MINUTES

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

Wednesday, January 10, 2007
9:30 AM
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services met on Wednesday, January 10, 2007, at 9:30 A.M. in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Janet Cowell, Charlie Dannelly, Vernon Malone, and William Purcell and Representatives Martha Alexander, Jeff Barnhart, Beverly Earle, Bob England, Carolyn Justice, Edd Nye and Fred Steen. Advisory members, Senator Larry Shaw and Representatives Jean Farmer-Butterfield and Earline Parmon were present.

Kory Goldsmith, Ben Popkin, Shawn Parker, Andrea Russo-Poole, Natalie Towns and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order, welcoming members and guests. She asked for a motion to approve the minutes from the December 6, 2006, meeting. Representative Farmer-Butterfield made the motion and the minutes were approved.

Representative Insko said the committee still had work to do before the final report would be ready. She said the committee would likely review recommendations at the next meeting and come back for an additional meeting after Session begins to finalize and approve the report, and to discuss final decisions regarding appropriation requests for the General Assembly.

Representative Insko then recognized Representative Edd Nye and thanked him for his years of service and guidance in the House and to the LOC. She also recognized intern David Kelly, who will be working in the Research Division.

Dr. Allan Dobson, Assistant Secretary for Health Policy and Medical Assistance, gave an update on the CAP/MR/DD waiver technical amendment. He stated that the amendment had several issues that needed to be addressed: 1) The number of hours a single caregiver can be paid in a week caring for a recipient; and 2) The need for separation between the person paid for caring for the recipient, and the person overseeing and approving the person centered plan. Dr. Dobson stated that the goal was to attain a policy that addresses accountability, but provides flexibility to recipients receiving service. He said implementation had been delayed 60 days, but might take longer since the amendment would not be implemented until it is right. He also said that there were currently 3 LMEs

that were participating in a data exchange pilot that enables them to access the Medicaid database to track what is happening with consumers. The goal is to have all LMEs partner with the State in managing Medicaid benefits. Once the Attorney General approves an amendment to the LME performance contract, all LMEs will be able to utilize the program. The LMEs would be able to access the paid claims data which would include client specific data based on the type of service as well as other elements in the LME catchment area.

Jeff Weaver, General Assembly Chief of Police, addressed the building evacuation policy. (See Attachment No. 2) Representative Insko reminded those attending that there had been a fire drill during the previous meeting in which several in attendance had been in wheelchairs creating an evacuation problem because the elevators are typically turned off for a fire drill. Mr. Weaver said that in the event there was a fire, each floor has a primary monitor and an alternate monitor. He said that the elevators did run during an alarm, but that it was recommended that the stairs be used instead. The floor monitors would escort wheelchair bound people to the platform of the stairwell and once the Fire Department arrived, it would be determined if the elevators could be used or if those in wheelchairs needed to be carried down the stairs. In the event of a bomb threat, the General Assembly Police would evacuate those individuals if it was determined it could be done safely. It was suggested that meetings held with 3 or more individuals in wheelchairs be moved to a ground floor. However, it was also noted that there were no rooms large enough on the ground level to accommodate a large meeting. It was also suggested that the Sergeant-At-Arms could notify the General Assembly Police as to the number of people in wheelchairs attending meetings in the building in case of emergency.

Representative Insko took a moment to recognize the passing of Representative Howard Hunter and Senator Robert Holloman. She acknowledged the respect felt for those lost and offered sympathy to the families.

Next, Eddie Caldwell, Executive Vice President and General Counsel to the North Carolina Sheriffs' Association, offered information regarding the availability of mental health services for pre-trial detainees in county jails. He said that many county jails have services for those detained, but some do not. For those offering services, they are obtained through a local provider, such as a government agency, local mental health authorities, or in other cases they are offered through private corporations. Some sheriffs have a private psychiatrist on contract and some have contracts with companies that provide all medical care needed including mental health services. Others receive assistance from the county health department and as a last resort; they can transfer inmates to the Department of Corrections. Mr. Caldwell was asked to get information on which counties were lacking in services. He also pointed out the lack of basic prescription medications for those incarcerated. It was noted that many individuals are on the streets, in emergency rooms, or in jails because of the lack of community facilities. Issues surrounding the problems of transportation were also discussed.

Senator Nesbitt told members that the report today would not answer all of the questions. He said that it was imperative that the committee have all the information and that

everyone was on the same page before recommendations are made. He suggested that evening meetings may be necessary after Session begins in order to offer the best possible recommendations to the General Assembly.

Kory Goldsmith, Research Division, noted that members had copies of 2 of the 3 deliverables provided by the consultant. She also noted that the reports were available on the Division website for review. (www.dhhs.state.nc.us/mhddsas/) Ms. Goldsmith reviewed the study provisions related to the consultant's reports. (See Attachment No. 3) She provided a brief outline of what should be in each of the studies according to legislation.

Dr. Christine Thompson, Heart of the Matter Consulting, Inc., gave her presentation on the Final Report and Gaps Analysis. (See Attachment No. 4) She first reviewed the major gaps in services which included: 1) MH and SA services are under-funded while DD services are adequately funded; 2) NC over utilizes State institutions; 3) NC needs to increase treated prevalence; and 4) NC needs to increase continuity of care for MH and SA. Dr. Thompson explained that the consultants had made assumptions about parameters and clinical positions to create models that state policy makers and others in the system may not agree with, but the models are such that the criteria can be changed and the assumptions can be modified. The models can be run for different counties and include or delete services already included in the model. She explained that prevalence is a statistical number that is calculated to determine how many people have a given condition in a given area. Treated prevalence is how many people that have been served in the system of that group of people are thought to have that condition. Prevalence data is not available for people with DD because some receive services from the school system, or vocational rehabilitation or from mental health. The data for MH and SA is more straight forward and clearer. In the methodology, Dr. Thompson pointed out that service units purchased with local dollars were not reported. It was suggested that the State needed to require the LMEs to report local service data because services are being provided that are not being accounted for. It was stated that it was imperative that information be available on the amount of State, local, and Medicaid dollars being spent in order to access who is being served. Ms. Wainwright stated that the statewide average for county dollars was 6%. She said the Department knows how much money counties are spending, but not how the money is being spent.

Dr. Thompson then explained the "recipe" for the model. Prevalence is the number of people being served and continuity of care is how consistently or how often they are being served. She said the services delivered and the units of service on the number of people getting those services drive the prospective model. She then stated that N.C. was serving more people, but not providing an adequate dose of care. She said that it costs more to provide the right level of continuity than to increase treated prevalence. Dr. Thompson explained that there was a lack of continuity because there was an estimated 26% failure to show up for service, but with adequate outreach and coordination of care, that number can be reduced. Other reasons for low continuity are: Evidence Best Practice is not being adequately used; the Assertive Community Treatment Model requires a certain dose of service that people are not getting; case loads are too high for the workers; and providers do not have enough front line service delivery workers to provide service.

Dr. Thompson stated that substance abuse treatment nationally was not good and North Carolina in particular was not good. A lot of substance abusers are in state facilities and local emergency rooms that are in need of detoxification. She said the best way to lower the state inpatient rate was to put money in community detox and the follow-up programs to help people with addictions.

Regarding Crisis Services, Dr. Thompson stated that LMEs were reluctant to use mobile crisis units and used facility based services more. Using the mobile crisis units allows direct contact with the consumer, affords better information, and does not relying on other methods of transporting individuals. She said that this would probably be controversial in the system among the LMEs. Senator Nesbitt pointed out that the appropriations approved by the General Assembly last year were not in the system yet since the crisis plans that must be approved by the Department, will not be in until March 1, 2007, at which time the funds will be released. It was suggested that LMEs be involved in controlling State hospitals admissions in order to redirect people to the crisis units at the local level or into a crisis management service situation. Dr. Thompson said that North Carolina used State facilities twice as much as the national average.

Dr. Thompson emphasized the importance of the culture shift that goes along with the reform effort. Consumers must be involved in planning and deliberation in designing the system. She suggested that the State needed to use consumer owned and operated programs for mental health and substance abuse, and focus on recovery which will reduce cost. Dr. Thompson also stated that there were obvious gaps in services in the rural areas of the State; that the State was below the national average in serving the elderly; and she said the system needs to engage consumers more in their own individual recovery plan. She also discussed policy needs. She said more rules must be established to enforce policy. Dr. Thompson said more must be done in the area of community inpatient care, or downsizing State facilities will not be successful. In other states, under a certificate of need or Medicaid or hospital facilities, the hospitals have to operate a certain number of psychiatric hospital beds per capita. That allows for inpatient community capacity. She suggested that legislation be enacted establishing the LME to act as the single gate to the State hospital, and the hospital emergency room be required to contact the LME to offer an opportunity for alternative care before placing a patient in a State facility. She said it was imperative to have a single gate keeper and financial incentives in order to downsize.

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

Continuing, Dr. Thompson stated that care coordination was a big problem in North Carolina, and allowing the LMEs access to the Medicaid data base would allow the LME to see if patients are participating in treatment, if they are receiving service, and if they are receiving enough of that service. The provider network system is fragmented because there is no one managing the system. She said there must be control over the system to see that the person centered plan of service for the client is being followed. There is no current mechanism in place for LMEs to know when a client is in crisis. She recommended legislation so private insurance is routinely billed before public dollars are

expended, and to also establish a slide scale that is statewide. She also listed several items the Division on MHDDSAS needed regarding monitoring and oversight.

Dr. Thompson then reviewed estimates of funding resources based on recommendations made in the report. She said that State facility reductions would save $25 million based on the model as calculated, but over 10 years the cost of living would affect that figure. Medicaid increase for new clients or population increases was $12 million in federal shares. $23 million could be recuperated from a sliding fee schedule. Requiring SSI to go directly to the provider for room and board would save $39 million. Dr. Thompson also stated that there were a lot of providers and no way to indicate if all the providers were needed which increase costs to the system. Too many providers can cause an increase cost to the system.

In closing, Dr. Thompson stated that the collective impact of Long Range Planning changes would cost $2.7 billion over a 5 year period. This would bring the system up to the national average treated prevalence rate, downsize State facilities, implement new EBP, sustain population growth and economic increases the system is currently facing, and implement strong levels of continuity of care. Senator Nesbitt warned the committee to not be overwhelmed by the figure. He said that if $2.7 billion was put into the system it would far outreach other states, and that the committee should not measure what the committee does against the $2.7 billion figure. He indicated that there were other ways to generate money such as to increase Medicaid eligibility. He cautioned that the committee's job was to find the next incremental step. Mr. Moseley stated that the most important item that came from the report was a model that allows the Division to move forward, to have a rational, sustainable, and a more objective way of projecting future needs. He said that the Department supported the report but felt that some the recommendations needed further study.

Andrea Russo-Poole, Fiscal Research, reviewed a summary of the *Psychiatrist Access Funding*, which included a summary of where the funding is going in the Office of Rural Health, where it is going by LME from the Division, and also included is a narrative from the Office of Rural Health and from the Division. (See Attachment No. 5) She also distributed and reviewed a copy of *Options to Increase Funding to the NC MHDDSAS System*. (See Attachment No. 6) She said that the LOC staff requested the Division to estimate the cost of certain items. She stressed that the estimates where from the Division and staff had not had an opportunity to verify the numbers. She said that once staff had reviewed the figures, they would return with final cost estimates for the committee to review.

Representative Insko then asked members of the audience for their comments. Concerns expressed by those wishing to address the committee included:

- Concern regarding technical amendment to CAP/MRDD waiver limiting the number of hours a parent can be paid to provide personal care to an adult child.

- Lack of competent provider care.

- The need for local hospitals to be involved in providing services.
- Parity in the Mental Health System.
- DD not adequately funded as suggested in report.
- Waiting list for CAP/MR/DD slots is too long.
- Substance Abuse Facility – difficulty obtaining reimbursement from DMA for perinatal maternal care for women under age 21 – Authorization EPFET.

There being no further business, the meeting adjourned at 1:10 PM.

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

Rennie Hobby, Committee Assistant