 2007, at 6:00 P.M. in Room 643 of the Legislative Office Building. Committee staff began a review of the Committee's draft report. Because of the late hour, the LOC adjourned until the following day. The LOC met at 10:00 A.M., 1:00 P.M., and 5:00 P.M. on Wednesday, March 7, 2007. Staff completed a review of the draft report and the LOC voted on eight proposed amendments. The LOC then approved the report.

COMMITTEE FINDINGS

Introduction

In 2001, the General Assembly adopted significant reform legislation to restructure the delivery of services to individuals with mental illnesses, developmental disabilities, and substance abuse disorders. The foundations of reform included: local management of the system, decreased reliance on State institutions, community-based best practice treatments, increased consumer involvement, access to multiple and qualified providers, and performance and fiscal accountability to the State and local governments. As part of the legislation, the General Assembly directed the Secretary of DHHS (Secretary) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division) to undertake administering system reform. The reform has been overseen by the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC).

During the 2005-2006 interim, the LOC examined the status of services, the strength of State leadership, and the role of local agencies (LMEs). It found that mental health and substance abuse services are substantially under-funded when compared to other states. It also found that reform was moving away from strong local management. In response to these findings, the LOC recommended and the 2006 Session of the General Assembly approved significant increases in funding and modifications to the reform laws. The following is a summary of those changes:

1. The General Assembly appropriated $95.8 million in additional funding for mental health, developmental disabilities, and substance abuse services and authorized $328.3 million in certificates of participation for the construction of new psychiatric hospitals in Goldsboro and Morganton and to complete construction of the new facility in Butner. Major areas funded included:

- **Developmental Therapies** - $26 million recurring to replace services to the developmentally disabled lost due to changes in federal policy and cuts in federal support.
- **Community-Based Services** - $21.4 million recurring for mental health, substance abuse, and crisis services.
- **Housing** - $10.9 million in non-recurring funds for the North Carolina Housing Trust Fund and $1.2 million in recurring funds for operating assistance for 400 new apartments.

- **Mental Health Trust Fund** - $14.39 million in non-recurring funds.

2. The General Assembly also enacted laws to clarify the role of LMEs, increase the qualifications for LME directors and finance officers, strengthen local governing boards, codify the roles of consumer and family advisory committees, and require that the Secretary develop State and local performance measures.

Despite the gains made during the 2006 Session, the system continues to face significant challenges. The ability of LMEs to manage publicly funded services continues to be compromised by policy decisions made at the departmental level. The State psychiatric hospitals are experiencing record admission rates while at the same time keeping individuals for shorter and shorter periods of time. Communities are struggling to develop crisis services, including in-patient hospitalization. The continued lack of appropriate and affordable housing impacts all disability groups, making it very difficult for individuals to leave institutions and live and work in their communities.

1. Start-up Funding for Substance Abuse Treatment Programs

A 2003-2004 National Survey on Drug Use and health conducted by SAMHSA (U.S. Substance Abuse and Mental Health Administration) estimated that 2.59% of North Carolina's population needed, but did not receive, treatment for illicit drug use. An estimated 5.09% needed, but did not receive, treatment for alcohol use. Using North Carolina population estimates, this means that approximately 220,000 people were lacking treatment for illicit drug use and approximately 475,000 lacked treatment for alcohol use.

In 2005, almost twenty percent (20%) of persons admitted to the State psychiatric hospitals had a primary diagnosis of drug or alcohol abuse. The median length of stay for these individuals ranged from three to six (3-6) days.

Most substance abuse consumers are not Medicaid eligible, meaning indigent persons must rely upon State funds to pay for services. To achieve the national average per capita funding in FY2007-08 for substance abuse services, DMH estimates it would cost over thirty-five million dollars ($35,000,000).

It is widely acknowledged that to be effective, substance abuse treatment must be available when the consumer is willing to accept it. This means the provider must be able to respond to consumer needs twenty-four hours a day, seven days a week, 365 days a year. This is sometimes referred to as the "fire house" model. However, under the current funding system, providers only receive payment upon actually rending a service to an individual consumer. This is sometimes

referred to as the "fee for service" model. The fee for service payment system does not lend itself to the fire house model of service delivery.

2. Additional Housing Assistance

Lack of affordable housing options continues to be sited as one of the major barriers to successfully treating individuals in the community. However, in 2006, the LOC recommended, and the General Assembly funded, the Housing 400 Initiative. This initiative appropriated $1.2 million (recurring) for operating assistance of 400 independent- and supportive-living apartments and also appropriated $10.94 million (non-recurring) for financing the apartments. The North Carolina Housing Finance Agency and the Department of Health and Human Services are jointly operating this initiative.

3. Support Proposals Regarding Mentally Ill in Adult Care Homes

Currently there is no level of care between the hospital inpatient setting and the adult care home setting, and there is a lack of options for independent living.

In 2005, the public mental health system served over 174,000 adults with mental illness, 1,149 of whom lived in licensed mental health homes and 5,000 of whom lived in adult care homes. Nationally, approximately 10% of adults with serious mental illness need specialized housing. It was reported that over 40% of the adult care home population carries an active diagnosis of mental illness.

The co-chairs of the Study Commission on Aging and the LOC determined it would be beneficial to appoint a joint, ad hoc subcommittee to study issues relating to serving mentally ill individuals who reside in long term care facilities. That subcommittee made several recommendations.

4. Crisis and Acute Care Services

The LOC has heard repeatedly from sheriffs and other first responders that there is a lack of adequate crisis service providers, and that persons with mental illness and substance abuse disorders are disproportionately ending up in emergency rooms, county jails, and the State prison system.

In 2006, the General Assembly made an investment in crisis services by appropriating $7 million (recurring). These funds are currently available to LMEs. However, they were allocated by DMH according to age and disability groupings and could be spent only for identified services on a fee-for-service

(UCR) basis. While UCR payments make it easier to track how funds are spent, they reduce flexibility to use the funds to retain key personnel. LMEs also expressed concern that by allocating the funds according to disability and age categories, the usefulness of the new funding was diluted.

In 2006, the North Carolina General Assembly also invested $5.25 million (non-recurring) for crisis services start-up funding. The start-up funds were to be allocated to regional groups of LMEs based upon crisis plans developed in conjunction with a consultant retained by DHHS. That consultant has been retained and the plans submitted by March 1, 2007. DMH has also set aside $3 million from the Mental Health Trust Fund for this purpose. However, it is anticipated that the start-up needs will greatly exceed the available funding.

5. Hospital Bed Day Allocation

Currently, there is no incentive for LMEs to avoid over utilizing the state institutions.

LMEs "authorize" State psychiatric Hospital usage, but have no authority to prohibit a person from being sent to the hospital. Subject to federal anti-dumping laws, community hospitals can send person in crisis to State hospitals directly. In addition, the decision whether to admit a consumer to a State hospital is made by staff at the State institution.

The current hospital bed day allocation distributed bed days to LMEs based on their historical utilization. It also built-in a gradual change over a three year period to allocate bed days based on the LME's population. This transition has never occurred. In addition, the current plan charges LMEs $500 per additional bed day utilized over their initial bed day allocation. This practice was suspended after an LME sued DMH in 2002.

6. County Jails and Justice System – Mental Health and Substance Abuse Services

The LOC continues to hear that there are not sufficient mental health or substance abuse programs; and, as a result, state and local law enforcement resources are being utilized by the mentally ill and persons suffering from substance abuse disorders. In FY2004-05, 64% of 22,145 inmates (14,113) newly admitted to North Carolina prisons were assessed to have substance dependency problems. However, only 6,583 inmates in the same year received treatment.

DMH currently funds 12 Jail Diversion programs that serve 17 counties at an average cost of $60,000 annually. DMH is working with LMEs and other community partners (police and sheriff's departments, CFACs, and NAMI chapters) to expand the use of CITs (Crisis Intervention Teams). DMH administers the TASC Program (Treatment Accountability for Safer Communities) for individuals charged or convicted of crimes eligible for intermediate or community punishment. In FY 2005-06, 498 intermediate punishment offenders exited prison and the probation population consisted of 29,051 offenders. DMH estimates that of those individuals, 6,791 are currently being served. The services needed for this population include: detoxification services, crisis services, intensive outpatient treatment, comprehensive outpatient treatment, residential services, community support, and halfway houses.

7. Restructure the MH/DD/SA Trust Fund

G.S. 143-15.3D[1] creates the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs (Trust Fund). It is an interest-bearing, nonreverting special trust fund in the Office of State Budget and Management. Moneys in the Trust Fund are held in trust to be used solely to meet the mental health, developmental disabilities, and substance abuse services needs of the State. Any balance remaining in the Trust Fund at the end of any fiscal year is carried forward in the Trust Fund for the next succeeding fiscal year.

The Trust Fund only can be used for specified purposes. These are:

- Provide start-up funds and operating support for programs and services that provide more appropriate and cost-effective community treatment alternatives for individuals currently residing in the State's institutions.
- Facilitate the State's compliance with the United States Supreme Court decision in Olmstead v. L.C. and E.W.
- Facilitate reform of the mental health, developmental disabilities, and substance abuse services system and expand and enhance treatment and prevention services in these program areas to remove waiting lists and provide appropriate and safe services for clients.
- Provide bridge funding to maintain appropriate client services during transitional periods as a result of facility closings, including departmental restructuring of services.
- Construct, repair, and renovate State mental health, developmental disabilities, and substance abuse services facilities.

[1] Effective July 1, 2007, G.S. 143-15.3D is recodified as G.S. 143C-9-2.

DHHS has never developed a strategic plan for how the funds should be spent. There is no specific process for applying for funds, or criteria (other than purpose) regarding how the funds may be spent. Six years into reform, over $75,000,000 has been placed in the Trust Fund. However, under $43,000,000 (or less than sixty percent) had been expended. Of the funds expended by February 2007, over 20% were allocated to State-operated facilities.

8. Waivers/Funding Flexibility

DMH has implemented a single stream funding project which allows it to allocate state appropriations to selected LMEs without dividing the funding into age and disability categories. This gives those LMEs much more flexibility to fully utilize State funding to address community needs. Other LMEs continue to express great interest in obtaining similar flexibility.

Piedmont Behavioral Healthcare has a Medicaid Waiver that allows it to independently manage its Medicaid services and resources. This waiver gives Piedmont Behavioral Healthcare the authority to create and manage its provider network, manage rates, authorize services, and pay provider claims. Many legislators and LOC members have expressed interest in expanding the Medicaid waiver to include more LMEs.

9. Service Dollars for Mental Health

North Carolina ranked 45th nationally in mental health spending ($49.64 per capita), 16th in spending for state mental hospitals ($34.68 per capita), and 49th in spending for community-based programs ($14.96 per capita).[2] Two lower states are New Mexico and Arkansas. Arkansas also does not include the Medicaid data and New Mexico doesn't include children's mental health. North Carolina ranked 43rd in per capita funding for mental health services nationally in 2003 in "Grading the States – A Report on America's Health Care System for Serious Mental Illness" (a study by the National Alliance for the Mentally Ill). An additional $30 million per year for mental health services would increase North Carolina's per capita spending on state-funded mental health services from $17.36 to $20.43 per capita (not factoring in any other proposed appropriations).

[2] These rankings only include funds controlled by the State Mental Health Agency. For North Carolina, this does not include services paid for by Medicaid.

Because access to state-funded services is not an entitlement, LMEs lack sufficient funds to provide adequate services to consumers. LMEs must choose between serving more people with fewer services or serving fewer people with more services. If LMEs paid for the same level of services as Medicaid for state-funded services, it is estimated that only twenty-five percent (25%) of current mental health patients would receive services.

Another indication of the lack of sufficient services to the mentally ill is the rise in acute admissions to the State psychiatric hospitals. Since reform, hospital populations have decreased, but admissions have increased and admissions are increasing faster than population growth. Acute admissions (persons who are discharged in 30 days or less) have increased 22% from 2001 to 2005. Stays from one to seven days have increased by 83% from 2001 to 2005.

10. Services to the Developmental Disabled

The LOC has heard that Sheltered Workshops, which the State currently funds, are not an evidence-based practice, but that Supported Employment is. The LOC has also made it a priority to serve individuals with developmental disabilities in the community rather than institutions.

In 2006, CMS refused to approve Developmental Therapies (previously known as Community Based Services or CBS) as a Medicaid reimbursable service for the developmentally disabled. The State moved to place as many persons as possible on CAP-MR/DD waivers and find other appropriate services. DMH also recommended, and the General Assembly appropriated, $26 million to be used to "replace services lost due to changes in federal policy and cuts in federal support." It is not clear whether these funds were meant to "hold harmless" individuals who had been receiving CBS or whether the funds were meant to create a new service that is available regardless of whether a person had previously been receiving CBS.

11. Implementation of New LME Administrative Cost Model and Additional Funding Needed

S.L. 2006-66, Section 10.32 directed DHHS to review and revise the LME systems management cost model and to recalculate LME systems management allocations for fiscal year 2006-07. This calculation was to include funds for each LME to implement 24-hour, seven-days-a-week screening, triage, and referral, and to review, monitor, and comment on all person centered plans. The special provision also required DHHS to develop a cost model that fully funded the core LME functions outlined in G.S. 122C-115.4(b).

DHHS has failed to request adequate funds to pay for local administrative costs for the last three years, which has consistently resulted in shortfalls in the DMH budget. In order to cover these shortfalls, in FY 2004-05, DHHS transferred $24,828,452 in funds from the Division of Medical Assistance to DMH and used $5,130,144 in DMH funds appropriated to other areas. In FY 2005-06, DHHS transferred $15,502,332 from the Divisions of Aging, Public Health, and Social Services to DMH and used $14,401,656 in DMH funds appropriated to other areas. In FY 2006-07, DMH cut $19,525,273 from services at the direction of DHHS. In 2004 and 2005, DHHS failed to inform the General Assembly of the existence or extent of the shortfall. In 2006, DHHS failed to inform the General Assembly of the extent of the shortfall.

DMH presented a new LME Administrative Cost Model to the LOC in November of 2006. The new model is based on the old LME Administrative Cost Model with some adjustments in the cost categories. DMH informed the LOC that the total cost is similar to the LME administrative cost for FY 2006-07, but will require an additional seventeen million two hundred sixty-seven thousand three hundred eighty-six dollars ($17, 267,386) in state general funds to be fully funded. DMH has recently increased that figure because it was determined that the cost model did not provide full funding for LMEs to review, monitor, and comment on all person centered plans. The new total needed is $19, 200,000.

LMEs are not currently required to report how local funds are spent or collect income data on consumers. This lack of information makes it difficult to determine the extent of service gaps or the extent that some consumers might be able to supplement the cost of their services.

12. Uniform Sliding Fee Schedule

G.S. 122C-146 requires LMEs and their contractual agencies to prepare fee schedules for services and make a reasonable effort to collect appropriate reimbursement for costs from individuals or entities based upon ability to pay or third-party payment. Funds collected from fees for LME operated services must be used for the fiscal operation or capital improvements of the LME's programs.

A survey of LMEs by the Division during the fall of 2006 showed that there is no uniformity across the State regarding these fee schedules. LMEs may or may not use the same fee schedule for all services. Some look at gross income, others do not. Some set an income floor below which no fee is charged, others do not. All LMEs that reported on their sliding fee scale had a maximum income above which no relief was provided. However, those maximum incomes ranged from

$7,200 to $99,000 for a family of one. A couple of LMEs charged for "no shows", but the vast majority did not. Only one LME had a maximum monthly liability limit.

A uniform fee schedule would ensure that consumers are treated consistently across the State.

13. Clarify Screening, Triage, and Referral Roles

The purpose of the LME function of Screening, Triage and Referral (STR) is to gather basic demographic information about the consumer, determine whether the consumer is target or non-target population, make a very broad initial determination about the consumer's condition, and provide information regarding providers who could assist the consumer.

In the spring of 2006, DMH and LMEs negotiated a memorandum of agreement (MOA) that outlined how STR should be handled. The MOA stated that only LMEs would implement STR for both Medicaid and non-Medicaid eligible consumers. The rational for this position was that LMEs needed to know who was entering the system and this was the most efficient way for LMEs to have that information. LMEs were also concerned about "self-referral" by the providers conducting STR.

During the summer of 2006, the Division of Medical Assistance (DMA) took the position that private providers should be able to do STR for Medicaid eligible consumers. DMA argued that this implemented the "no wrong door" policy of the system and that when a consumer walks in the door of a private provider, that consumer has already exercised his or her choice. LMEs objected to this position, arguing that there was no mechanism for LMEs to know when a Medicaid eligible consumer enters the system if the provider conducts STR. Eventually, DMH, DMA and the LMEs negotiated a system by which a provider must "register" a consumer with the LME within 5 days of the provider conducting STR. While some LMEs were satisfied with this solution, others took the position that the policy contradicted language adopted by the General Assembly in 2006 that lists STR as a "core function" of LMEs. Those LMEs also argued that the registration system would be inefficient.

It should be noted that the State and Medicaid provide administrative funds for LMEs to conduct STR. However, STR is not a "service", therefore neither the State nor Medicaid will pay providers for conducting STR. It is possible that as more providers conduct STR, Medicaid will reduce its contribution to LME

administrative funding on the basis it is paying for a function LMEs are not implementing.

The Secretary has been under a statutory obligation since 2001 to adopt rules implementing a "uniform portal process". This term refers to how consumers enter and exit the public system. Who is authorized to conduct STR is directly related to the uniform portal process. The LOC co-chairs sent a letter to the Secretary requesting that she suspend the policy until such time as rules could be adopted. The Secretary took the issue to the State Consumer and Family Advisory Council (state CFAC) who supported the policy as being consumer friendly. The Secretary has responded to the rules issue with a letter that indicates that the General Assembly had tacitly given DHHS the authority to adopt policies outside the rulemaking process. The Secretary has also proposed a rule that would allow private providers to conduct STR for Medicaid consumers. The Commission on Mental Health, Developmental Disabilities and Substance Abuse Services passed a resolution in February of 2007, stating that the proposed rule conflicts with the policies in G.S. 122C-115.4(b) and requesting that the Secretary withdraw the rule.

14. First Commitment Pilot Program

Session Law 2003-178 authorized the Secretary to temporarily waive certain statutory requirements pertaining to initial (first-level) examinations conducted as part of the involuntary commitment process. Current law requires that first-level examinations be conducted by either a physician or eligible PhD-level psychologist. The temporary waiver allowed the Secretary to approve LME requests to substitute appropriately trained licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct first-level examinations. The Secretary could grant waivers to up to five LMEs for periods of time not to exceed three years and required that participating LMEs, "…assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary."

The Secretary approved the following five LMEs to participate in the pilot program: CenterPoint Human Services, Crossroads Behavioral Healthcare, Pathways MH/DD/SAS, Smoky Mountain Center, and Piedmont Behavioral Healthcare. DMH delivered a report to the LOC on the "effectiveness, quality, and efficiency" of services provided under the waiver. The report recommended that the change be extended state wide and made permanent. However, the vast majority of the data in the report came from a single LME, making it difficult to draw broad conclusions about the program.

COMMITTEE CONCLUSIONS

The Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services makes the following four recommendations to the 2007 General Assembly. Each proposal is followed by a bill draft.

1. That the General Assembly enact comprehensive legislation to build the necessary services (infrastructure) at the community level to begin to address the system's needs.
2. That DHHS adopt a uniform sliding fee schedule.

3. That the General Assembly extend the First Commitment Pilot Program and clarify that only LMEs may conduct LME core functions.

4. That the General Assembly adopt legislation requiring all health insurers to provide health insurance coverage for the treatment of mental illness and substance abuse. The coverage shall be subject to the same benefits and limitations as the coverage provided for all other covered conditions.

Note: Recommendations 1-3 above are outlined in greater detail in the following pages. Each proposal is accompanied by draft legislation.

LEGISLATIVE PROPOSAL #1

BUILD COMMUNITY INFRASTRUCTURE

LEGISLATIVE PROPOSAL #1

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SA
TO THE 2007 GENERAL ASSEMBLY

AN ACT TO BUILD COMMUNITY INFRASTRUCTURE FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE

Short Title: **Build Community Infrastructure – MH/DD/SA**

Brief Overview: This bill would appropriate one hundred thirty-five million, forty-two thousand, forty-eight dollars ($135,042,048) for Fiscal Year 2007-08 and one hundred thirty-four million, seven hundred seventy-seven thousand, six hundred forty-seven dollars ($134,777,647) for Fiscal Year 2008-09 to build community infrastructure for mental health, developmental disabilities, and substance abuse services. All funds distributed to LMEs are to be allocated by DHHS as a percentage of the total allocation that is equal to the LME's percentage of the State's total population that is below the federal poverty level.

The bill directs the following action and appropriates funds as provided:

Part 1. Funds for Substance Abuse Treatment Programs

- **$10,000,000** for FY 2007-08 and **$5,000,000** for FY 2008-09 from the General Fund to DHHS to be allocated to LMEs for the purpose of operational start up, capital, or subsidies related to the creation of residential or outpatient Substance Abuse Treatment Programs. The LME would determine program needs and would be allowed to work in conjunction with other LMEs to address regional needs.
- **$500,000** for FY 2007-08 and **$500,000** for FY 2008-09 from the General Fund to the North Carolina Area Health Education Centers to provide technical assistance to LMEs in the identification and implementation of substance abuse treatment programs.

- Amends G.S. 122C-147.1 to include language providing funds for substance abuse services be appropriated in a broad disability category, thereby removing the age categories.
- Directs the Secretary to develop and implement a system to track funds expended by LMEs on a grant basis (single stream funding) for each disability and age/disability category and that identifies specific services purchased with funds.
- Allows LMEs to use up to 1% of funds allocated to provide nominal incentives for substance abuse service consumers that meet specific treatment benchmarks
- Encourages LMEs to use funds for prevention and education.
- **$4,000,000** for FY 2007-08 and **$4,000,000** for FY 2008-09 from the General Fund to DHHS to provide substance abuse treatment services and case management for existing pre- and post-plea drug treatment courts.

Part 2. Additional Housing Assistance

Independent- and Supportive-Living Apartments Initiative:

- **$5,250,000** FY 2007-08 and FY 2008-09 to DHHS for additional operating cost subsidies for an estimated 1,000 independent- and supportive-living apartments for individuals with MH/DD/SA disabilities.

- Directs DHHS to maximize the number of subsidies that it can pay for with these funds by first giving priority to NCHFA-financed apartments, giving second priority to other publicly subsidized apartments, and finally to market-rate apartments. The apartments shall be made affordable to individuals with incomes at or below the SSI level. Up to $250,000 can be used for administration of the subsidies.

- **$10,000,000** FY 2007-08 and FY 2008-09 to the North Carolina Housing Trust Fund of the North Carolina Housing Finance Agency (NCHFA) to finance independent- and supportive-living apartments for individuals with MH/DD/SA disabilities. These funds can be used to continue the current Housing 400 Initiative as currently operated.

- Requires DHHS and NCHFA to work together to plan the most efficient and effective use of state resources in the financing and construction of additional independent- and supportive-living apartments for individuals with MH/DD/SA disabilities.

Support Proposals Regarding Mentally Ill in Adult Care Homes:

- Directs DHHS to develop a "Transitional Residential Treatment Program" to provide 24-hour residential treatment and rehabilitation for adults who have a pattern of difficult behaviors related to mental illness and which exceed the capabilities of traditional community residential settings.

- Directs DHHS to complete a Uniform Screening Tool and notify LMEs of the mental illness status of any individual admitted to a long-term care facility within the LME's catchment area.

- Authorizes DHHS to increase the maximum number of assignments to the special assistance in-home program to 2,000 persons.

- Reauthorizes the joint ad hoc Subcommittee on Adult Care Home Residents with Mental Illness to continue its study on identifying rules and laws to regulate facilities that provide housing for adults with mental illness in the same location as adults without mental illness.

Part 3. Crisis and Acute Care Services

Expand Crisis Services:

- **$10,000,000** for FY 2007-08 and **$5,000,000** for FY 2008-09 from the General Fund to DHHS to be allocated to LMEs to continue to implement the crisis plans developed under S.L. 2006-66 Section 10.26. **$250,000** to extend the contract with the existing crisis services consultant.

- **$15,000,000** for FY 2007-08 and **$20,000,000** for FY 2008-09 from the General Fund to DHHS to be allocated to LMEs to continue increasing the crisis services available around the State.

- Requires LMEs to make crisis services available to all age and disability groups, but directs DMH to cease allocating crisis service funds according to those categories.

- Directs DHHS to develop a system for reporting on crisis visits to community hospital emergency departments.

State Psychiatric Hospital Utilization Pilot:

- **$5,000,000** for FY 2007-08 and FY 2008-09 to be used by selected LMEs to provide crisis services as part of a pilot program to increase community resources for persons with mental illness and to reduce acute admissions to State psychiatric hospitals.

Part 4. Assistance to Law Enforcement

Services to Persons in Jail:

- Directs LMEs to work with public health departments and County Sheriffs to provide assessments and medications for suicidal, hallucinating or delusional inmates in county jails.

- Directs that the LMEs, county Public Health Departments, and County Sheriffs to work together to develop standardized mental health screening tools, protocols, and training related to persons in jails.

- **$1,000,000** for FY 2007-08 and FY 2008-09 for LMEs to provide the assistance described above.

- **$900,000** for FY 2007-08 and **$1,800,000** for FY 2008-09 from the General Fund to DHHS for 15 additional jail diversion programs, expanding jail diversion to all counties.

Crisis Intervention Teams:

- **$100,000** for FY 2007-08 and FY 2008-09 from the General Fund to DHHS for technical assistance and training of Crisis Intervention Teams.

Post-Conviction Substance Abuse Treatment Programs:

- **$4,080,000** for FY 2007-08 and **$8,160,000** for FY 2008-09 from the General Fund to DHHS for 68 additional care managers per year for the Treatment Accountability for Safer Communities (TASC) program to cover all known substance abuse offenders eligible for the program**.**
- **$1,412,048** for FY 2007-08 and **$1,167,647** for FY 2008-09 from the General Fund for to the Department of Correction to establish a community-based, residential substance abuse treatment facility for female offenders on probation and female DWI offenders paroled to treatment.

Part 5. Restructure the MH/DD/SA Trust Fund

- Repeals language in G.S. 143C-9-2 that allows Trust Fund money to be used to construct, repair, and renovate State mental health, developmental disabilities, and substance abuse services facilities**.**
- Requires funds remaining in the Trust fund that are not obligated as of February 1, 2007, to only be obligated to provide community based programs.

Part 6. Strengthen Services Network

- Requires DMH to implement an application process that would allow up to four additional LMEs to be considered for the single stream funding process. If the designation is not made by June 1, 2007, the General Assembly would make the designation.

- Directs DMH to study the effectiveness of Piedmont Behavioral Healthcare's Medicaid Waiver and requires the Secretary to commence the process for three additional LMEs to apply for the waiver.

Part 7. Filling Service Gaps

Additional Service Dollars for Mental Health:

- **$30,000,000** for FY 2007-08 and FY 2008-09 from the General Fund to DHHS to be allocated to LMEs for the purchase mental health services.

Additional Services for the Developmental Disabilities:

- **$7,000,000** for FY 2007-08 and FY 2008-09 for start-up and ongoing support of Supported Employment services.

- **$9,900,000** for FY 2007-08 and for FY 2008-09 for an additional 660 slots in the Community Alternatives Program for Mental Retardation / Developmental Disabilities (CAP-MR/DD).

- Beginning July 1, 2007, developmental therapies will only be available for participants who are receiving these services on June 30, 2007.

Community Supports/Tiered Rate Structure:

- Directs DHHS to establish at least three rate tiers for the service of Community Supports.

Part 8. LME Administrative Funding

- **$19,200,000** for FY 2007-08 and FY 2008-09 from the General Fund to DHHS the purpose to fully funding the LME cost model.

- Requires LMEs to report to DMH on all services provided (including services provided with county funds), income data of all consumers, and

on non-UCR spending. The data shall be reported by service and by disability, and shall include information regarding any services to Medicaid eligible consumers that are being augmented with State funds. DMH and the LMEs shall develop a method of reporting on services delivered with non-UCR funding that allows DMH to measure outcomes achieved with the use of the funds and also allows more funding to be used on a non-UCR basis.

- **$1,700,000** for FY 2007-08 and FY 2008-09 from the General Fund to DHHS to be used by the LMEs to pay for the cost of the additional reporting requirements.

Effective Date: This bill would become effective July 1, 2007.

A copy of the proposed legislation begins on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U **D**

BILL DRAFT 2007-RCz-1 [v.18] (01/24)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/8/2007 10:02:31 AM

Short Title:	Build Community Infrastructure - MH/DD/SA.	(Public)
Sponsors:	.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO BUILD COMMUNITY INFRASTRUCTURE FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES AND TO APPROPRIATE FUNDS AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

PART I. INCREASE AVAILABILITY OF SUBSTANCE ABUSE TREATMENT.

START-UP FUNDING FOR SUBSTANCE ABUSE TREATMENT PROGRAMS.

SECTION 1.1. There is appropriated from the General Fund to the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH), the sum of ten million dollars ($10,000,000) for the 2007-2008 fiscal year and the sum of five million ($5,000,000) for the 2008-2009 fiscal year. DHHS shall distribute the funds no later than 30 days after the enactment of the Current Operations and Capital Appropriations Act for the 2007-2009 biennium.

Funds appropriated in this Section shall be allocated to local management entities (LMEs) such that each LME receives a percentage of the total allocation that is equal to that local management entity's percentage of the State's total population that is below the federal poverty level. LMEs shall use the funds for operational start-up, capital, or subsidies related to the creation of both residential and outpatient substance abuse treatment programs. Each LME shall determine the type of substance abuse treatment programs that are needed in that LME's catchment area, issue requests for proposals for the creation of those programs, and award funds for appropriate proposals.

LMEs may work together to identify regional needs and may also issue combined requests for proposals to create regional substance abuse treatment programs. LMEs shall distribute funds appropriated under this section no later than six months after the funds are distributed to LMEs by DHHS, and in no event later than June 30, 2008.

SECTION 1.2. There is appropriated from the General Fund to the North Carolina Area Health Education Centers (AHEC), the sum of five hundred thousand dollars ($500,000) for the 2007-2008 fiscal year and the sum of five hundred thousand dollars ($500,000)for the 2008-2009 fiscal year. AHEC shall use the funds to provide technical assistance to LMEs in the identification of substance abuse treatment program needs in the LMEs' catchment areas, the development of requests for proposals, and oversight and accountability for the implementation of substance abuse treatment programs. AHEC shall make recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services by February 1, 2009, and October 1, 2010, regarding whether there is a need for additional funds for substance abuse start-up and services.

SUBSTANCE ABUSE TREATMENT SERVICES AND PREVENTION.

SECTION 1.3. G.S. 122C-147.1 reads as rewritten:

"**§ 122C-147.1. Appropriations and allocations.**

(a) Except as provided in subsection (b) of this section, funds for services delivered to mentally ill and developmentally disabled clients shall be appropriated by the General Assembly in broad age/disability categories. Funds for services delivered to substance abuse clients shall be appropriated by the General Assembly in a broad disability category. The Secretary shall allocate and account for funds in broad disability or age/disability categories so that the ~~area authority~~ LME may, with flexibility, earn funds in response to local needs that are identified within the payment policy developed in accordance with G.S. 122C-143.1(b).

(b) When the General Assembly determines that it is necessary to appropriate funds for a more specific purpose than the broad disability or age/disability category, the Secretary shall determine whether expenditure accounting, special reporting within earning from a broad fund, the Memorandum of Agreement, or some other mechanism allows the best accounting for the funds.

(c) Funds that have been appropriated by the General Assembly for a more specific purpose than specified in subsection (a) of this section shall be converted to a broad disability or age/disability category at the beginning of the second biennium following the appropriation, unless otherwise acted upon by the General Assembly.

(d) The Secretary shall allocate funds to ~~area programs:~~LMEs as follows:

(1) To be earned in a purchase of service basis, at negotiated reimbursement rates, for services that are included in the payment policy and delivered to mentally ~~ill,~~ ill and developmentally ~~disabled, and substance abuse~~ disabled clients and for services that are included in the payment policy to other ~~recipients; or~~ recipients.

(2) To be paid under a grant on the basis of agreed-upon ~~expenditures, when the Secretary determines that it would be impractical to pay on a purchase of service basis.~~expenditures.

(d1) The Secretary shall allocate funds to LMEs for services to substance abuse clients. Notwithstanding subsection (d) of this section, each LME shall determine whether to earn the funds for services to substance abuse clients in a purchase for service basis, under a grant, or some combination of the two.

(d2) No later than November 1, 2007, the Secretary shall develop and implement a system that LMEs shall use to track the funds each LME expends on a grant basis for each disability and for each age/disability category and that identifies the specific services purchased with the funds.

(e) After the close of a fiscal year, final payments of funds shall be ~~made:~~made as follows:

(1) Under the purchase of service basis, on the earnings of the ~~area authority~~ LME for the delivery to individuals within each age/disability group, of any services that are consistent with the payment policy established in G.S. 122C-143.1(b), up to the final allocation ~~amount; or~~amount.

(2) When awarded on an expenditure basis, on allowable actual expenditures, up to the final allocation amount.

(e1) Under rules adopted by the Secretary, final payments made under subsection (e) of this section shall be adjusted on the basis of the audit required in G.S. 122C-144.1(d)."

SECTION 1.4. Consistent with G.S. 122C-2, the General Assembly strongly encourages LMEs to use a portion of the funds appropriated for substance abuse treatment services to support prevention and education activities.

SECTION 1.5. An LME may use up to one percent (1%) of funds allocated to it for substance abuse treatment services to provide nominal incentives for consumers who achieve specified treatment benchmarks.

DRUG TREATMENT COURTS.

SECTION 1.6. There is appropriated from the General Fund to the to the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities and Substance Abuse Services the sum of four million dollars ($4,000,000) for the 2007-2008 fiscal year and the sum of four million dollars ($4,000,000) for the 2008-2009 fiscal year. The funds shall be used to provide substance abuse treatment services and case management for existing pre- and post-plea Adult Drug Treatment Courts, DWI Treatment Courts, Youth Drug Treatment Courts, Mental Health Treatment Courts and Family Drug Treatment Courts.

PART II. ADDITIONAL HOUSING ASSISTANCE

INDEPENDENT- AND SUPPORTIVE-LIVING APARTMENTS INITIATIVE

SECTION 2.1 There is appropriated from the General Fund to the Department of Health and Human Services (DHHS) the sum of five million two hundred fifty thousand dollars ($5,250,000) for the 2007-2008 fiscal year and the sum of five million two hundred fifty thousand dollars ($5,250,000) for the 2008-2009 fiscal year. The funds shall be used to pay for operating cost subsidies for approximately one thousand (1,000) independent- and supportive-living apartments for individuals with mental health, developmental, or substance abuse disabilities. DHHS shall maximize the number of subsidies that can be paid for with these funds by giving first priority to North Carolina Housing Finance Agency-financed apartments, giving second priority to other publicly subsidized apartments, and third priority to market-rate apartments. Up to two hundred fifty thousand dollars ($250,000) may be used for administration of the subsidies.

SECTION 2.2. There is appropriated from the General Fund to the North Carolina Housing Trust Fund the sum of ten million dollars ($10,000,000) for the 2007-2008 fiscal year and the sum of ten million dollars ($10,000,000) for the 2008-2009 fiscal year. The funds shall be used to finance independent- and supportive-living apartments for individuals with mental health, developmental, or substance abuse disabilities. The funds shall be used to continue and expand the Housing 400 Initiative created in 2006.

SECTION 2.3. The independent and supportive living apartments for persons with disabilities constructed from funds appropriated in this act for that purpose shall be affordable to persons with incomes at or below the Supplemental Security Income (SSI) level.

SECTION 2.4. The Department of Health and Human Services and the North Carolina Housing Finance Agency shall work together to develop a plan for the most efficient and effective use of State resources in the financing and construction of additional independent- and supportive-living apartments for individuals mental health, developmental, or substance abuse disabilities. This plan shall address gaps in the housing continuum identified by the study that DHHS will conduct during SFY 2006-07 and SFY 2007-08. DHHS and NCHFA shall report this plan and also the progress of the Housing 400 Initiative to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services by March 1, 2008.

SUPPORT PROPOSALS REGARDING MENTALLY ILL IN ADULT CARE HOMES.

SECTION 2.5. The Department of Health and Human Services shall develop a "Transitional Residential Treatment Program" service definition to provide 24-hour residential treatment and rehabilitation for adults who have a pattern of difficult behaviors related to mental illness and which exceed the capabilities of traditional community residential settings. DHHS shall submit the new service definition to the Centers for Medicare and Medicaid for approval no later than 90 days after the enactment of the Current Operations and Capital Appropriations Act for the 2007-2009 biennium.

SECTION 2.6. The joint ad hoc subcommittee regarding the mentally ill in adult care homes convened by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services and the North Carolina Commission on Aging may continue to study and identify rules and laws that are necessary to regulate facilities that provide housing for adults with mental illness in the same location with adults without mental illness.

SECTION 2.7. The Department of Health and Human Services shall complete the development of a Uniform Screening Tool (UST) to be used by LMEs to determine the mental health of any individual admitted to any long term care facility within an LME's catchment area. The UST shall be available for use no later than 90 days after the enactment of the Current Operations and Capital Appropriations Act for the 2007-2009 biennium.

SECTION 2.8. The Department of Health and Human Services shall make available placements for at least two thousand (2,000) adults through the State/County Special Assistance In-Home Program. LMEs shall be responsible for the delivery of case management for recipients who have a mental illness, developmental disability, or substance abuse disorder and are within the target populations for those disabilities.

PART III. CRISIS AND ACUTE CARE SERVICES

EXPAND CRISIS SERVICES

SECTION 3.1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of ten million dollars ($10,000,000) for the 2007-2008 fiscal year and the sum of five million dollars ($5,000,000) for the 2008-2009 fiscal year. LMEs shall use these funds to continue to implement the crisis plans developed under S.L. 2006-66, Section 10.26. DHHS may use up to two hundred fifty thousand dollars ($250,000) of the funds appropriated under this Section to extend its contract with the crisis services consultant authorized under Section 10.26(b) of S.L. 2006-66.

SECTION 3.2. S.L. 2006-66, Section 10.26(d) reads as rewritten:

"SECTION 10.26.(d) With the assistance of the consultant, the ~~area authorities and county programs~~ LMEs within a crisis region shall work together to identify gaps in their ability to provide a continuum of crisis services for all consumers and use the funds allocated to them to develop and implement a plan to address those needs. At a minimum, the plan must address the development over time of the following components: 24-hour crisis telephone lines, walk-in crisis services, mobile crisis outreach, crisis respite/residential services, crisis stabilization units, 24-hour beds, facility-based crisis, in-patient crisis, detox, and transportation. Options for voluntary admissions to a secured facility must include at least one service appropriate to address the mental health, developmental disability, and substance abuse needs of adults, and the mental health, developmental disability, and substance abuse needs of children. Options for involuntary commitment to a secured facility must include at least one option in addition to admission to a State facility.

If all ~~area authorities and county programs~~ LMEs in a crisis region determine that a facility-based crisis center is needed and sustainable on a long-term basis, the crisis region shall first attempt to secure those services through a community hospital or other community facility. If all the ~~area authorities and county programs~~LMEs in the crisis region determine the region's crisis needs are being met, the ~~area authorities and county programs~~LMEs may use the funds to meet local crisis service needs."

SECTION 3.3. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of fifteen million dollars ($15,000,000) for the 2007-2008 fiscal year and the sum of twenty million dollars ($20,000,000) for the 2008-2009 fiscal year to be used to provide crisis services.

Funds appropriated in this Section shall be allocated to local management entities (LMEs) such that each LME receives a percentage of the total allocation that is equal to that LME's percentage of the State's total population that is below the federal poverty level. DHHS shall distribute the funds no later than 30 days after the enactment of the Current Operations and Capital Appropriations Act for the 2007-2009 biennium. LMEs shall work with sheriffs and county public health agencies to serve individuals who are incarcerated or being held in county jails and who are in need of crisis services.

SECTION 3.4. G.S. 122C-147.1, as amended by Section 1.3 of this act reads as rewritten:

"**§ 122C-147.1. Appropriations and allocations.**

(a) Except as provided in subsection (b) of this section, funds for services delivered to mentally ill and developmentally disabled clients shall be appropriated by the General Assembly in broad age/disability categories. Funds for services delivered to substance abuse clients shall be appropriated by the General Assembly in a broad disability category. The Secretary shall allocate and account for funds in broad disability or age/disability categories so that the LME may, with flexibility, earn funds in response to local needs that are identified within the payment policy developed in accordance with G.S. 122C-143.1(b).

(b) When the General Assembly determines that it is necessary to appropriate funds for a more specific purpose than the broad disability or age/disability category, the Secretary shall determine whether expenditure accounting, special reporting within earning from a broad fund, the Memorandum of Agreement, or some other mechanism allows the best accounting for the funds.

(b1) Notwithstanding subsection (b) of this section, funds appropriated by the General Assembly for crisis services shall not be allocated in broad disability or age/disability categories.

(c) Funds that have been appropriated by the General Assembly for a more specific purpose than specified in subsection (a) of this section shall be converted to a broad disability or age/disability category at the beginning of the second biennium following the appropriation, unless otherwise acted upon by the General Assembly. This subsection shall not apply to funds appropriated by the General Assembly for crisis services.

(d) The Secretary shall allocate funds to LMEs as follows:

(1) To be earned in a purchase of service basis, at negotiated reimbursement rates, for services that are included in the payment policy and delivered to mentally ill and developmentally disabled clients and for services that are included in the payment policy to other recipients.

(2) To be paid under a grant on the basis of agreed-upon expenditures.

(d1) The Secretary shall allocate funds to LMEs for crisis services and services to substance abuse clients. Notwithstanding ~~subsection~~ subsections (b) and (d) of this section, each LME shall determine whether to earn the funds for crisis services and funds for services to substance abuse clients in a purchase for service basis, under a grant, or some combination of the two.

(d2) No later than November 1, 2007, the Secretary shall develop and implement a system that LMEs shall use to track the funds each LME expends on a grant basis for each disability and for each age/disability category and that identifies the specific services purchased with the funds.

(e) After the close of a fiscal year, final payments of funds shall be made as follows:

(1) Under the purchase of service basis, on the earnings of the LME for the delivery to individuals within each age/disability group, of any services that are consistent with the payment policy established in G.S. 122C-143.1(b), up to the final allocation amount.

(2) When awarded on an expenditure basis, on allowable actual expenditures, up to the final allocation amount.

(e1) Under rules adopted by the Secretary, final payments made under subsection (e) of this section shall be adjusted on the basis of the audit required in G.S. 122C-144.1(d)."

SECTION 3.5. The Department of Health and Human Services shall develop a system for reporting to LMEs information regarding all visits to community hospital emergency departments by individuals who are in crisis due to a mental illness, a developmental disability or a substance abuse disorder. The system shall be implemented no later than 90 days after the enactment of the Current Operations and Capital Appropriations Act for the 2007-2009 biennium.

STATE PSYCHIATRIC HOSPITAL – UTILIZATION PILOT

SECTION 3.6. In addition to the crisis service funds appropriated under Section 3.3 of this act, there is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of five million dollars ($5,000,000) for the 2007-2008 fiscal year and the sum of five million dollars ($5,000,000) for the 2008-2009 fiscal year to be used by selected LMEs to provide crisis services as part of a pilot program to increase community resources for persons with mental illness and to reduce acute admissions to State psychiatric hospitals. LMEs that have at least one of all of the following shall be eligible to use the funds appropriated under this section: mobile crisis team, facility-based crisis unit, walk-in facility, and a contract with a community

hospital for inpatient beds for involuntary commitments. An LME that participates in this pilot program during the 2007-2008 fiscal year shall be eligible to participate in the program during the 2008-2009 fiscal year if the LME can document a reduction in the involuntary commitment admissions from that LME's catchment area to the State psychiatric hospital that serves that catchment area during the 2007-2008 fiscal year.

The budgets for the State psychiatric hospitals shall not be reduced during the 2007-2008 fiscal year as a result of this pilot. However, those budgets shall be adjusted in following years to reflect the previous year's use by the LMEs participating in the pilot program.

PART IV. ASSISTANCE TO LAW ENFORCEMENT

SERVICES TO PERSONS IN JAIL

SECTION 4.1. Local Management Entities shall work with County Public Health departments and County Sheriffs to provide medical assessments and medication, if appropriate, for inmates housed in county jails who are suicidal, hallucinating or delusional. LMEs shall also examine ways to provide additional treatment to persons who are determined to be psychotic, severely depressed, suicidal, or who have substance abuse disorders. LMEs, County Public Health departments and County Sheriffs shall work together to develop all of the following:

(1) A standardized evidence-based screening instrument to be used when offenders are booked.

(2) A designated LME employee who is responsible for screening the daily jail booking log for known mental health consumers.

(3) Protocols for effective communication between the LME and the jail staff including collaborative development of medication management protocols between the jail staff and the mental health providers.

(4) Training to help detention officers recognize signals of mental illness.

There is appropriated from the General Fund to the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH), the sum of one million dollars ($1,000,000) for the 2007-2008 fiscal year and the sum of one million ($1,000,000) for the 2008-2009 fiscal year. Funds appropriated in this Section shall be allocated to local management entities (LMEs) such that each LME receives a percentage of the total allocation that is equal to that local management entity's percentage of the State's total population that is below the federal poverty level. LMEs shall use the funds to provide the assistance required under this Section.

SECTION 4.2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services the sum of nine hundred thousand dollars ($900,000) for the 2007-2008 fiscal year and the sum of one million eight hundred thousand dollars ($1,800,000) for the 2008-2009 fiscal year. The funds shall be used by LMEs to expand post-arrest jail diversion programs. The funds would expand the program by fifteen (15) programs each year.

CRISIS INTERVENTION TEAMS

SECTION 4.3. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services the sum of one hundred thousand dollars ($100,000) for the 2007-2008 fiscal year and the sum of one hundred thousand dollars ($100,000) for the 2008-2009 fiscal year. The funds shall be used by LMEs to develop Crisis Intervention Teams (CITs) statewide. The Division shall develop the ability to provide training within North Carolina.

POST-CONVICTION SUBSTANCE ABUSE TREATMENT PROGRAMS

SECTION 4.4. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services the sum of four million eighty thousand dollars ($4,080,000) for the 2007-2008 fiscal year and the sum of eight million one hundred sixty thousand dollars ($8,160,000) for the 2008-2009 fiscal year. The funds shall be used to increase the number of TASC (Treatment Alternative for Safer Communities) case managers by sixty-eight per year.

SECTION 4.5 There is appropriated from the General Fund to the Department of Correction the sum of one million four hundred twelve thousand, forty-eight dollars ($1,412,048) for the 2007-2008 fiscal year, and the sum of one million one hundred sixty-seven thousand six hundred forty-seven dollars ($1,167,647) for the 2008-2009 fiscal year. These funds shall be used to establish a community-based residential substance abuse treatment facility for female offenders on probation and female DWI offenders paroled to treatment. The facility shall provide thirty 90-day therapeutic beds and twenty 28-day short term treatment beds.

PART V. USE OF MENTAL HEALTH TRUST FUNDS

SECTION 5.1. Funds remaining in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs that are not obligated as of February 1, 2007, may only be obligated to provide community-based programs. Any funds not obligated as of February 1, 2007 and not subsequently obligated to provide community-based programs shall be deemed to be unencumbered and shall be allocated to local management entities (LMEs) such that each LME receives a percentage of the total allocation that is equal to that local management entity's percentage of the State's total population that is below the federal poverty level. DHHS shall distribute the funds no later than 30 days after the enactment of the Current Operations and Capital Appropriations Act for the 2007-2009 biennium.

SECTION 5.2. Effective July 1, 2007, G.S. 143C-9-2 reads as rewritten:

"**§ 143C-9-2. Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs.**

(a) The Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs is established as an interest-bearing, nonreverting special trust fund in the Office of State Budget and

Management. Moneys in the Trust Fund shall be held in trust and used solely to increase community-based services that meet the mental health, developmental disabilities, and substance abuse services needs of the State. The Trust Fund shall be used to supplement and not to supplant or replace existing State and local funding available to meet the mental health, developmental disabilities, and substance abuse services needs of the State.

The State Treasurer shall hold the Trust Fund separate and apart from all other moneys, funds, and accounts. The State Treasurer shall be the custodian of the Trust Fund and shall invest its assets in accordance with G.S. 147-69.2 and G.S. 147-69.3. Investment earnings credited to the assets of the Trust Fund shall become part of the Trust Fund. Any balance remaining in the Trust Fund at the end of any fiscal year shall be carried forward in the Trust Fund for the next succeeding fiscal year.

Moneys in the Trust Fund shall be expended only in accordance with subsection (b) of this section and in accordance with limitations and directions enacted by the General Assembly.

(b) Moneys in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs shall be used only to:

(1) Provide start-up funds and operating support for programs and services that provide more appropriate and cost-effective community treatment alternatives for individuals currently residing in the State's mental health, developmental disabilities, and substance abuse services institutions.

(2) Facilitate the State's compliance with the United States Supreme Court decision in Olmstead v. L.C. and E.W.

(3) ~~Facilitate reform of the mental health, developmental disabilities, and substance abuse services system and expand~~ Expand and enhance mental health, developmental disabilities, and substance abuse treatment and prevention services ~~in these program areas~~ in the community to remove waiting lists and provide appropriate and safe services for clients.

(4) Provide bridge funding to maintain appropriate client services during transitional periods as a result of facility closings, including departmental restructuring of services.

~~(5) Construct, repair, and renovate State mental health, developmental disabilities, and substance abuse services facilities.~~

(c) Notwithstanding G.S. 143C-1-2, any nonrecurring savings in State appropriations realized from the closure of any State psychiatric hospitals that are in excess of the cost of operating and maintaining a new State psychiatric hospital shall not revert to the General Fund but shall be placed in the Trust Fund and shall be used for the purposes authorized in this section. Notwithstanding G.S. 143C-1-2, recurring savings realized from the closure of any State psychiatric hospitals shall not revert to the General Fund but shall be credited to the Department of Health and Human Services to be used only for the purposes of subsections (b)(1), (b)(2) and (b)(3) of this section.

(d) Beginning July 1, 2007, the Secretary of the Department of Health and Human Services shall report annually to the Fiscal Research Division on the expenditures made during the preceding fiscal year from the Trust Fund. The report shall identify each expenditure by recipient and purpose, shall indicate the authority under subsection (b) of this section for the expenditure."

PART VI. STRENGTHEN THE SERVICES NETWORK

SECTION 6.1. The Department of Health and Human Services shall designate four additional local management entities to receive all State allocations through single stream funding. If DHHS has not made the designations by June 1, 2007, then the General Assembly shall make the designations.

SECTION 6.2. No later than June 1, 2007, the Department of Health and Human Services shall commend the process for three additional local management entities to apply for a 1915(b) Medicaid waiver.

SECTION 6.3. The Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities and Substance Abuse Services shall study the effectiveness of the 1915(b) Medicaid waiver and of those LMEs operating under a waiver.

PART VII. FILLING SERVICE GAPS

ADDITIONAL MENTAL HEALTH SERVICES

SECTION 7.1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the sum of thirty million dollars ($30,000,000) for the 2007-2008 fiscal year, and the sum of thirty million dollars ($30,000,000) for the 2008-2009 fiscal year. The funds shall be used to purchase mental health services. Funds appropriated in this Section shall be allocated to local management entities (LMEs) such that each LME receives a percentage of the total allocation that is equal to that local management entity's percentage of the State's total population that is below the federal poverty level.

ADDITIONAL SERVICES FOR THE DEVELOPMENTALLY DISABLED

SECTION 7.2. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the sum of nine million nine hundred thousand dollars ($9,900,000) for the 2007-2008 fiscal year and the sum of nine million nine hundred thousand dollars ($9,900,000) for the 2008-2009 fiscal year. The funds shall be used to increase the number of individuals who can participate in the Community Alternatives Program for Mental Retardation/Developmental Disabilities (CAP MR/DD).

SECTION 7.3. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the sum of seven million dollars

($7,000,000) for the 2007-2008 fiscal year and the sum of seven million dollars ($7,000,000) for the 2008-2009 fiscal year. The funds shall be used to for start-up and ongoing support of Supported Employment Long-Term Support services.

SECTION 7.4. Beginning July 1, 2007, Developmental Therapies services shall only be available to individuals who were receiving that service on June 30, 2007. Developmental Therapy funds that are not utilized shall be made available to LMEs to use for CAP MR/DD slots or for other Supported Employment Long-Term Support services for the developmentally disabled. An LME that receives all its State appropriated allocations through a grant basis shall also receive its Developmental Therapies allocation on the same basis.

The Department of Health and Human Services shall develop a new, Medicaid reimbursable service for submission to the Center for Medicare and Medicaid Services to replace Developmental Therapies no later than November 1, 2007.

SECTION 7.5. The Department of Health and Human Services shall develop and apply to the Centers for Medicare and Medicaid Services for additional home and community-based waivers for persons with developmental disabilities. In conjunction with the existing CAP MR/DD waiver, the new waivers will create a tiered system of services.

COMMUNITY SUPPORT SERVICES/ TIERED RATE STRUCTURE

SECTION 7.6. The Department of Health and Human Services shall establish at least three rate tiers for the service of Community Supports. The rates shall be based upon the level of qualifications of the individuals delivering the service and shall include a professional-level case management tier, a professional-level skill building tier, and a paraprofessional-level tier.

PART VIII. LME ADMINISTRATIVE FUNDING

SECTION 8.1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the sum of nineteen million two hundred thousand dollars ($19,200,000) for the 2007-2008 fiscal year and the sum of nineteen million two hundred thousand dollars ($19,200,000) for the 2008-2009 fiscal year to be used to fully fund the LME administrative cost model developed by the Division pursuant to S.L. 2006-66, Sec. 10.32.(b).

Based upon information provided to the General Assembly by the Division, it is the understanding of the General Assembly that the funds appropriated under this Section in addition to the funds contained in the Governor's Base Budget proposal are sufficient to fully fund the State's contribution for LME systems administration as determined by the LME administrative cost model developed under S.L. 2006-66, Sec. 10.32.(b). Notwithstanding any provision in Chapter 143C of the General Statutes or any other provision of law, the Secretary shall not transfer funds from any other fund code or program category within DHHS to fund LME system administration.

SECTION 8.2. The General Assembly finds that counties have budgeted almost one hundred twenty-one million dollars ($121,000,000) to LMEs to pay for mental health, developmental disabilities and substance abuse services. However, the General Assembly lacks information regarding the specific services that are purchased with those county funds. The General Assembly also lacks data regarding the incomes of persons receiving mental health, developmental disabilities and substance abuse services that are paid for by either State or county funds. This lack of data severely limits the General Assembly's ability to determine the distribution of services that are being paid for with public funds, whether persons who are eligible for Medicaid are being enrolled in that program, and whether expanding the State's Medicaid eligibility criteria would impact a significant number of mental health, developmental disabilities and substance abuse service consumers. Therefore, LMEs shall report to the Division all expenditures by the LME for services, start-up expenses, and capital and operational expenditures, regardless of the source of the funds and regardless of whether the funds were earned on a payment for service or grant basis. This reporting shall include specific information regarding the expenditure of all funds provided to the LME by the county or counties contained in the LME's catchment area. To the extent possible, the information shall be submitted through the Integrated Payment and Reimbursement System. LMEs shall also gather income data for all individuals receiving services. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the sum of one million seven hundred thousand dollars ($1,700,000) for the 2007-2008 fiscal year and the sum of one million seven hundred thousand dollars ($1,700,000) for the 2008-2009 fiscal year to be used by LMEs to pay for the cost of the additional data reporting required under this Section..

PART IX. EFFECTIVE DATE

SECTION 9.1. This act becomes effective July 1, 2007.

LEGISLATIVE PROPOSAL #2

UNIFORM SLIDING FEES

LEGISLATIVE PROPOSAL #2

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SA
TO THE 2007 GENERAL ASSEMBLY

AN ACT TO CREATE A UNIFORM SLIDING FEE SCHEDULE FOR MH/DD/SA SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Short Title: **Uniform Sliding Fees – MH/DD/SA Services**

Brief Overview: This bill would:

1. Direct the Secretary to adopt rules to set a uniform sliding fee schedule. The fee schedule shall apply to all services paid for with either State of local funds. Private providers will be required to utilize the schedule. Amend G.S. 122C-146 accordingly.

2. Direct DHHS to identify all services that do not have income-related eligibility requirements.

Effective Date: This bill would become effective when it becomes law and apply to services provided on or after the fee schedule is adopted.

A copy of the proposed legislation begins on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U **D**

BILL DRAFT 2007-RCfz-5 [v.3] (02/23)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/2/2007 1:47:55 PM

Short Title:	Uniform Sliding Fees - MH/DD/SA Services.	(Public)
Sponsors:	.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO CREATE A UNIFORM SLIDING FEE SCHEDULE FOR MH/DD/SA SERVICES AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-146 reads as rewritten:

"**§ 122C-146. Fee for service.**

(a) The ~~area authority~~LME and its contractual provider agencies shall ~~prepare fee schedules~~ implement the standardized fee schedule and sliding fee schedule adopted by the Secretary ~~for services and~~ under G.S. 122C-112.1(a). The LME and its contractual provider agencies shall also make every reasonable effort to collect appropriate reimbursement for costs in providing these services from individuals or entities able to pay, including insurance and third-party ~~payment, except that individuals~~ However, no individual may be refused services because of an inability to pay.

(b) Individuals may not be charged for free services, as required in "The Amendments to the Education of the Handicapped Act", P.L. 99-457, provided to eligible infants and toddlers and their families. This exemption from charges does not exempt insurers or other third-party payors from being charged for payment for these services, if the person who is legally responsible for any eligible infant or toddler is first advised that the person may or may not grant permission for the insurer or other payor to be billed for the free services. ~~However, no individual may be refused services because of an inability to pay.~~

(c) All funds collected from fees from ~~area authority~~LME operated services shall be used for the fiscal operation or capital improvements of the ~~area authority's~~LME's

programs. The collection of fees by an ~~area authority~~LME may not be used as justification for reduction or replacement of the budgeted commitment of local tax revenue. All funds collected from fees by contractual provider agencies shall be used to provide services to individuals in targeted populations."

SECTION 2. 122C-112.1(a) is amended by adding a new subdivision to read:

"**§ 122C-112.1. Powers and duties of the Secretary.**

(a) The Secretary shall do all of the following:

. . .

(34) Adopt rules to implement a standard fee schedule and sliding fee schedule to be used by LMEs and by contractual provider agencies under G.S. 122C-146."

SECTION 3. The Secretary of the Department of Health and Human Services shall identify all services that are funded by or through the Department's budget and that do not require income-based criteria in order for an individual to be eligible to receive the service. The Secretary shall develop a proposal for implementing income-based criteria for eligibility for those programs and shall submit the proposal to the General Assembly and the Fiscal Research Division by November 1, 2007.

SECTION 4. This act is effective when it becomes law and applies to services provided on or after the effective date of the rules adopted by the Secretary under Section 2 of this act.

LEGISLATIVE PROPOSAL #3

EXTEND PILOT/CLARIFY LME FUNCTIONS

LEGISLATIVE PROPOSAL #3

A RECOMMENDATION OF THE LEGISLATIVE OVERSIGHT COMMITTEE FOR MH/DD/SA
TO THE 2007 GENERAL ASSEMBLY

AN ACT TO EXTEND THE FIRST COMMITMENT PILOT PROGRAM AND TO FURTHER CLARIFY LME CORE FUNCTIONS, AND TO ALLOW ADDITIONAL TIME FOR AN LME TO MERGE WHEN IT HAS GONE BELOW THE 200,000 POPULATION OR SIX COUNTY THRESHOLD DUE TO A CHANGE IN COUNTY MEMBERSHIP AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

Short Title: Extend Pilot/Clarify LME Functions – MH/DD/SA
Brief Overview: This bill would:

1. **First Commitment Pilot Program –** Reauthorizes the pilot program and adds five additional LMEs.

2. **Clarify Screening/Triage/Referral Rolls** – Amends G.S. 122C-115.4(b) to clarify that only LMEs are authorized to conduct the core LME functions.

3. **LME Size Requirements** – Amends G.S. 122C-115(a1) to allow that an LME that does not comply with the catchment area requirements because of a change in county membership has 12 months from the effective date of the change to comply with LME size requirements.

Effective Date: The act would be effective when it becomes law.

A copy of the proposed legislation begins on the next page

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

U **D**

BILL DRAFT 2007-RCz-6 [v.6] (02/23)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
3/7/2007 3:51:58 PM

Short Title: Extend Pilot/Clarify LME Functions/LME Admin. (Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO EXTEND THE FIRST COMMITMENT PILOT PROGRAM, TO FURTHER CLARIFY LME CORE FUNCTIONS AND TO ALLOW ADDITIONAL TIME FOR AN LME TO MERGE WHEN IT HAS GONE BELOW THE 200,000 POPULATION OR SIX COUNTY THRESHOLD DUE TO A CHANGE IN COUNTY MEMBERSHIP AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a). S.L. 2003-178, as amended by S.L. 2006-66, Section 10.27, reads as rewritten:

"**SECTION 1.** The Secretary of Health and Human Services may, upon request of ~~a phase-one local management entity~~a LME, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from ~~a phase-one local management entity~~an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the ~~local management entity~~LME shall ~~be submitted as part of the entity's local business plan and shall~~ specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the ~~local management entity~~LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver. The Secretary shall send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substances Abuse Services ~~on or before July 1, 2006.~~ by October 1, 2009. The report shall include data gathered from all participating LMEs since the beginning of the pilot.

(4) The waiver granted by the Secretary under this section shall be in effect until October 1, ~~2007.~~ 2010.

(5) The Secretary may grant a waiver under this section to up to ~~five~~ ten ~~local management entities that have been designated as phase one entities as of July 1, 2003.~~LMEs

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver. The Department shall involve stakeholders including, but not limited to, the North Carolina Psychiatric Association, The North Carolina Nurses Association, National Association of Social Workers, The North Carolina Substance Abuse Professional Certification Board, North Carolina Psychological Association, The North Carolina Society for Clinical Social Work, and the North Carolina Medical Society in developing required staff competencies.

(8) The ~~local management entity~~LME shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

SECTION 2. This act becomes effective July 1, 2003, and expires October 1, ~~2007.~~ 2010."

SECTION 1.(b). The Joint Legislative Oversight Committee for Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) shall review the report submitted by the Secretary under S.L. 2003-178, as amended by S.L. 2006-66, Section 10.27 and Section 1.(b) of this act. The LOC shall make recommendations to the 2011 General Assembly regarding whether to further extend the pilot or make it permanent and state wide.

SECTION 2. G.S. 122C-115.4 reads as rewritten

"**§ 122C-115.4. Functions of local management entities.**

(a) Local management entities are responsible for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.

(b) The primary functions of an LME are designated in this subsection and shall not be conducted by any other entity unless an LME voluntarily enters into a contract with that entity under subsection (c) of this section. The primary functions include all of the following:

(1) Access for all citizens to the core services described in G.S. 122C-2. In particular, this shall include the implementation of a 24-hour a day, seven-day a week screening, triage, and referral process and a uniform portal of entry into care.

(2) Provider endorsement, monitoring, technical assistance, capacity development, and quality control. An LME may remove a provider's endorsement if a provider fails to meet defined quality criteria or fails to provide required data to the LME.

(3) Utilization management, utilization review, and determination of the appropriate level and intensity of services including the review and approval of the person centered plans for consumers who receive State-funded services. Concurrent review of person centered plans for all consumers in the LME's catchment area who receive Medicaid funded services.

(4) Authorization of the utilization of State psychiatric hospitals and other State facilities. Authorization of eligibility determination requests for recipients under a CAP-MR/DD waiver.

(5) Care coordination and quality management. This function includes the direct monitoring of the effectiveness of person centered plans. It also includes the initiation of and participation in the development of required modifications to the plans for high risk and high cost consumers in order to achieve better client outcomes or equivalent

outcomes in a more cost-effective manner. Monitoring effectiveness includes reviewing client outcomes data supplied by the provider, direct contact with consumers, and review of consumer charts.

(6) Community collaboration and consumer affairs including a process to protect consumer rights, an appeals process, and support of an effective consumer and family advisory committee.

(7) Financial management and accountability for the use of State and local funds and information management for the delivery of publicly funded services.

(c) Subject to subsection (b) of this section and all applicable State and federal laws and rules established by the Secretary, an ~~area authority, or county program or consolidated human services agency~~ LME may contract with a public or private entity for the implementation of LME functions ~~articulated~~ designated under subsection (b) of this section. Nothing in this subsection shall be construed to supercede the authority of an LME to be the sole entity with the authority to implement the functions designated in subsection (b) of this section.

(d) Except as provided in G.S. 122C-142.1 and G.S. 122C-125, the Secretary may not remove from an LME or designate another entity as also eligible to implement any function enumerated under subsection (b) of this section unless all of the following applies:

(1) The LME fails during the previous three months to achieve a satisfactory outcome on any of the critical performance measures developed by the Secretary under G.S. 122C-112.1(33).

(2) The Secretary provides focused technical assistance to the LME in the implementation of the function. The assistance shall continue for at least six months or until the LME achieves a satisfactory outcome on the performance measure, whichever occurs first.

(3) If, after six months of receiving technical assistance from the Secretary, the LME still fails to achieve or maintain a satisfactory outcome on the critical performance measure, the Secretary shall enter into a contract with another LME or agency to implement the function on behalf of the LME from which the function has been removed.

(e) Notwithstanding subsection (d) of this section, in the case of serious financial mismanagement or serious regulatory noncompliance, the Secretary may temporarily remove an LME function after consultation with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(f) The Commission shall adopt rules regarding the following matters:

(1) The definition of a high risk consumer. Until such time as the Commission adopts a rule under this subdivision, a high risk consumer means a person who has been assessed as needing emergent crisis services three or more times in the previous 12 months.

(2) The definition of a high cost consumer. Until such time as the Commission adopts a rule under this subdivision, a high cost consumer means a person whose treatment plan is expected to incur costs in the top twenty percent (20%) of expenditures for all consumers in a disability group.

(3) The notice and procedural requirements for removing one or more LME functions under subsection (d) of this section."

SECTION 3. G.S. 122C-115(a1) reads as rewritten:

"(a1) Effective July 1, 2007, ~~The~~ the Department of Health and Human Services shall reduce by ten percent (10%) annually the administrative funding for ~~area authorities and county programs~~ LMEs that do not comply with the catchment area requirements of ~~this section.~~subsection (a) of this section. However, an LME that does not comply with the catchment area requirements because of a change in county membership shall have twelve months from the effective date of the change to comply with subsection (a) of this section."

SECTION 4. This act is effective when it becomes law.