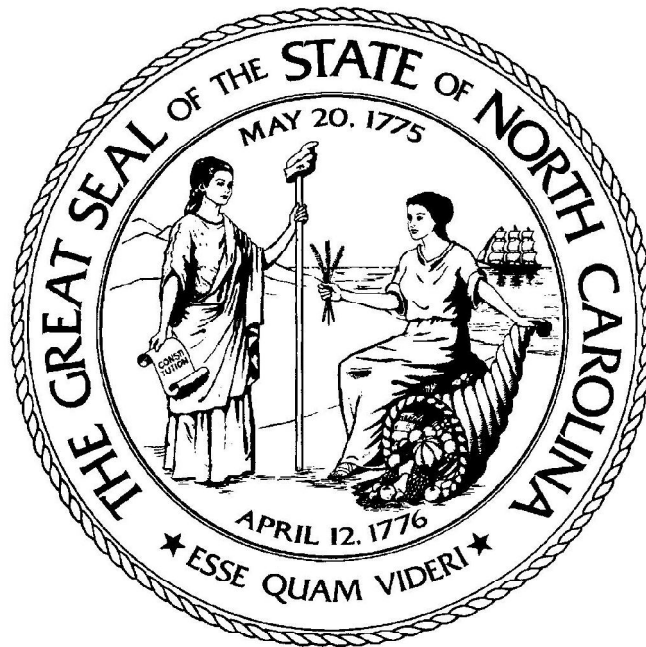


**JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON
MENTAL HEALTH, DEVELOPMENTAL DISABILITIES,
AND SUBSTANCE ABUSE SERVICES**



**REPORT TO THE 2010 REGULAR SESSION
OF THE
2009 GENERAL ASSEMBLY**

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**JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES
State Legislative Building
Raleigh, North Carolina 27601**

Senator Martin Nesbitt, Co-Chair

Representative Verla Insko, Co-Chair

May 6, 2010

TO THE MEMBERS OF THE 2009 GENERAL ASSEMBLY:

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services submits this report for your consideration.

Respectfully,

Sen. Martin Nesbitt, Co-Chair

Rep. Verla Insko, 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 continually examining system-wide issues that affect the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues related to governance, accountability and service quality.

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 members of the Senate Committee on Appropriations, the Chair of the Senate Appropriations Committee on Human Resources, and at least two members of the minority party. The members appointed by the Speaker of the House must include all of the following: at least two members of the House Committee on Appropriations, the Co-Chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services, and at least two members of the minority party. Advisory members may also serve on the LOC. The Co-Chairs for 2009-2010 are Senator Martin Nesbitt and Representative Verla Insko.

COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) met nine times during the 2009-2010 interim. The LOC heard from the individuals listed below during the specified meeting dates. Detailed minutes and information from each LOC meeting are available in the Legislative Library.

September 23, 2009

- Lisa Hollowell, Fiscal Analyst, Fiscal Research Division and Shawn Parker, Legislative Analyst, Research Division provided an overview of 2009 legislative actions.
- Lanier Cansler, Secretary, Department of Health and Human Services, presented the Department of Health and Human Services response to budget cuts and enacted legislation from the 2009 Session.
- Dr. Craigan Gray, MD, Director, Division of Medical Assistance, Department of Health and Human Services, discussed the status of community support services.
- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, presented an overview for the transition of community support services.
- Lanier Cansler, Secretary, Department of Health and Human Services spoke briefly on the Department's organizational structure.

October 14, 2009

- Lanier Cansler, Secretary, Department of Health and Human Services provided an update on the budget reductions to the health care system required by the Legislature.
- Christina Carter, LCSW, Implementation Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on the transition of Level III and Level IV group homes across the State.

- Grace Crockett, Director, Mecklenburg Area Mental Health, discussed the impact on Local Management Entities (LMEs) of the Level III and Level IV group home transition.
- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, responded to concerns over Community Supports and discussed alternative services.
- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, addressed the expenditures of Community Supports as well as other mental health services within the Medicaid budget.
- Dr. Melissa Johnson, Ph.D., Wake County Young Child Mental Health Collaborative and Mecklenburg Infant Mental Health Collaborative, requested that the LOC consider funding a study by the North Carolina Institute of Medicine to determine mental health needs for young children and effective strategies for serving this population.
- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on the status of the Community Alternatives Program Supports and Comprehensive Waivers.
- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, discussed the consolidation of Case Management as directed by the General Assembly.

November 10, 2009

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, presented the Department's perspective on the Local Management Entities (LMEs) funding reductions.
- Rhett Melton, Director of Pathways LME, gave a presentation on budget reductions at the community level.
- Lanier Cansler, Secretary, Department of Health and Human Services, discussed Critical Access Behavioral Health Agencies ability to ensure flexibility for providers while still controlling costs.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, presented information about former Thomas S. class members including funding and services offered.
- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on the funding changes for Community Alternatives Program waivers.
- Curtis Venable, Pisgah Legal Services, discussed concerns about the mental health system.
- Kathy Crocker, State Consumer and Family Advisory Committee, presented the results of a survey sent to Local Consumer and Family Advisory Committees as well as recommendations for the Secretary of Health and Human Services and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
- Luckey Welsh, Director, Division of State Operated Healthcare Facilities, Department of Health and Human Services, discussed the organizational structure of the new Division and the State psychiatric hospitals.
- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, gave an update on local inpatient psychiatric community hospital contracts.
- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, addressed follow-up questions on Case Management from the October LOC meeting.

December 9, 2009

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, provided an update on Medicaid utilization and expenditures.
- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, addressed the Critical Access Behavioral Health Agency (CABHA) and the changes to provider qualifications.

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, provided a report on Community Support services with other enhanced services.
- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, responded to questions from the last LOC meeting regarding Case Management for people with developmental disabilities.
- Christina Carter, LCSW, Implementation Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, provided an update on Residential Level III and Level IV Group Homes and Private Psychiatric Residential Treatment Facilities (PRTF).
- Flo Stein, Chief, Community Policy Management of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, gave an update on substance abuse treatment and recovery – Cross Area Service Program (CASP).

January 13, 2010

- Barry Boardman, Fiscal Analyst, Fiscal Research Division, presented an overview of revenue projections.
- Lee Dixon, Fiscal Analyst, Fiscal Research Division, provided an update on the Medicaid budget shortfall.
- Dr. John Gilmore, M.D., Department of Psychiatry, University of North Carolina at Chapel Hill, discussed the Critical Access Behavioral Health Agencies model from the perspective of a psychiatrist.
- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, presented the system vision for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for the next two years.
- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, addressed follow-up questions on Critical Access Behavioral Health Agencies from the December LOC meeting.

- Mark O'Donnell, LME Liaison and Project Director for the First Evaluation Pilot Project, together with Dr. Nidu Menon, Director of Evaluation, Health and Wellness Trust Fund, provided an update on the First Commitment Pilot Project.
- Members of the audience were recognized for a period of public comment.

February 10, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided an update on various mental health issues.
- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, presented information on utilization and expenditures for: Community Supports Services, Targeted Case Management, Community Supports Team, and Intensive In-Home Services.
- Rose Burnette, DD Project Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, addressed plans for implementation of the Community Alternatives Program Supports and Comprehensive Waivers.
- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, discussed the establishment of the developmental disabilities waiting list.
- Dr. Craigan Gray, MD, Director, Division of Medical Assistance, Department of Health and Human Services, provided information on the demographics of recipients and providers participating in the Medicaid program.
- Michael Lancaster, Chief of Clinical Policy, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, reported on telemedicine, the outpatient commitment process, and mobile crisis teams.
- Christina Carter, LCSW, Implementation Manager, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, discussed the North Carolina

Systemic, Therapeutic, Assessment, Respite, and Treatment Program (NC-START).

- Luckey Welsh, Director, Division of State Operated Healthcare Facilities, Department of Health and Human Services, provided an update on Alcohol and Drug Abuse Treatment Centers (ADATCs).

March 10, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided a brief update on current issues related to funding programs within the Department.
- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, provided details on expanding the 1915(b)(c) Medicaid Waiver to other LMEs.
- Dan Coughlin, Area Director/CEO, PBH and Pam Shipman, Chief Operations Officer, PBH, gave a presentation on the 1915(b)(c) Medicaid Waiver from the LMEs perspective.
- Arthur Carder, CEO, Western Highlands Network; Jennifer Webe, Executive Director, Access II Care of Western North Carolina; and Dr. Richard Hudspeth, Medical Director, Access II Care of Western North Carolina, gave a presentation on Community Care of North Carolina (CCNC) and LME integrated care.
- Joel Corcoran, Director of the International Center for Clubhouse Development (ICCD), discussed the structure and services the Clubhouse model provides.
- Charlene Lee, Club Nova member, discussed the positive effect that Club Nova, an ICCD Certified Clubhouse model, has had on her life.
- Sue Estroff, Ph.D., Department of Social Medicine, School of Medicine, University of North Carolina at Chapel Hill, explained the need for a Clubhouse specific service definition.
- Rob Lamme, Consultant, former Director of Government Relations, Department of Health and Human Services, presented a proposal for the North Carolina Mental Health Policy and Practice Hub.

- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, reported on Case Management consolidation.
- Andrea Stevens, Services Task Team, State Consumer Family and Advisory Committee (SCFAC), discussed efforts focused on service gaps and underserved populations.
- Carl Noyes, State Consumer Family and Advisory Committee representative, expressed concern that services provided by Critical Access Behavioral Health Agencies would not be available in less populated areas of the State.
- David Cornwell, Executive Director, North Carolina Mental Hope, discussed the need for collaboration between consumers and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

April 14, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided a brief update on various Department goals for the upcoming fiscal year.
- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, provided updated information on implementation and monitoring of the Critical Access Behavioral Health Agency model, including pending requests to CMS regarding a six-month transition period for existing providers.
- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, presented information on utilization and expenditures for: Community Support Team, Individual and Group Community Support Services for Children and Adults, Targeted Case Management, Intensive In-Home Services, and Child and Adolescent Day Treatment Expenditures.
- Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, Department of Health and Human Services, and Julian Mann, III, Director and Chief Administrative Law Judge, Office of Administrative Hearings, presented an overview of the Medicaid recipient appeal process;

reported on the activities, progress, and effectiveness of the appeal process; and made recommendations concerning the appeal process.

- Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, Department of Health and Human Services, provided updated information on three-way local inpatient psychiatric community hospital contracts.
- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, provided information on Psycho-social Rehabilitation and Clubhouse Services in North Carolina and gave a brief comparative overview of clubhouse programs in other states.
- Ms. Wainwright also reviewed and compared the structure, services and financial components of current North Carolina CAP-MR/DD Waivers, the PBH Innovations Waiver, and the new NC Innovations Waiver.
- Dr. John Gilmore, M.D., Department of Psychiatry, University of North Carolina at Chapel Hill,
- Dr. Patricia Porter, Consultant to the LOC, reviewed reports currently submitted to the LOC and made recommendations about requiring new reports and modifying or eliminating existing reports.

May 6, 2010

- Lanier Cansler, Secretary, Department of Health and Human Services, provided an update on the Department's response to a recent incident in a State-Operated Healthcare Facility including plans for improved employee training.
- John Agosta, Ph.D., Vice President, Human Services Research Institute, reviewed a report on DD Residential Services entitled "Where Does NC Stand? A Comparison of Medicaid-Funded Residential Service Trends, National and in North Carolina for People with Intellectual and Developmental Disabilities, 1998-2008."
- Shawn Parker, Legislative Analyst, Research Division, provided information about term limits for county managers serving on area boards.
- LOC staff presented a review of the LOC's draft report; the LOC adopted the report as amended.

INTRODUCTION

The basic tenant of Mental Health Reform, enacted in S.L. 2001-437, is that consumers are best and most effectively served when the services they need are delivered in a community setting. Moreover, the system must be:

- participant-driven
- prevention-focused
- recovery-oriented
- State directed and locally managed
- cost-effective
- based on recognized best practice treatments, and self-determination of outcomes.

Every year since 2001, the General Assembly has enacted legislation to support the reform and restructuring of the State's system for delivering MH/DD/SAS services. These reform efforts have aimed to increase local management of the system, decrease reliance on State institutions, encourage the use of community-based best practice treatments, increase consumer involvement in the system, allow access to a range of qualified providers, and hold system providers and managers accountable to both State and local government. Through provisions it has enacted, the General Assembly has directed the Secretary of the Department of Health and Human Services (Department) and the Division of MH/DD/SAS (Division) to administer the system's reform. Oversight of reform efforts has been provided by the General Assembly and its Joint Legislative Oversight Committee on MH/DD/SAS (LOC).

The General Assembly of the 2009 session faced decreased revenues and was forced to make significant reductions to state agencies' budgets, including the Division and Division of Medical Assistance (DMA) that resulted in less services for individuals. Significant budget reductions included:

- -\$40 million in state funded services nonrecurring for each year of the biennium,
- Elimination of Community Supports services,
- -\$16 million of state funds that was used to supplement the Community Alternatives Program waiver, and
- Reduction in size for children's group homes; no more than 16 children may be served at any one group home for level III and level IV care.

However, the General Assembly honored an LOC recommendation and increased the funding for the State, Local Management Entity, and community hospital "Three-Way Contracts" by \$12 million, raising the total funds in this initiative to \$20 million.

At LOC meetings, members heard from the Division and local entities on how the reductions impacted their agency and local services. Within this report, the 2010 LOC has recommended restoring some funding for services.

The LOC also focused a great deal of its attention this interim on Critical Access Behavioral Health Agencies (CABHAs). CABHAs are a new federally approved designation of provider agency which the Department has begun to implement with the goal of ensuring that critical services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a continuum of services, and with an effort to move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment. Effective July 1, 2010, CABHAs will be the only category of providers authorized to offer services in three key categories: Community Support Teams for adults, Intensive In-Home Treatment for children, and Day Treatment for children and adults. Pending approval from the Centers for Medicare and Medicaid Services (CMS), Case Management and Peer Support for recovery initiatives will also be provided exclusively within the CABHA structure.

Reform of the State's public system for individuals in need of mental health, developmental disabilities, and substance abuse services is a monumental undertaking. It has requires enormous effort at the State and local levels with support and input by consumers, families, and providers. While the target of reform has not changed, the system has been dynamic. Thus, while significant mechanisms of reform are in place, there needs to be flexibility in future implementations. The LOC continues to monitor reform implementation and reports its findings and recommendations to the General Assembly.

COMMITTEE FINDINGS AND RECOMMENDATIONS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) makes the following recommendations presented in this section to the 2010 session of the 2009-2010 General Assembly. Many recommendations are followed by additional background information. Corresponding legislative proposals appear in the appendix of this report.

Restoration of LME Community Service Funds

The LOC recommends the General Assembly appropriate \$40 million for community services for FY2010-11 and that these funds be allocated to LMEs based on the amount of reduction LMEs received resulting from the \$40 million nonrecurring reduction planned for FY2010-11.

The total reduction made by the General Assembly for the services managed through the LMEs was \$60M for FY 2009-2010 and FY 2010-2011. A \$40M reduction for the non-disability specific general service fund; a \$16M reduction of services supplementing the CAP-MR/DD waiver package; and a \$4M reduction of services identified as “non-core” to the mission of the Division of MH/DD/SAS. There was an additional 5% reduction (\$15M) of the services administered through the LMEs but that money was reinstated by the Governor.

On November 10, 2009, Mike Watson reviewed, for the LOC, last year's LME budget reductions, including how funds were allocated to LMEs, how LMEs reduced their budgets, the effect of the reductions on fund balances, and the impact on services. Rhett Melton, Director of Pathways LME, discussed budget reductions at the community level. Pathways experienced a net loss of \$4.6M, which is equal to a 26% reduction of State funds for the LME. Expressed concern over gaps that already exist and the impact of the elimination of additional services, and noted that there was no way to continue same level of care as in the past with 26% less funding.

Support Initiatives to Strengthen LMEs

The Department is encouraged to continue to expand the number of LMEs implementing 1915(b)(c) Medicaid waivers.

During the FY2009-10 interim, the LOC heard from Piedmont Behavioral Health and its success with the Medicaid waiver. The Department has received approval from CMS to add additional LMEs; the Department issued an RFP for interested

LMEs and is currently evaluating those applications. The tentative start up for adding LMEs in the waiver program is January 1, 2011.

The Department is encouraged to return Utilization Management functions to LMEs.

LMEs' core functions, as defined by General Statute 122C-115, include utilization management, utilization review, and determination of the appropriate level and intensity of services to ensure that services are needed and appropriately provided. In recent years these functions have been transferred to an outside vendor, which is Value Options. The 2008 General Assembly directed the Department to return utilization management to LMEs representing at least 30% of the State's population. Currently, there are two LMEs (Durham and East Point) willing to take on this responsibility. Beginning in September 2010, it is expected that these two LMEs will assume utilization management of Medicaid services.

The Department is encouraged to promote Single Stream funding for LMEs

There are currently 17 single stream funded LMEs of the 23 total programs. The use of single stream funding allows LMEs to set and fund community priorities. With single stream funding, the designated streams of funding lose their identity and may be used for any mental health, developmental disabilities, and substance abuse services as needed. In addition, the LMEs receive advance funding for purchase of services, negotiation of contracts, pay providers, and then file "shadow claims" to the Division.

Fund a Leadership Academy for LME Managers

The LOC recommends that of the funds appropriated to the Division for the 2010-2011 fiscal year, up to five hundred thousand dollars (\$500,000) should be used to support development of a mental health leadership academy that provides professional development to local management entities

In FY2008-09, the Division funded a leadership academy at UNC's Kenan Flagler Business School. This initiative utilized the Business School's statewide initiative to train senior LME staff, Division staff, and community partners. The training provided resources and expertise to the LMEs to help manage money, people, information, and partnerships. In FY2009-10, there was not funding to continue the program. The LOC recommends funding the program for FY2010-11.

LME Independent Assessment Pilot

The LOC recommends the Department establish a pilot project within 4 local management entities for the purpose of evaluating the cost and program efficacy of independent assessments to determine eligibility and need for IPRS enhanced services and certain Medicaid enhanced services (Personal Care Services and Private Duty Nursing).

The Department shall select at least one LME with utilization management responsibilities and at least one LME without such responsibilities. Those two LMEs will establish a process for assessing individuals seeking or receiving services provided through the LMEs that is independent of the delivery of those services. The Department shall select two additional LMEs, one with utilization management responsibilities and one without, that are comparable to the first two LMEs selected to participate in the pilot. The two "matching" LMEs shall be comparable in population, demographics, location, numbers of persons currently enrolled in IPRS enhanced services, and numbers of persons currently enrolled in Medicaid enhanced services. The "matching" LMEs will continue to provide client assessments without regard to whether the professional conducting the assessment is independent from the delivery of those services. All assessments administered by LMEs participating in the pilot project should be as close to identical as possible, except for the independence of the assessment professional. The Division shall provide the LOC with a plan for implementing this pilot by October 1, 2010, and shall report its findings and recommendations to the LOC by October 1, 2011.

Data from the pilot shall include:

- numbers of persons assessed per site,
- numbers of persons recommended for IPRS enhanced services or Medicaid enhanced services at each site, along with a listing of those services,
- any costs associated with independent assessment, broken down by each site,
- comparative data on utilization of IPRS enhanced services and Medicaid enhanced services at sites conducting independent assessments versus sites conducting non-independent assessments, and
- comparative costs among the four sites.

Funds for Local Hospital Three Way Contracts

The LOC recommends the General Assembly appropriate an additional \$12 million for the expansion of local inpatient psychiatric beds to allow purchase of an additional 50 beds out in the community.

General Assembly appropriations over the past few years have increased the resources available for in-patient community care to \$20 million. There are many benefits of community-based care including ameliorating the demand on expensive State hospital usage. Because Medicaid will not pay for inpatient care at a stand-alone psychiatric hospital for consumers aged 18-64, research by the North Carolina General Assembly's Program Evaluation Division indicates that the State pays 81% of the cost of care for adults in State hospitals, but only 41% of the cost of community-based care.

It is the State's policy that beds in the three State-run psychiatric hospitals are intended for longer-term admissions for consumers who cannot be adequately or safely treated in the community, including in community general hospitals with psychiatric beds. With the increase of community-based beds, the shorter term needs can now be handled within the communities.

Implementation of the Tiered CAP/MR-DD Waiver Program

The LOC encourages the Department to continue to implement the tiered CAP-MR/DD waiver system.

The 2008 General Assembly directed the Department to develop and implement four CAP-MR/DD tiers. The primary purpose of a tiered CAP-MR/DD waiver system is to assure that individuals receive the services they need at the intensity level required to fully participate in everyday activities. The Department reported to the LOC that it has developed and implemented Tier 1 and Tier 4 and a plan to develop and implement a third tier containing two levels. Each tier represents an array of services reflecting intensity and complexity of service need. There has been no plan provided by the Department on the critical formula or tool to be used to determine how waiver recipients will be deemed eligible for each of these tiers/levels.

Supports Intensity Scale Evaluations

The LOC recommends requiring all DD consumers within the 7 region pilot catchment areas to undergo a Supports Intensity Scale (SIS) evaluation and directing the Department to develop and utilize a mechanism to employ the

results of the SIS as the basis for assigning those individuals to CAP waiver tiers and other services according to each individual's relative intensity of need.

The Department began implementation of a pilot project in 2008 to administer the Supports Intensity Scale (SIS) to a set of individuals with developmental disabilities residing within seven (7) local management entities. The purpose of the SIS is to measure the intensity of an individual's needs in critical areas resulting in specific information that can assist in identifying the unique strengths and support needs of that individual. The SIS was specifically designed to assess support needs, determine the intensity of needed supports, monitor progress, and evaluate outcomes of adults with intellectual and developmental disabilities

The SIS is not yet being administered to all persons with DD in the pilot LMEs and there is no data reported on its use in determining level of needs, particularly in the CAP-MR/DD waiver program and other services.

CABHA Implementation and Certification Process

The LOC recommends the Department consider and seek approval for a three to six month extension of the transition period for full implementation of the CABHA model in order to ensure that client access to an array of appropriate clinical services is not disrupted, and to provide additional time for small providers to gain CABHA accreditation.

In addition, the LOC recommends that the General Assembly direct the Division to develop a plan for modifying the CABHA certification process in order to ensure that new providers are eligible to qualify to participate in the CABHA network. The Division should submit a report on the modification plan to the LOC and the Fiscal Research Division not later than October 1, 2010.

The Department reported to the LOC that it has approved a definition and description of a new category of provider agency, a Critical Access Behavioral Health Agency (CABHA). Effective July 1, 2010, CABHAs will be the only category of providers authorized to offer services in three key categories: Community Support Teams for adults, Intensive In-Home Treatment for children, and Day Treatment for children and adults. Pending approval from the Centers for Medicare and Medicaid Services (CMS), Case Management and Peer Support for recovery initiatives will also be provided exclusively within the CABHA structure.

The main implementation goals of the CABHA model, as expressed by Mr. Michael Watson, Assistant Secretary for Mental Health, Developmental Disabilities, and Substance Abuse Services Development, are to ensure that critical

services are delivered by a clinically competent organization with appropriate medical oversight and the ability to deliver a continuum of services; and to move the public system over time to a more coherent service delivery model that reduces clinical fragmentation at the local level and begins to prepare the provider community for the changes that will be required in a waiver environment.

At the December, January, and April LOC meetings, Mr. Watson explained the three-step CABHA certification process. First, a provider must submit an attestation letter with documentation evidencing the provider's ability to meet basic certification requirements, namely:

- Delivery of three core services: comprehensive clinical assessment, medication management, and outpatient therapy;
- Delivery of at least two enhanced services in the same location where it provides the three core services to create a continuum of care;
- Active National Accreditation of at least 3 years;
- A Full-Time or Part-Time Medical Director, depending upon the number of consumers served (100% FTE for providers serving more than 750 consumers – 60% billing; 50% FTE for providers serving less than 376 – 749 consumers – 60% billing; 8 hours per week – 0 – 375 consumers – no billing)
- A Full-Time Clinical Director
- A Full-Time Quality Management/Staff Training Director

Second, the provider must undergo a desk review of the letter of attestation and supporting documentation, which is conducted by DMH/DD/SAS, in collaboration with DMA and DHSR staff, and verified by an LME. Third, the provider must undergo an onsite review conducted by DMH/DD/SAS, DMA, and LME staff. The onsite review includes staff interviews of the Medical Director, Clinical Director, Quality Improvement/Training Director, and other provider agency staff as deemed appropriate.

The most controversial aspects of the CABHA model are the requirements that the provider must (i) have active three-year national accreditation at the time of application and (ii) hire or contract a medical director who has education and experience with the population being served. LOC members questioned DHHS about how new professionals could enter the system and provide the array of services offered within the CABHA model if CABHA certification requires applicants to obtain three-year national accreditation. The Department anticipates that providers will enter the system and become accredited with non-CABHA services and then have an opportunity to become nationally accredited in order to move into CABHA services. LOC members and providers also expressed concern that providers with fewer than 750 cases annually will have difficulty achieving

CABHA certification due to the costs associated with hiring or contracting a medical director. While the Department has scaled down the Medical Director requirement for smaller providers, it is still unclear how this requirement will impact the ability of smaller providers to achieve CABHA certification.

Providers that do not achieve CABHA certification will be required to transfer their clients to certified CABHA providers for the five key services that must be delivered within the CABHA structure. LOC members expressed a sense of responsibility for ensuring that the transfer of clients and their medical records to certified CABHA providers is accomplished with minimal disruption to service delivery and that there are a sufficient number of providers within the CABHA network to give clients State-wide access to key services.

Club House Model Study Rates

The LOC recommends the General Assembly direct DMA, in conjunction with the Division, to examine and, as the Divisions deem necessary, adjust the rates for community support services provided through International Center for Clubhouse Development clubhouse models of psychosocial rehabilitation.

The Clubhouse Model is a type of psychosocial rehabilitation designed to address the needs of the whole person in his/her recovery from serious mental illness. Supporting psychiatric and healthcare symptom management, the Clubhouses offer vocational supports, community-based employment, education, housing, outreach, advocacy and access to health care and substance abuse services as well as social and recreational opportunities. Using a membership concept, the Clubhouses are founded on the importance of "consumer ownership". Each member shares in the operation of the community center. The Clubhouse model is outcome based and in North Carolina, the Clubhouses work closely with Universities to provide internship sites, collaborative research projects and service integration.

There are currently 85 licensed Psychosocial Rehabilitation providers in the state and 44 of these follow the Clubhouse model. Eight N.C. Clubhouses have received national certification by the International Center for Clubhouse Development having met the ICCD standards.

Psychosocial rehabilitation programs are licensed by the state and must operate 5 days per week for at least 5 hours per day. All PSR programs, including Clubhouses receive funding via Medicaid, receive the same PSR rate which is \$2.74 for each 15 minute unit of service.

The NC ICCD Clubhouse Coalition presented to the LOC in March and noted that they were sustainable with the additional delivery of Community Support Services. With the elimination of the opportunity to draw down funding for Community Support services, these programs report that they are in jeopardy of closure due to the very low rate for the expansive services they provide. Members of the LOC noted that they support the Clubhouses and acknowledge the importance of the services they provide.

NCIOM Study Childhood Mental Health Services in North Carolina

The LOC recommends that the General Assembly continue recurring funds to the NCIOM in order to continue the work of the Task Force on Behavioral Health Services for the Military, the Task Force on the Co-Location of Different Populations in Adult Care Homes, and the Health Care Access Group.

In addition, the LOC recommends that the General Assembly direct the NCIOM to conduct a study of the needs of children from birth to age five and their families. The NCIOM may submit an interim report of its findings and recommendations to the LOC by January 15, 2012, and shall submit a final report of its findings and any recommended legislation to the LOC on or before the convening of the 2013 General Assembly.

In Section 10.78.(ff) of S.L. 2009-451, the General Assembly appropriated \$250,000 from the Substance Abuse Prevention and Treatment Block Grant to the Division for the 2009-2010 fiscal year for the NCIOM to do all of the following:

- Study the availability of mental health, developmental disabilities, and substance abuse services funded with Medicaid and state funds that are currently available to active duty, reserve, and veteran members of the military and National Guard. NCIOM was also directed to determine any gaps in services. The Task Force provided an interim report to the 2010 Session of the General Assembly. A final report is due from this Task Force to the General Assembly during the 2011 Session. Section 10.78.(ff)(1).
- Continue the work of the Health Access Study Group on issues related to cost, quality, and access to appropriate and affordable health care for all North Carolinians, and also to monitor federal health-related legislation to determine how the legislation will impact costs, quality, and access to health care. Section 10.78.(ff)(2).

- Study short-term and long-term strategies to address issues within adult care homes that provide residence to persons who are frail and elderly and to persons suffering from mental illness. Section 10.78ff(3) of S.L. 2009-451. In its Interim Report, the Task Force reported that its main focus will be on: (1) The problems created by the co-location of different populations in adult care homes; (2) how to appropriately identify/screen people for behavioral health disorders; (3) the training of adult care home staff; and (4) other options to ensure those with mental illness, behavioral health problems, the frail elderly, and others with disabilities are receiving appropriate care. Section 10.78.(ff)(3).

The Task Force on Behavioral Health Services for the Military, the Task Force on the Co-Location of Different Populations in Adult Care Homes, and the Health Care Access Group have all issued Interim Reports on the above-referenced studies. However, additional funding is necessary in order for the Task Forces to complete their work and, at the direction of the General Assembly, issue final reports with findings, recommendations, and suggested legislation to the 2011 General Assembly upon its convening.

During the LOC meeting on October 14, 2001, the LOC was made aware of one additional area of study for the NCIOM. Ms. Sarah Sabornie, Coordinator of the Young Child Mental Health Collaborative of Wake County, presented information concerning the unique needs of children from birth to age five with mental health issues. Ms. Sabornie stressed the need for early identification and intervention in order to accomplish cost-effective treatment and remediation of mental health issues in this population. In addition, she emphasized the need to integrate, collaborate, and support the resources of each State agency or system to address the mental health needs of those children. Toward that end, she requested, on behalf of the Young Child Mental Health Collaborative, that the NCIOM conduct a study to examine the needs, strengths, and resources of the service systems throughout the State as they affect the mental health of our birth to five population; to evaluate potential use of research-based interventions; and to make recommendations for moving forward with limited resources.

Support Regionally-Purchased Locally-Hosted Substance Abuse Services

The LOC recommends that the General Assembly direct the Department to continue allocating substance abuse funds for regionally-purchased, locally-hosted substance abuse programs at the same level.

The budget for the 2009-2010 fiscal year did not appropriate any additional funds for regionally-purchased, locally-hosted substance abuse services (often called Cross Area Service Programs, or CASP). During the LOC meeting of December 9, 2010, Ms. Flo Stein, Chief of the Community Policy Management Section in the Division, reported to the LOC that CASP funds were used to establish new programs to (i) increase adult substance abuse comprehensive community treatment capacity and supportive housing services; (ii) increase adolescent substance abuse comprehensive community treatment capacity and residential program services; (iii) increase community capacity for substance abuse prevention coalitions; (iv) increase community capacity for substance abuse services specific to pregnant women or women with children utilizing gender-specific treatment; and (v) develop expanded residential substance abuse programs. As further evidence that CASP is an appropriate and effective use of substance abuse dollars, the Division reported that a model CASP piloted in North Carolina has been identified as a national model in versions of health reform regarding how to provide addiction services.

Expand and Extend the First Commitment Pilot Program

The LOC recommends the General Assembly authorize the Secretary to extend and expand the first commitment pilot program, direct the Department to establish continued training for current certified providers, direct the Department to utilize the Stakeholder group to examine the participation rates by each "waived" masters level health care professionals area, and determine if this should be expanded or reduced based on scope of practice and report any findings to the LOC.

Pursuant to Section 1.1(b) of S.L. 2007-504, the LOC recommends extending the First Commitment Pilot Program through October 1, 2012 and to authorize the Secretary to grant a waiver to up to 20 LMEs. The LOC further recommends directing the Department to expand its standardized training program to include refresher training for all certified providers, and to study participation rates by provider practice area and determine how the services are within each professional's scope of practice and whether this group should be expanded or reduced, and report any findings to the LOC not later than April 1, 2012.

In 2003, the General Assembly passed legislation (S.L. 2003-178) which has been referred to as the "First Commitment Pilot Program". The legislation 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. Under the Pilot Program, 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 Appropriations Act of 2006 extended the pilot by 1 year. In the Fall of 2006, the Department made a presentation and report to the LOC on the pilot in which it recommended that it be made permanent and extended Statewide. The LOC recommended and the General Assembly enacted in S.L. 2007-504 a three-year extension and authorized up to five more LMEs. In 2009, the Secretary was authorized in S.L. 2009-340 to expand the program to 15 LMES.

On January 13, 2010, Mark O'Donnell, LME Liaison and Project Director for the First Evaluation Pilot Project, together with Dr. Nidu Menon, Director of Evaluation, Health and Wellness Trust Fund, provided an update on the First Commitment Pilot Project. The Division's recommendation to the LOC was that the waiver be continued and expanded statewide, since the pilot project indicates that licensed clinical social workers and licensed clinical addictions specialists who are properly trained, tested and certified, would make decisions similar to those made by psychologists, physicians, and psychiatrists.

Questions were raised after the report relating to whether the program can be expanded to include other properly trained health care professionals and to what extent the current "waived" professionals participate at the first evaluation stage, and whether there are training needs of currently certified evaluators.

Medicaid Appeals Process Changes

The LOC recommends the General Assembly make the temporary Medicaid appeals process for Medicaid applicants and recipients permanent and codify the process in Chapter 108 of the General Statutes.

The Office of Administrative Hearings (OAH) processes all appeals of contested Medicaid cases commenced by Medicaid applicants or recipients. OAH began to experience a significant backlog of cases due in part to adverse actions consumers and provider experienced relating to changes to Community Support services. As reported to the LOC in 2007, there were 2, 291 total cases; in 2008 there were 3,717 cases; and in 2009 there were 6,693 cases. The Department and OAH were directed by S.L. 2008-107 to work together to streamline the process for hearing Medicaid recipient appeals.

SL. 2008 -107, as amended by S.L. 2008-118 and S.L. 2009-526, established a temporary appeals process for Medicaid applicants and recipients who have been

denied, terminated, suspended, or have had benefits reduced. Some of the major tenants of the temporary process are as follows:

- 10 days prior to the effective date of an adverse action, the Department shall provide proper notice and notice shall be as "user friendly" as possible.
- During the appeal an appellant has a right to services at the level or manner prior to the appeal.
- OAH must hear cases with 55 days of appeal.
- Hearings shall be conducted telephonically or by video conference, unless the appellant requests an in-person hearing. In-person hearings are to be in Wake County, but can be moved to the appellant's county of residence upon good show of cause.
- Prior to the hearing before the administrative law judge, mediation must be offered to the recipient. If mediation is successful, the mediator must indicate this outcome to the administrative law judge. If mediation is unsuccessful, the administrative law judge must hear the case and make a determination.
- The petitioner may submit evidence obtained prior to and subsequent to the Department's action.
- Provides that in each adverse action the hearing shall determine if the Department substantially prejudiced the rights of the appellant by exceeding its authority, acting erroneously, failing to use proper procedure, acting arbitrarily or capriciously, or failing to act as required by law.

On April 14, 2010, Julian Mann, III, Director and Chief Administrative Law Judge, Office of Administrative Hearings (OAH), presented an overview of the Medicaid recipient appeal process. Judge Mann recognized the coordination and cooperation of different agencies in developing a process that is working successfully. He credited mediation with giving those without representation an opportunity to have resolution with 80% of the mediated cases being settled and said this was accomplished within 25 days. As of March 1, it was reported that OAH expended \$1,409,201 in personnel, mediation services and operational costs at the same time the savings for the State as result of the process was almost twenty times the amount. OAH recommended to the LOC that the process should become permanent as it has been successful in achieving a desired result of having individuals able to file their appeal, receive the opportunity for mediation, and have their appeal heard and decided in an efficient and timely manner. OAH also requested funding to continue the mediation process and funding for additional personnel.

Agency Reversal of Administrative Law Judge Decisions

The LOC recommends the General Assembly authorize Joint Legislative Program Evaluation Oversight Committee shall include in 2010 Work Plan for the Program Evaluation Division of the General Assembly a study of Chapter 150B contested cases. The Division shall study the number of decisions rendered by administrative law judges that are overturned as a final agency decision. For these cases the Division shall evaluate the nature of the case, the basis of the reversal, the number of cases appealed to Superior Court and the results of those appeals.

Implement Report Review Recommendations

The LOC recommends the General Assembly enact legislation that directs the Department of Health and Human Services to develop and submit the following reports:

- By January 1, 2011, the Department shall report on the status of Community Support Services to include numbers of individuals no longer receiving any service, numbers moved to other services with a list of those services and numbers for each, cost increases and decreases and projected cost savings. Status of new service definitions (e.g. peer supports)
- By September 1, 2010, the Department shall report on deaths that have occurred within in state MH-DD-SA facilities, and, if known, the death of any former client of a facility who dies within 14 days of release from the facility
- Annually, beginning 10-1-10, the Department shall provide status report on the expenditures and balance in the Mental Health Trust Fund
- Annually, beginning January 1, 2011, the Department shall report on the strategic plan regarding how state and local resources shall be organized and used to provide services. Included will be criteria for the allocation of dollars, restrictions on how these dollars may be used, guidelines for utilization of funds and list of expenditures.
- Annually, beginning May 1, 2011, the department shall collect and report on LME fund balances.
- By January 1, 2011, the Department shall report on the status of the implementation of the CAP-MR/DD Tiered Waiver to include mechanism for determination of assignment into each of the tiers for both new and current CAP recipients, movement from one tier to another, and cost impact.
- Biannual report beginning January 1, 2011, the Department shall report on Statewide System Performance to include the following criteria:

- Access to Services
- Individualized Planning and Supports
- Promotion of Best Practices
- Consumer-Friendly Outcomes
- Quality Management Systems
- System Efficiency and Effectiveness
- Equitable Allocation of Resources
- Prevention and Early Intervention
- Statewide System of Crisis Response for Adults and Children
- Management of the Utilization of State Facilities
- Semi-Annual report due on September 1 and April 1, beginning September 1,2010, the Department shall report on the uniform system of beds or bed days purchased (i) with local funds;(ii) from existing state appropriations,(iii) under the hospital utilization pilot, and (iv)under three-way contracts

In support of and cooperation with the Department of Health and Human Services in their efforts to streamline reporting, a review was conducted of the complete catalog of reports required to be submitted to the LOC from 2006-2010. A review was made of the Session Law that provided the source of the direction for these reports and determination was made for each of these reports of the need for continuation, end, change in frequency of periodic reportage or requirement for a new report request.

A total of 165 reports were reviewed and 22 of these were discovered to be in need of some change. These recommendations were provided to the members of the LOC for review and comment. The Recommendation above reflects the list of reports in need of new and/or revised language.

APPENDIX

Copies of the proposed legislation begin on the following page.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

S/H

D

BILL DRAFT 2009-MGz-106* [v.6] (04/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

5/11/2010 7:46:14 PM

Short Title: Restore State-Funded LME Services. (Public)

Sponsors: Senator Nesbitt./Representative Insko.

Referred to:

A BILL TO BE ENTITLED

1
2 AN ACT TO APPROPRIATE FUNDS TO THE DIVISION OF MENTAL HEALTH,
3 DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES OF THE
4 DEPARTMENT OF HEALTH AND HUMAN SERVICES TO RESTORE STATE-
5 FUNDED SERVICES PROVIDED THROUGH LOCAL MANAGEMENT ENTITIES,
6 AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON
7 MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE
8 SERVICES.

9 The General Assembly of North Carolina enacts:

10 **SECTION 1.** There is appropriated from the General Fund to the Department of
11 Health and Human Services, Division of Mental Health, Developmental Disabilities, and
12 Substance Abuse Services, the sum of forty million dollars (\$40,000,000) for the 2010-2011
13 fiscal year. These funds shall be used to increase the amount of State service dollars allocated
14 for State-funded services provided through local management entities (LMEs). The amount of
15 State service dollars allocated to an LME pursuant to this section shall be (i) identical to the
16 amount by which State service dollars were reduced on a non-recurring basis for that LME
17 during the 2009-2010 fiscal year, and (ii) used by the LME only to restore State-funded
18 services provided by the LME prior to enactment of the budget reductions for the 2009-2010
19 fiscal year.

20 **SECTION 2.** This act becomes effective July 1, 2010.
21

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H/S

D

BILL DRAFT 2009-MGz-107* [v.9] (04/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

5/11/2010 7:47:17 PM

Short Title: Develop MH Leadership Academy for LMEs/Funds.

(Public)

Sponsors: Representative Insko./Senator Nesbitt.

Referred to:

1 A BILL TO BE ENTITLED

2 AN ACT TO APPROPRIATE FUNDS FOR DEVELOPMENT OF A MENTAL HEALTH
3 LEADERSHIP ACADEMY TO PROVIDE PROFESSIONAL DEVELOPMENT
4 OPPORTUNITIES FOR LOCAL MANAGEMENT ENTITIES, AS RECOMMENDED
5 BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH,
6 DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

7 The General Assembly of North Carolina enacts:

8 **SECTION 1.** Of the funds appropriated to the Department of Health and Human
9 Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse
10 Services for the 2010-2011 fiscal year, up to five hundred thousand dollars (\$500,000) may be
11 used to support development of a mental health leadership academy that provides professional
12 development to local management entities, enabling senior LME staff to enhance their
13 leadership and management skills.

14 **SECTION 2.** This act becomes effective July 1, 2010.
15

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

H/S

D

BILL DRAFT 2009-MGz-114* [v.5] (05/05)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

5/11/2010 7:55:09 PM

Short Title: Pilot Independent Assessments by LMEs.

(Public)

Sponsors: Representative Insko./Senator Nesbitt.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND
SUBSTANCE ABUSE SERVICES TO IMPLEMENT A PILOT PROJECT TO
EVALUATE THE COST AND PROGRAM EFFICACY OF INDEPENDENT
ASSESSMENTS FOR INTEGRATED PROGRAM AND REPORTING SYSTEM
ENHANCED SERVICES AND MEDICAID ENHANCED SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of
Mental Health, Developmental Disabilities, and Substance Abuse Services shall establish a
pilot project within four local management entities (LMEs) for the purpose of evaluating the
cost and program efficacy of conducting independent assessments of individuals seeking or
receiving services provided through LMEs, in order to determine their eligibility and need for
Integrated Program and Reporting System (IPRS) enhanced services and Medicaid enhanced
services. The Department shall select the four participating LMEs as follows:

(1) The Department shall select at least one LME with utilization management
responsibilities and at least one LME without utilization management responsibilities. The two
LMEs selected pursuant to this subdivision shall establish a process for assessing individuals
seeking or receiving IPRS enhanced services or Medicaid enhanced services provided through
the LMEs that is independent of the delivery of those services.

(2) The Department shall select two additional LMEs, one with utilization
management responsibilities and one without utilization management responsibilities, that are
comparable to the first two LMEs selected pursuant to subdivision (1) of this subsection in
population, demographics, location, and number of individuals currently enrolled in IPRS
enhanced services or Medicaid services. The LMEs selected pursuant to this subdivision shall
assess individuals seeking or receiving IPRS enhanced services or Medicaid enhanced services
provided through the LMEs without regard to whether the professional conducting the
assessment is independent from the delivery of those services.

All assessments conducted by LMEs participating in the pilot project should be as
close to identical as possible, except for the independence of the professional conducting the
assessment.

1 **SECTION 1.(b)** The Department shall submit to the Joint Legislative Oversight
2 Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services an
3 interim report on the implementation plan for the pilot project authorized by Section 1.(a) of
4 this act by October 1, 2010, and a final report on the pilot project by October 1, 2011. In
5 addition to the Department's findings and recommendations, the final report shall include all of
6 the following information:

- 7 (1) The number of clients assessed at each project site.
- 8 (2) The number of persons recommended for IPRS enhanced services or
9 Medicaid enhanced services at each project site, along with a listing of those
10 services.
- 11 (3) Any costs associated with independent assessment, broken down by each
12 project site.
- 13 (4) Comparative data on utilization of IPRS enhanced services and Medicaid
14 enhanced services at project sites conducting independent assessments and
15 project sites conducting non-independent assessments.
- 16 (5) Comparative costs among the four project sites.

17 **SECTION 2.** This act is effective when it becomes law.
18

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S/H

D

BILL DRAFT 2009-MGz-113* [v.3] (05/04)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

5/11/2010 7:54:23 PM

Short Title: Expand Inpatient Psych. Bed Capacity/Funds. (Public)

Sponsors: Senator Nesbitt./Representative Insko.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE ADDITIONAL FUNDS FOR THE EXPANSION OF LOCAL
INPATIENT PSYCHIATRIC BEDS OR BED DAYS.

The General Assembly of North Carolina enacts:

SECTION 1. Section 10.12.(b) of S.L. 2009-451 reads as rewritten:

"SECTION 10.12.(b) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of twenty million one hundred twenty-one thousand six hundred forty-four dollars (\$20,121,644) for the 2009-2010 fiscal year and the sum of ~~twenty million one hundred twenty-one thousand six hundred forty-four dollars (\$20,121,644)~~ thirty-two million one hundred twenty-one thousand six hundred forty-four dollars (\$32,121,644) for the 2010-2011 fiscal year shall be allocated for the purchase of local inpatient psychiatric beds or bed days. ~~These beds or bed days shall be distributed across the State according to need as determined by the Department. The Department shall work to ensure that these beds or bed days are distributed equitably across the State.~~ The Department shall enter into contracts with the LMEs and community hospitals for the management of these beds or bed days. Local inpatient psychiatric beds or bed days shall be managed and controlled by the LME, including the determination of which local or State hospital the individual should be admitted to pursuant to an involuntary commitment order. Funds shall not be allocated to LMEs but shall be held in a statewide reserve at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to pay for services authorized by the LMEs and billed by the hospitals through the LMEs. LMEs shall remit claims for payment to the Division within 15 working days of receipt of a clean claim from the hospital and shall pay the hospital within 30 working days of receipt of payment from the Division. If the Department determines (i) that an LME is not effectively managing the beds or bed days for which it has responsibility, as evidenced by beds or bed days in the local hospital not being utilized while demand for services at the State psychiatric hospitals has not reduced, or (ii) the LME has failed to comply with the prompt payment provisions of this subsection, the Department may contract with another LME to manage the beds or bed days, or, notwithstanding any other provision of law to the contrary, may pay the hospital directly. The Department shall develop reporting requirements for LMEs regarding the utilization of the beds or bed days. Funds appropriated in this section for the

1 purchase of local inpatient psychiatric beds or bed days shall be used to purchase additional
2 beds or bed days not currently funded by or through LMEs and shall not be used to supplant
3 other funds available or otherwise appropriated for the purchase of psychiatric inpatient
4 services under contract with community hospitals, including beds or bed days being purchased
5 through Hospital Utilization Pilot funds appropriated in S.L. 2007-323. ~~Not later than March 1,~~
6 ~~2010, the Beginning September 1, 2010, the~~ Department shall report semiannually to the House
7 of Representatives Appropriations Subcommittee on Health and Human Services, the Senate,
8 the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and
9 Substance Abuse Services, and the Fiscal Research Division on a uniform system for beds or
10 bed days purchased (i) with local funds, (ii) from existing State appropriations, (iii) under the
11 Hospital Utilization Pilot, and (iv) purchased using funds appropriated under this subsection."

12 **SECTION 2.** This act becomes effective July 1, 2010.
13

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

H/S

D

BILL DRAFT 2009-MGz-118* [v.2] (5/10)

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 7:55:55 PM**

Short Title: Expand Use Of SIS Assessment Tool. (Public)

Sponsors: Representative Insko./Senator Nesbitt.

Referred to:

1 A BILL TO BE ENTITLED
2 AN ACT TO REQUIRE LOCAL MANAGEMENT ENTITIES PARTICIPATING IN THE
3 SUPPORTS INTENSITY SCALE ASSESSMENT PILOT PROJECT TO USE THE
4 ASSESSMENT FOR EVALUATION AND DETERMINATION OF SERVICES FOR
5 CLIENTS WITH DEVELOPMENTAL DISABILITIES, AS RECOMMENDED BY THE
6 JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH,
7 DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.
8 The General Assembly of North Carolina enacts:
9 **SECTION 1.** The Department of Health and Human Services, Division of Mental
10 Health, Developmental Disabilities, and Substance Abuse Services shall require the seven
11 LMEs participating in the current Supports Intensity Scale (SIS) assessment tool pilot project to
12 administer a SIS assessment to all clients with developmental disabilities. The participating
13 LMEs shall use the results of the SIS assessment to assign clients with developmental
14 disabilities to one of the Tiers within the CAP-MR/DD Waiver and to other needed services,
15 according to their relative intensity of need.
16 **SECTION 2.** This act is effective when it becomes law.
17

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S/H

D

BILL DRAFT 2009-MGz-105* [v.9] (04/29)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

5/11/2010 7:44:52 PM

Short Title: Modify CABHA Certification Process.

(Public)

Sponsors: Senator Nesbitt./Representative Insko.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL
DISABILITIES, AND SUBSTANCE ABUSE SERVICES OF THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES TO DEVELOP AND REPORT ON A PLAN FOR
MODIFYING THE CERTIFICATION PROCESS FOR CRITICAL ACCESS
BEHAVIORAL HEALTH AGENCIES, 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. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall develop a plan for modifying the current certification process for Critical Access Behavioral Health Agencies (CABHAs) in a manner that will ensure new provider agencies are able to qualify for participation in the CABHA network. The Division shall submit a report of the modification plan to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research Division not later than October 1, 2010.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H/S

D

BILL DRAFT 2009-MGz-110A* [v.6] (05/01)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/12/2010 9:55:39 AM

Short Title: Examine And Adjust Rates/Clubhouses. (Public)

Sponsors: Representative Insko./Senator Nesbitt.

Referred to:

A BILL TO BE ENTITLED

1
2 AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
3 DIVISION OF MEDICAL ASSISTANCE, IN CONSULTATION WITH THE DIVISION
4 OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE
5 ABUSE SERVICES, TO EXAMINE AND ADJUST THE RATES FOR SERVICES
6 PROVIDED THROUGH THE INTERNATIONAL CENTER FOR CLUBHOUSE
7 DEVELOPMENT CLUBHOUSE MODEL OF PSYCHOSOCIAL REHABILITATION.

8 The General Assembly of North Carolina enacts:

9 **SECTION 1.** The Department of Health and Human Services, Division of Medical
10 Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and
11 Substance Abuse Services, shall examine and, as the Divisions deem necessary, adjust the rates
12 for community support services provided through the International Center for Clubhouse
13 Development (ICCD) clubhouse model of psychosocial rehabilitation. The Department shall
14 report on any adjustment in rates to the Senate Appropriations Committee on Health and
15 Human Services, the House of Representatives Appropriations Subcommittee on Health and
16 Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee
17 on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than
18 October 1, 2010.

19 **SECTION 2.** This act is effective when it becomes law.
20

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

H

D

BILL DRAFT 2009-MGz-86 [v.5] (01/26)

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/3/2010 7:24:00 PM**

Short Title: NCIOM Studies/Funds. (Public)

Sponsors: Representative Insko.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE NORTH CAROLINA INSTITUTE OF MEDICINE TO COMPLETE ITS CURRENT STUDIES AND TO ESTABLISH A TASK FORCE TO STUDY THE NEEDS OF YOUNG CHILDREN WITH MENTAL HEALTH PROBLEMS AND THEIR FAMILIES, 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. There is appropriated from the General Fund to the North Carolina Institute of Medicine (NCIOM) the sum of two hundred fifty thousand dollars (\$250,000) in recurring funds for the 2010-2011 fiscal year. These funds shall be used by NCIOM to complete the following Task Force studies authorized in Section 10.78.(ff) of S.L. 2009-451:

- (1) The availability of Medicaid and State-funded mental health, developmental disabilities, and substance abuse services to active duty, reserve, and veteran members of the military and National Guard. The study should discuss the current availability of services, the extent of use, and any gaps in services.
- (2) The Health Access Study Group on issues related to cost, quality, and access to appropriate and affordable health care for all North Carolinians, and the impact of federal health-related legislation on costs, quality, and access to health care.
- (3) Short-term and long-term strategies to address issues within adult care homes that provide residence to persons who are frail and elderly and to persons suffering from mental illness.

SECTION 2.(a) There is appropriated from the General Fund to the North Carolina Institute of Medicine the sum of one hundred fifty thousand dollars (\$150,000) for the 2010-2011 fiscal year. These funds shall be used to convene a Task Force to study the needs of young children with mental health problems and their families. The Task Force shall:

- (1) Examine the current mental health needs of young children, defined as children from birth to age five.

- 1 (2) Examine existing public and private systems of mental health care that are
2 currently available to families of young children with mental health
3 problems.
4 (3) Identify evidence-based and promising universal, selective and indicated
5 prevention strategies to promote the emotional well-being of young children.
6 (4) Identify strategies for early screening and identification of young children
7 with mental health risk factors or mental health problems. The screening and
8 identification strategies shall address the impact of parents' behavioral health
9 problems on the mental health of their young children.
10 (5) Review evidence-based and promising interventions and systems to promote
11 the positive mental health and emotional well-being of young children and
12 their families.
13 (6) Identify strategies to ensure that children who are at high risk of developing
14 mental health problems and their families have access to a comprehensive
15 range of treatments and services, coordinated across agencies and service
16 systems that are (i) culturally, linguistically, and developmentally sensitive;
17 (ii) individualized; (iii) family-centered; (iv) home, school, and
18 community-based; and (v) evidence-based.
19 (7) Examine workforce adequacy and training needs of mental health
20 professionals and other professionals who provide services to young children
21 and their families.
22 (8) Examine the adequacy of state and other funding to support a comprehensive
23 array of evidence-based services.
24 (9) Recommend strategies to develop, evaluate, and disseminate treatment and
25 service delivery models to meet young children's mental health needs.
26 (10) Examine any other issue that the NCIOM deems relevant to the study.
27 **SECTION 2.(b)** The NCIOM shall make an interim report to the Joint Legislative
28 Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse
29 Services no later than January 15, 2012, which may include legislative and other
30 recommendations, and shall issue its final report with findings, recommendations, and any
31 proposed legislation to the 2013 General Assembly upon its convening.
32 **SECTION 3.** This act becomes effective July 1, 2010.

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

U

D

BILL DRAFT 2009-SQz-28 [v.1] (05/04)

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/4/2010 12:14:09 PM**

Short Title: Extend and Expand First Commit Pilot.

(Public)

Sponsors: .

Referred to:

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TEMPORARILY WAIVE CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES FOR PARTICIPANTS IN THE FIRST EVALUATION PILOT PROGRAM AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY CERTAIN ISSUES RELATING TO THE PROGRAM 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. S.L. 2003-178, as amended by Section 10.27 of S.L. 2006-66, as amended by Section 1.1(a)(5) of S.L. 2007-504, and as further amended by Section 3 of S.L. 2009- 340 reads as rewritten:

"SECTION 1. The Secretary of Health and Human Services may, upon request of an 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 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 LME 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 LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

- 1 c. How the services to be provided by the licensed clinical social
2 worker, the masters level psychiatric nurse, or the masters level
3 certified clinical addictions specialist under the waiver are within
4 each of these professional's scope of practice.
- 5 d. How the health, safety, and welfare of individuals will continue to be
6 at least as well protected under the waiver as under the statutory
7 requirement.
- 8 (2) The Secretary shall review the request and may approve it upon finding that:
9 a. The request meets the requirements of this section.
10 b. The request furthers the purposes of State policy under G.S. 122C-2
11 and mental health, developmental disabilities, and substance abuse
12 services reform.
13 c. The request improves the delivery of mental health, developmental
14 disabilities, and substance abuse services in the counties affected by
15 the waiver and also protects the health, safety, and welfare of
16 individuals receiving these services.
17 d. The duties and responsibilities performed by the licensed clinical
18 social worker, the masters level psychiatric nurse, or the masters
19 level certified clinical addictions specialist are within the individual's
20 scope of practice.
- 21 (3) The Secretary shall evaluate the effectiveness, quality, and efficiency of
22 mental health, developmental disabilities, and substance abuse services and
23 protection of health, safety, and welfare under the waiver. The Secretary
24 shall send a report on the evaluation to the Joint Legislative Oversight
25 Committee on Mental Health, Developmental Disabilities, and Substances
26 Abuse Services by October 1, 2009. The report shall include data gathered
27 from all participating LMEs since the beginning of the pilot.
- 28 (4) The waiver granted by the Secretary under this section shall be in effect until
29 October 1, 2010.
- 30 (5) The Secretary may grant a waiver under this section to up to ~~45~~20 LMEs.
- 31 (6) In no event shall the substitution of a licensed clinical social worker, masters
32 level psychiatric nurse, or masters level certified clinical addictions
33 specialist under a waiver granted under this section be construed as
34 authorization to expand the scope of practice of the licensed clinical social
35 worker, the masters level psychiatric nurse, or the masters level certified
36 clinical addictions specialist.
- 37 (7) The Department shall assure that staff performing the duties are trained and
38 privileged to perform the functions identified in the waiver. The Department
39 shall involve stakeholders including, but not limited to, the North Carolina
40 Psychiatric Association, The North Carolina Nurses Association, National
41 Association of Social Workers, The North Carolina Substance Abuse
42 Professional Certification Board, North Carolina Psychological Association,
43 The North Carolina Society for Clinical Social Work, and the North Carolina
44 Medical Society in developing required staff competencies.
- 45 (8) The LME shall assure that a physician is available at all times to provide
46 backup support to include telephone consultation and face-to-face
47 evaluation, if necessary.

1 **SECTION 2.** This act becomes effective July 1, 2003, and expires ~~October 1, 2010~~[October](#)
2 [1, 2012](#)."

3 **SECTION 2.** The Division of Mental Health, Developmental Disabilities, and
4 Substance Abuse Services shall expand its standardized certification training program to include
5 refresher training for all certified providers and shall report to the Legislative Oversight
6 Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on
7 the participation rate of licensed clinical social workers, the masters level psychiatric nurse, or
8 the masters level certified clinical addictions specialist in the pilot program and whether the
9 program should include other licensed or certified health care professionals.

10 **SECTION 3.** This act is effective when it becomes law.
11

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S/H

D

BILL DRAFT 2009-MGz-108C* [v.2] (04/30)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

5/11/2010 7:48:30 PM

Short Title: Establish Medicaid Appeals Process.

(Public)

Sponsors: Senator Nesbitt./Representative Insko.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH A PERMANENT APPEALS PROCESS FOR MEDICAID APPLICANTS OR RECIPIENTS, 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. Article 2 of Chapter 108A of the General Statutes is amended by adding two new sections to read:

§ 108A-70.6A. Appeals commenced by Medicaid applicants or recipients.

(a) Definitions. – The following definitions apply in this section, unless the context clearly requires otherwise:

(1) "Adverse determination." – A determination by the Department to deny, terminate, suspend, or reduce Medicaid covered services.

(2) "Applicant" or "recipient." – This term includes an applicant's or recipient's parent, guardian, or legal representative.

(b) General Rule. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid applicant or recipient to appeal a determination made by the Department to deny, terminate, suspend, or reduce Medicaid covered services.

(c) Notice. – Except as otherwise provided by federal law or regulation, at least 10 days before the effective date of an adverse determination, the Department shall notify the applicant or recipient, and the provider, if applicable, in writing of the adverse determination and of the applicant's or recipient's right to appeal the adverse determination. The Department shall not be required to notify an applicant's or recipient's parent, guardian, or legal representative unless the parent, guardian, or legal representative has requested in writing to receive the notice. The notice shall be mailed on the date indicated on the notice as the date of the determination. The notice shall include:

(1) An identification of the applicant or recipient whose services are being affected by the adverse determination, including full name and Medicaid identification number.

- 1 (2) An explanation of what service is being denied, terminated, suspended, or
2 reduced and the reason for the determination.
- 3 (3) The specific regulation, statute, or medical policy that supports or requires
4 the adverse determination.
- 5 (4) The effective date of the adverse determination.
- 6 (5) An explanation of the applicant's or recipient's right to appeal the
7 Department's adverse determination in an evidentiary hearing before an
8 administrative law judge.
- 9 (6) An explanation of how the applicant or recipient can request a hearing and a
10 statement that the applicant or recipient may represent himself or herself or
11 use legal counsel, a relative, or other spokesperson.
- 12 (7) A statement that the applicant or recipient will continue to receive Medicaid
13 services at the level provided on the day immediately preceding the
14 Department's adverse determination or the amount requested by the
15 applicant or recipient, whichever is less, if the applicant or recipient requests
16 a hearing before the effective date of the adverse determination. The services
17 shall continue until the hearing is completed and a final decision is rendered.
- 18 (8) The name and telephone number of a contact person at the Department to
19 respond in a timely fashion to the applicant's or recipient's questions.
- 20 (9) The telephone number by which the applicant or recipient may contact a
21 Legal Aid/Legal Services office.
- 22 (10) The appeal request form described in subsection (e) of this section that the
23 applicant or recipient may use to request a hearing.

24 (d) Appeals. – Except as provided by this section and section 108A-70.6B, a request for
25 a hearing to appeal an adverse determination of the Department under this section is a contested
26 case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The
27 applicant or recipient must request a hearing within 30 days of the mailing of the notice
28 required by subsection (c) of this section by sending an appeal request form to the Office of
29 Administrative Hearings and the Department. Where a request for hearing concerns the
30 reduction, modification, or termination of Medicaid services, upon the receipt of a timely
31 appeal, the Department shall reinstate the services to the level or manner prior to action by the
32 Department as permitted by federal law or regulation. The Department shall immediately
33 forward a copy of the notice to the Office of Administrative Hearings electronically. The
34 information contained in the notice is confidential unless the recipient appeals. The Office of
35 Administrative Hearings may dispose of the records after one year. The Department may not
36 influence, limit, or interfere with the applicant's or recipient's decision to request a hearing.

37 (e) Appeal Request Form. – Along with the notice required by subsection (c) of this
38 section, the Department shall also provide the applicant or recipient with an appeal request
39 form which shall be no more than one side of one page. The form shall include the following:

- 40 (1) A statement that in order to request an appeal, the applicant or recipient must
41 send the form by mail or fax to the address or fax number listed on the form
42 within 30 days of mailing of the notice.
- 43 (2) The applicant's or recipient's name, address, telephone number, and
44 Medicaid identification number.
- 45 (3) A preprinted statement that indicates that the applicant or recipient would
46 like to appeal the specific adverse determination of which the applicant or
47 recipient was notified in the notice.

1 (4) A statement informing the applicant or recipient that he or she may choose
2 to be represented by a lawyer, a relative, a friend, or other spokesperson.

3 (5) A space for the applicant's or recipient's signature and date.

4 (f) Final Decision. – After a hearing before an administrative law judge, the judge shall
5 return the decision and record to the Department in accordance with section 108A-70.6B. The
6 Department shall make a final decision in the case within 20 days of receipt of the decision and
7 record from the administrative law judge and promptly notify the applicant or recipient of the
8 final decision and of the right to judicial review of the decision pursuant to Article 4 of Chapter
9 150B of the General Statutes.

10 (g) Nothing in this section shall prevent the Department of Health and Human Services
11 from engaging in an informal review of the case with the applicant or recipient prior to issuing
12 a notice of adverse determination as provided by subsection (c) of this section.

13 (h) All informal appeals by Medicaid applicants or recipients under the informal
14 appeals process that was discontinued pursuant to section 10.15A.(h4) of S.L. 2008-118 which
15 are still pending and for which a hearing has not been held shall be discontinued and the
16 applicant or recipient offered an opportunity to appeal to the Office of Administrative Hearings
17 in accordance with the provisions of section 108A-70.6A. The Department shall make every
18 effort to resolve or settle all of the backlogged cases prior to the effective date of this act.

19 **"§ 108A-70.6B. Contested Medicaid cases.**

20 (a) Application. – This subsection applies only to contested Medicaid cases commenced
21 by Medicaid applicants or recipients under section 108A-70.6A. Except as otherwise provided
22 by section 108A-70.6A and this section governing time lines and procedural steps, a contested
23 Medicaid case commenced by a Medicaid applicant or recipient is subject to the provisions of
24 Article 3 of Chapter 150B. To the extent any provision in this section or section 108A-70.6A of
25 this act conflicts with another provision in Article 3 of Chapter 150B, this section and section
26 108A-70.6A controls.

27 (b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter
28 150B of the General Statutes, the chief administrative law judge may limit and simplify the
29 procedures that apply to a contested Medicaid case involving a Medicaid applicant or recipient
30 in order to complete the case as quickly as possible. To the extent possible, the Hearings
31 Division shall schedule and hear contested Medicaid cases within 45 days of submission of a
32 request for appeal. The simplified procedure may include requiring that all prehearing motions
33 be considered and ruled on by the administrative law judge in the course of the hearing of the
34 case on the merits. An administrative law judge assigned to a contested Medicaid case shall
35 make reasonable efforts in a case involving a Medicaid applicant or recipient who is not
36 represented by an attorney to assure a fair hearing and to maintain a complete record of the
37 hearing. The administrative law judge may allow brief extensions of the time limits contained
38 in this section for good cause and to ensure that the record is complete. Good cause includes
39 delays resulting from untimely receipt of documentation needed to render a decision and other
40 unavoidable and unforeseen circumstances.

41 (c) Mediation. – Upon receipt of an appeal request form as provided by section
42 108A-70.6A(d) or other clear request for a hearing by a Medicaid applicant or recipient, the
43 chief administrative law judge shall immediately notify the Mediation Network of North
44 Carolina which shall within five days contact the petitioner to offer mediation in an attempt to
45 resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days
46 of submission of the request for appeal. If mediation is successful, the mediator shall inform the
47 Hearings Division, which shall confirm with the agency that a settlement has been achieved,
48 and the case shall be dismissed. If the petitioner rejects the offer of mediation or the mediation

1 is unsuccessful, the mediator shall notify the Hearings Division that the case will proceed to
2 hearing. Nothing in this subdivision shall restrict the right to a contested case hearing.

3 (d) Burden of Proof. – The petitioner has the burden of proof to show entitlement to a
4 requested benefit or the propriety of requested agency action when the agency has denied the
5 benefit or refused to take the particular action. The agency has the burden of proof when the
6 appeal is from an agency determination to impose a penalty or reduce, terminate, or suspend a
7 benefit previously granted. The party with the burden of proof on any issue has the burden of
8 going forward, and the administrative law judge shall not make any ruling on the
9 preponderance of evidence until the close of all evidence.

10 (e) Decision. – The administrative law judge assigned to a contested Medicaid case
11 shall hear and decide the case without unnecessary delay. The Hearings Division shall send a
12 copy of the audiotape or diskette of the hearing to the agency within five days of completion of
13 the hearing. The judge shall prepare a written decision and send it to the parties. The decision
14 must be sent together with the record to the agency within 20 days of the conclusion of the
15 hearing."

16 **SECTION 2.** This act is effective when it becomes law.
17

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

U

D

BILL DRAFT 2009-SQz-31 [v.2] (05/11)

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
5/11/2010 2:09:44 PM**

Short Title: Prgm Eval Study Agency reversal ALJ decision. (Public)

Sponsors: .

Referred to:

1 A BILL TO BE ENTITLED
2 AN ACT AUTHORIZING THE JOINT LEGISLATIVE PROGRAM EVALUATION
3 OVERSIGHT COMMITTEE TO DIRECT THE PROGRAM EVALUATION DIVISION
4 TO STUDY AGENCY REVERSAL OF ADMINISTRATIVE LAW JUDGE DECISIONS
5 IN CHAPTER 150B CONTESTED CASES, AS RECOMMENDED BY THE JOINT
6 LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH,
7 DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.
8 The General Assembly of North Carolina enacts:
9 **SECTION 1.(a)** The Joint Legislative Program Evaluation Oversight Committee
10 shall include in the 2010 Work Plan for the Program Evaluation Division of the General
11 Assembly a study of Chapter 150B contested cases. The Division shall study the number of
12 decisions rendered by administrative law judges that are overturned as a final agency decision.
13 For these cases the Division shall evaluate the nature of the case, the basis of the reversal, the
14 number of cases appealed to Superior Court and the results of those appeals.
15 **SECTION 1.(b)** The Program Evaluation Division shall submit its findings and
16 recommendations to the Joint Legislative Program Evaluation Oversight Committee, the Joint
17 Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance
18 Abuse Services, and the Joint Legislative Administrative Procedure Oversight Committee at a
19 date to be determined by the Joint Legislative Program Evaluation Oversight Committee.
20 **SECTION 2.** This act is effective when it becomes law.
21

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

H/S

D

BILL DRAFT 2009-MGz-111* [v.8] (5/1)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)

5/11/2010 7:53:27 PM

Short Title: Modify MHDDSAS Reporting Requirements.

(Public)

Sponsors: Representative Insko./Senator Nesbitt.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO MODIFY REPORTING REQUIREMENTS PERTAINING TO MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, 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) Not later than January 1, 2011, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall provide a final report on community support services to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The final report shall include a summary of the following information with respect to former recipients of community support services:

- (1) The number of individuals no longer receiving any services.
- (2) The number of individuals transferred to other mental health services, broken down by the specific type of service and the number of individuals transferred to each service.
- (3) The amount of any cost increase or cost savings resulting from the transfer of those individuals to other mental health services.
- (4) The status of any new service definitions developed in response to the elimination of community support services.

SECTION 1.(b) By September 1, 2010, and annually thereafter, the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services shall submit a report summarizing all deaths subject to the reporting requirements set forth in G.S. 122C-31 that occurred during the one-year period preceding the date of the report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

SECTION 1.(c) Section 143C-9-2(d) reads as rewritten:

1 "(d) Beginning ~~July 1, 2007, July 1, 2010,~~ the Secretary of the Department of Health and
2 Human Services shall report annually to the Joint Legislative Oversight Committee on Mental
3 Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research
4 Division on the expenditures made during the preceding fiscal year from the Trust Fund. The
5 report shall identify each expenditure by recipient and purpose and shall indicate the authority
6 under subsection (b) of this section for the expenditure."

7 **SECTION 1.(d)** Beginning January 1, 2011, and annually thereafter, the
8 Department of Health and Human Services, Division of Mental Health, Developmental
9 Disabilities, and Substance Abuse Services, shall report to the Senate Appropriations
10 Committee on Health and Human Services, the House of Representatives Appropriations
11 Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on
12 Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal
13 Research Division on a strategic plan for organizing State and local resources to fund services
14 provided through local management entities. The report shall include criteria for the allocation
15 of funds, guidelines for utilization of funds, restrictions on use of funds, and a list of
16 expenditures.

17 **SECTION 1.(e)** Section 10.19A.(c) of S.L. 2009-451 reads as rewritten:

18 "**SECTION 10.19A.(c)** The Department of Health and Human Services, Division
19 of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall require
20 quarterly reporting from LMEs in the format required under subsection (a) of this section. The
21 Department of Health and Human Services shall report the results of the quarterly reports to the
22 Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and
23 Substance Abuse Services, the House of Representatives Appropriations Subcommittee on
24 Health and Human Services, the Senate Appropriations Committee on Health and Human
25 Services, and the Fiscal Research Division on or before ~~May 1, 2010, May 1, 2011, and~~
26 annually thereafter."

27 **SECTION 1.(f)** Section 10.65A.(a) of S.L. 2009-451 reads as rewritten:

28 "**SECTION 10.65A.(a)** ~~For the purposes of improving efficiency in the~~
29 ~~expenditure of available funds and effectively identifying and meeting the needs of~~
30 ~~CAP-MR/DD eligible individuals, on or before April 1, 2010, the~~ By January 1, 2011, the
31 Department of Health and Human Services, Division of Medical Assistance, in conjunction
32 with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services,
33 shall submit to the Joint Legislative Oversight Committee on Mental Health, Developmental
34 Disabilities, and Substance Abuse Services a plan for status report on the implementation ~~of~~
35 ~~Tiers 1 through 4 of~~ plan for the CAP-MR/DD ~~program.~~ Tiered Waiver. The plan shall describe
36 the implementation of each of the Tiers ~~1 and 4 and the proposed implementation of Tiers 2~~
37 ~~and 3, and revisions of Tier 4,~~ and shall include detail on each of the following:

- 38 (1) The array and intensity level of services that will be available under each of
39 the ~~four~~ Tiers.;
- 40 (2) The range of costs for the array and intensity level of services under each of
41 the ~~four~~ Tiers.;
- 42 (3) How the relative intensity of need for each current and future CAP-MR/DD
43 eligible individual will be reliably determined.;
- 44 (4) How the determination of intensity of need will be used to assign current and
45 future CAP-MR/DD eligible individuals appropriately into one of the ~~four~~
46 Tiers.
- 47 (5) The criteria for moving individuals from one Tier to another and any costs
48 associated with that movement.

1 ~~The Department may develop an application to the Centers for Medicare and~~
2 ~~Medicaid services for additional Medicaid waivers for Tiers 2 and 3 of the~~
3 ~~CAP-MR/DD program. The Department shall not submit the application until after~~
4 ~~it has submitted the plan required under this subdivision.~~ Nothing in this subdivision
5 obligates the General Assembly to appropriate additional funds for the
6 CAP-MR/DD waiver."

7 **SECTION 1.(g)** Section 122C-102(c) reads as rewritten:

8 "(c) State Performance Measures. – The State Plan shall also include a mechanism for
9 measuring the State's progress towards increased performance on the following matters: access
10 to services, consumer-focused outcomes, individualized planning and supports, promotion of
11 best practices, quality management systems, system efficiency and effectiveness, ~~and~~
12 ~~prevention and early intervention. Beginning October 1, 2006, equitable allocation of~~
13 ~~resources, prevention and early intervention, State-wide system of crisis response for adults and~~
14 ~~children, and management of the utilization of State facilities. Beginning January 1, 2011,~~ and
15 every six months thereafter, the Secretary shall report to the General Assembly and the Joint
16 Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance
17 Abuse Services, on the State's progress in these performance areas."

18 **SECTION 2.** This act is effective when it becomes law.
19

