MINUTES

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

November 9, 2010
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, November 9, 2010 in Room 643 of the Legislative Office Building. Members present were Representative Verla Insko, Co-Chair; Senators Bob Atwater, Charlie Dannelly, Ellie Kinnaird, and William Purcell, and Representatives Jeff Barnhart, Jean Farmer-Butterfield, Beverly Earle, and Fred Steen. Advisory members Senator Larry Shaw and Representative William Brisson were present. Also in attendance were: Representatives Hugh Blackwell, Pat Hurley and Deborah Ross.

Lisa Hollowell, Joyce Jones, Shawn Parker, Jan Paul, Susan Barham, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the October 13, 2010 meeting. The motion was made by Senator Dannelly and the minutes were approved.

Lanier Cansler, Secretary of the Department of Health and Human Services provided an overview of the budget for DHHS for FY 2010-2011 and explained the challenges faced by the Department. (See Attachment No. 2) Points of interest included:

- DHHS is currently spending $20M more than is budgeted to operate the State facilities. Increasing costs to operate the facilities over time caused a larger deficit. Funds from other budget lines were used to cover these costs.
- Reducing the overall cost in the facilities will still leave DHHS $15M above budget. Right now, those additional funds are coming out of funds that would normally go to community mental health services.
- Administrative cost equals 7% of the overall budget.
- Optional services for adults have the most flexibility to make changes in Medicaid.
- Almost 80% of the budget consists of Federal funds. Seventy-nine percent of the DHHS appropriation is used to draw down those Federal funds.

Secretary Cansler introduced Dr. Nena Lekwauwa as the new Medical Director for DMH/DD/SAS.

Secretary Cansler then addressed the plan for the closure of Dorothea Dix Hospital. (See Attachment No. 3) He noted that DHHS was following the statutory requirements for

providing a plan of closure for the upcoming legislative session. He said the goal was to minimize the negative impact on the mental health system. The savings from the closure should be about $16M. Secretary Cansler emphasized the fact that the number of beds would not be reduced; the beds would be moved to other locations and Broughton Hospital would have 12 additional beds. Comments regarding the closing of Dorothea Dix included:

- The more difficult patients will be housed at Central Regional Hospital (CRH).
- The report describes what is being done regarding cost reduction measures; the plan for moving forward in the future; the plan to maintain services; and opportunities offered to the employees at the facilities.
- If legislation reverses the plan for the closure of Dix Hospital, an appropriation would be needed in order to not have the money come from community services.

Secretary Cansler said the expansion of the b-c waiver program was moving slowly due to the difficult, complex process. Two areas interested are Mecklenburg County, which has requested a delay for one year and Western Highlands. Smoky Mountain Center is interested and there are other LMEs that wish to work with PBH.

Kelly Crosbie, Behavioral Health Manager with DHHS provided the expenditures and utilization tracking update. (See Attachment No. 4) She reviewed data collected regarding children's services (community support, intensive in-home and multisystemic therapy and day treatment), adult services (community support, community support team, assertive community treatment team and psychosocial rehabilitation), and children and adult services (substance abuse intensive outpatient, mobile crisis and I/DD targeted case management). All community support service data shows a reduction in expenditures and service recipients in anticipation of the phase out of this service. Ms. Crosbie was asked what would happen to the appeals for those receiving services under Community Support-Child. She responded that there were appeals that would have to be finished but as of January 1, 2011, there would no longer be an appealable service.

Mike Kupecki, Assistant Area Director of East Coast Behavioral Health opened the presentation on Treatment Accountability for Safer Communities (TASC) by providing a brief history of the organization. (See Attachment No. 5)

- TASC first began in North Carolina in 1978. By 1993, TASC was in 10 of the old area programs that served 20 counties. By 1998, TASC had expanded to 23 of the 44 area programs serving 44 counties. In 2000, four area service programs were established across the State to provide economies of scale and statewide access to services.
- Services are available in all 100 counties and organized into 4 regions. TASC is administered through two LMEs; East Coast Behavioral Health administers Regions 1 and 2 through a contract with Coastal Horizons Center, and Western Highlands administers Regions 3 and 4 through a contract with Partnership for a Drug Free NC.
- The role of the LME is to prepare and disseminate the RFP, select providers, develop and administer the contract, to provide financial and programmatic oversight of the program and to be the liaison with the other 23 LMEs.

Michael Gray, Vice President of Region 3 TASC, Partnership for Drug Free NC, described what TASC is and what TASC does. Comments of interest included:

- The TASC mission is to work with individuals with behavioral health issues involved in the criminal justice system. TASC is the link between the courts and the treatment agencies to help individuals access treatment.
- After developing a person-centered plan, TASC works with community agencies and LMEs to develop a network of services appropriate for the clients.
- A standard Memorandum of Agreement ensures that all the agencies involved are working together with the offender with one plan and one common goal to make that individual successful throughout the program.

Next, Karen Chapple, Executive Vice President of Coastal Horizons Center, provided an overview of the demographics of the clients served, and their risks and needs. She said that Coastal Horizons operates TASC services in 53 counties in North Carolina. Items of interest included:

- Statistics indicate that 68% of probationers in North Carolina have a substance abuse disorder which is in keeping with the national average.
- Over the last 10 years, TASC went from serving 8,000 clients in 2001-2002, to over 17,000 in 2008-2009. Statistics shows that 88% of clients are either divorced, widowed, or have never married. In recovery, relationships are very important. TASC received 22,000 referrals from either probation or the court systems. Those that do not have a substance abuse disorder or mental health issue are screened and sent to another service.
- The number one drug used is marijuana. However, most of the clients are poly drug users.

A TASC client, by the name of Rose provided her personal story and described how TASC was a critical part of her recovery. She said that she had been drug free for 8 years, had completed school, and was working to become a councilor herself.

Lisa Hollowell from Fiscal Research provided an introduction to the 3 Way contracts update by Mike Watson, Deputy Secretary for DHHS. The Contracts with local hospitals, LME's, and DHHS for the purchase of the community psychiatric beds have been funded for three years; with the legislature increasing the current year's funding by $9M in the budget bill for a total appropriation of $29.1 million.

Today's presentation is a report to the Committee on the number of bed contracts, the cost, the location of these community beds, and methodology for determining the allocation of beds. The direction provided by the legislature is that the "The Department shall work to ensure that these contracts are awarded equitably around all regions of the State". For the past two years this Committee has supported this effort and has included in its report proposed increases.

Mr. Watson said the 3 way contract was in its third year and had been extraordinarily successful in the effort to increase capacity for inpatient psychiatric treatment. (See Attachment No. 6) Points made by Mr. Watson included these:

- The bundled rate paid to the hospitals of $750 per day includes: the daily charge - generally the Medicaid rate; the cost of psychiatric care; and the cost of medication upon the discharge of the patient. The State hospitals charge $1100-$1200 per day. (Note: Not always exactly the same patients.)
- The total available funding for FY 09-10 were State dollars designated towards non-Medicaid consumers. Children are billed through Medicaid and Medicare is billed for older adults.
- With the requirement for CABHAs to have medical directors and the expansion of the contracts across the State there has become a joint demand for psychiatric service. Therefore, there has been an increase in the number of psychiatrists coming back into the State and into the communities.
- 3 Way contracts support consumers by getting treatment closer to home, helping individuals to transition back into the community, help the ERs function better, and help law enforcement deal with seriously mentally ill adults.

Mr. Watson said there was still concern across the State regarding the waiting time in the ERs. Representative Insko said that before the State was paying for local psychiatric beds, there were 22 LMEs that had arrangements with their local hospitals to take psychiatric patients. Those hospitals now want to be paid as the others creating the danger of those beds being lost if the State does not pay. Mr. Watson said that a number of LMEs put their own state dollars into local in-patient contracts in addition to the 3 Way contracts. So, there is an additional $13-$14M going into those contracts. Representative Insko asked with the reduced number of short-term admissions at the State hospitals, how many of those people are now going to the ERs that are not admitted to local beds? Mr. Watson responded that the information would be difficult to find but that Mobile Crisis Teams go into the ER and where people are stable, try to move them back into the community.

Representative Insko then recognized members of the audience, who had signed up previously, to come forward for the public comment period. Concerns expressed by the audience included:

- Legislators need to prepare a bill to save Dorothea Dix Hospital so it can continue to serve those with mental illness.
- People should be carefully diagnosed to see if they really need to be hospitalized. Access to the right service at the level of need would prevent the need for additional hospital beds. Look at ways to prevent hospitalization. Put more money into services and less money towards hospitals.
- Transporting patients is too time consuming and costly for law enforcement.

Steve Jordan, Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services provided a cost analysis and comparison of the ICF-MR and CAP/MR-DD services. (See Attachment No. 7) Points of interest included:

- Developmental Center - If an individual accepts waiver services, they are waiving the right to enter an ICF-MR. The Murdoch Center does "need determination" on all ICF-MR recipients in the State.
- The services in the facilities are more comprehensive than in the community ICF-MR and in the CAP/MR-DD waiver.
- The 2 group homes for the PATH program (for children with autism and severe behavior disorders) are not housed on the Murdoch campus but rather are State facility- operated programs located in the community (Franklin County and Granville County.)
- People in the DD Centers are older and more disabled that those in community ICFs-MR and those served by CAP-MR/DD funds: – 70% are 45 years or older; over 70% have profound I/DD; 50% have seizure disorders; 65% require partial to total assistance with feeding – with 13% of those on feeding tubes; 75% need partial to total assistance with dressing; and 85% are non verbal and have limited ability to communicate.
- Community ICF/MR-DD: – In the 1990s there was established a moratorium on the development of new ICF-MR/DD beds. The moratorium is managed through the Certificate of Need process operated by the Division of Health Services Regulation; there must be a needs assessment approved to show that there is a need for more ICF-MR beds in the community, and letters of support are required from the DHHS, the Division and the LME.
- Pharmacy and dental services are covered by the regular Medicaid state plan dollars in the community ICFs-MR and CAP-MR/DD. The DD Centers offer both of these services as part of their ICF-MR daily rate.
- CAP-MR/DD – Home Supports are provided by a family member who is reimbursed for providing the treatment to their adult child while living in their home. Residential Services are 3-4 bed group homes which offer alternative family living. Room and board are covered by Social Security Disability and Supplemental Support. CAP-MR/DD funding is not available to cover room and board.
- 50% of the total Medicaid and State matched dollars in NC goes to funding support for ICF-MRs.
- Some states are closing large facilities moving to smaller facilities at the community level doing away with large 16 – 300 bed facilities. More information was requested on how the more seriously ill are managed by the states that have done away with ICFs-MR.
- All costs are covered by the rate at the DD Centers and most are covered in the community ICF-MRs. However, the DD Centers have a medical care unit. Those not residing in the DD Centers go to local hospitals but those costs are covered by the Medicaid state plan, not the ICF-MR rate.

Mr. Jordan was asked if there were any facilities in North Carolina with more than 100 beds. He replied that he did not believe so and would get the figures requested. Subsequently, Mr. Jordan acknowledged that there were such community ICF-MR facilities in the state and that several of these housed young children. Representative Insko asked when DHHS brings a proposal for self-direction and the addition of other

Tiers, would the appropriation request include the additional administrative costs that are a part of self-direction. Rose Burnette said the additional cost currently is through Medicaid administrative funds but she was not sure about where the funds would be located in the state budget in the future. She suggested that the question needed to be addressed to DMA regarding the proposal.

Joyce Jones from Bill Drafting provided an introduction to the overview of the DD Waiting List by Rose Burnette, DD Project Manager for DHHS. She reminded members that Session Law 2009-186 required the Department to improve supports for persons with developmental disabilities by creating a statewide data collection system containing waiting list information collected regularly and obtained annually from each LME. The Department is charged with establishing standardized criteria to be used by LMEs to ensure that the processes for collecting waiting list data are consistent across LMEs. Applying the standardized criteria, the LMEs are to develop and maintain a waiting list for persons with developmental disabilities who are:

- Waiting for residential services;
- Potentially eligible for CAP-MR/DD;
- In need of other State-funded services and supports for people with DD.

The Department was asked to update the Committee on the statewide DD waiting list data system.

Ms. Burnette explained that the presentation which was prepared for last month's meeting includes information on the DD Waiting List and the Tiered Waivers. (See Attachment No. 8) Additional points in her presentation included:

- The Supports Waiver is intended for those with a low level of need. The annual allowable expenditure is $17,500.
- The Comprehensive Waiver is intended for those with more extensive needs. The maximum cost limit currently is $17,501 - $135,000 per person, per year.
- For the Supports Waiver, one vendor was selected for the Financial Management Service Agency. The vendor will manage CAP- MR/DD; CAP-DA –a CAP Medicaid program for aging individuals with disabilities, and individuals who receive services within the aging and long-term care community. DMA will manage the contract.
- Major revisions to the Comprehensive Waiver will design services to meet the specific levels of intensity of need of individuals.
- The new Community Intensive Waiver is designed to meet the needs of those with the highest medical and behavioral supports needs.
- A survey of stakeholders regarding the CAP-MR/DD Waivers indicate that most are satisfied with the waiver and request that there not be any big changes.
- DHHS hopes to submit the waivers to CMS by March or April of next year. The current waivers expire 11/1/11.

Ms. Burnette was asked to provide members the cost per person, per month for Case Management. Comments were directed to DHHS regarding the extra cost in the use of SNAP and SIS for assessments. Evidence shows the current way the DD population is

measured does not correlate with each person's intensity of need. SIS would help bring the need in line with the cost. It was suggested that this may be a policy issue and it requires further review and consideration.

Continuing, Ms. Burnette made several points regarding the waiting list.

- Short Term solutions – spreadsheet was created with the LMEs, and the waiting list work group which included multiple stakeholders. Comprehensive data submitted the end of July suggests a substantial number of persons waiting for service are potentially eligible for CAP-MR/DD funding.
- Long Term solutions – look at other options beyond the spreadsheet. The spreadsheet can give duplicate information and count people multiple times-making it problematic if the results were to be used for program and budget planning.
- Residential Supports - Of the 5,481 waiting for Residential services, 669 are receiving some services. The other individuals are not receiving any services. There are 1,785 people waiting for support in order to work. Of those, 208 are receiving some other services, the other are receiving no services.
- A case manager can authorize emergency services in a crisis situation while the person centered plan is going through the authorization process.
- In January 2011, Value Options will not longer be doing the utilization review for CAP-MR/DD funded individuals. This responsibility is being transferred to the LMEs. Nine LMEs submitted applications indicating an interest in becoming a Utilization Review vendor for CAP-MR/DD. Of those nine, Eastpointe and Durham have been approved and 2 additional LMEs were selected, Pathways and Crossroads. The LMEs selected to provide UR for CAP-MR/DD will work with the 7 LMEs not selected to cover the service as well as the other LMEs who must depend on the 4 selected LMEs to manage utilization management for all CAP-MR/DD recipients. Ms. Burnette acknowledged that a great deal of training and support will be required of the Division prior to January, 2011.

There being no further business, the meeting adjourned at 2:35 PM.

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

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Rennie Hobby, Committee Assistant