GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H **D**

HOUSE BILL 576
PROPOSED COMMITTEE SUBSTITUTE H576-PCS80233-SQ-9

Short Title: Remove Endorsement for Denied Access LME. (Public)

Sponsors:

Referred to:

March 16, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE LOCAL MANAGEMENT ENTITIES TO REMOVE A PROVIDER'S ENDORSEMENT FOR FAILING TO ALLOW ACCESS FOR MONITORING PURPOSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-115.4(b) reads as rewritten:

"(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 and administrative functions 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, fails to adequately document the provision of services, fails to provide required staff training, or fails to provide required data to the LME.~~provider:

a. Fails to meet defined quality criteria.

b. Fails to adequately document the provision of services.

c. Fails to provide required staff training.

d. Fails to provide required data to the LME.

e. Fails to allow the LME access for monitoring in accordance with rules established under G.S. 143B-139.1.

If at anytime the LME has reasonable cause to believe a violation of licensure rules has occurred, the LME shall make a referral to the Division of Health Service Regulation. If at anytime the LME has reasonable cause to believe the abuse, neglect, or exploitation of a client has occurred, the LME shall make a referral to the local Department of Social Services, Child Protective Services Program, or Adult Protective Services Program.

(3) Utilization management, utilization review, and determination of the appropriate level and intensity of services. An LME may participate in the development of person centered plans for any consumer and shall monitor the implementation of person centered plans. An LME shall review and

approve person centered plans for consumers who receive State-funded services and shall conduct concurrent reviews of person centered plans for 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 involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination is sometimes referred to as "care management." Care coordination shall be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, when necessary to link clients to higher levels of care quickly and efficiently, to facilitate the resolution of disagreements between providers and clinicians, and to consult with providers, clinicians, case managers, and utilization reviewers. Care coordination activities for high-risk/high-cost consumers or consumers at a critical treatment juncture include the following:

a. Assisting with the development of a single care plan for individual clients, including participating in child and family teams around the development of plans for children and adolescents.
b. Addressing difficult situations for clients or providers.
c. Consulting with providers regarding difficult or unusual care situations.
d. Ensuring that consumers are linked to primary care providers to address the consumer's physical health needs.
e. Coordinating client transitions from one service to another.
f. Conducting customer service interventions.
g. Assuring clients are given additional, fewer, or different services as client needs increase, lessen, or change.
h. Interfacing with utilization reviewers and case managers.
i. Providing leadership on the development and use of communication protocols.
j. Participating in the development of discharge plans for consumers being discharged from a State facility or other inpatient setting who have not been previously served in the community.

(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.

Subject to all applicable State and federal laws and rules established by the Secretary and the Commission, nothing in this subsection shall be construed to preempt or supersede the regulatory or licensing authority of other State or local departments or divisions."

SECTION 2. This act is effective when it becomes law.