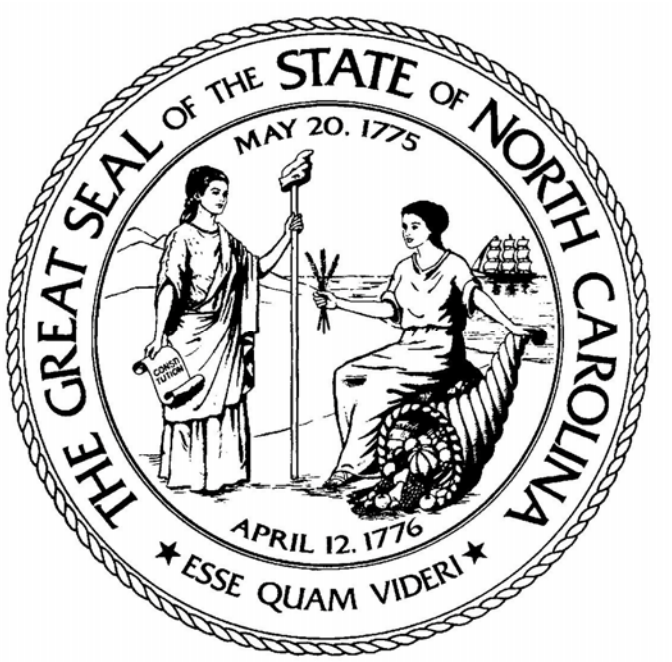
JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON
MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES



REPORT TO THE 2008 REGULAR SESSION
OF THE
2007 GENERAL ASSEMBLY

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

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

April 23, 2008

TO THE MEMBERS OF THE 2007 GENERAL ASSEMBLY (2008 Regular Session):

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

Respectfully Submitted,

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 Committee consists of sixteen members, eight appointed by the President Pro Tempore of the Senate and eight appointed by the Speaker of the House of Representatives. The members appointed by the President Pro Tempore must include all of the following: at least two must be members of the Senate Committee on Appropriations, the Chair of the Senate Appropriations Committee on Human Resources and at least two must be of the minority party. The members appointed by the Speaker of the House 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 Committee. The Co-Chairs for 2007-2008 are Senator Martin Nesbitt and Representative Verla Insko.

COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services met 10 times during the 2007-2008 interim. Following is a summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

September 25, 2007

The LOC convened its first meeting of the interim on Tuesday, September 25, 2007, at 10:00 A.M. in Room 643 of the Legislative Office Building. Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed returning members, new members, and guests.

Dempsey Benton, Secretary of the Department of Health and Human Services (DHHS), presented DHHS priorities for improving the mental health system that included: implementation of the crisis services system, increasing provider capacity, enhancing substance abuse treatment facilities, and providing guidance and direction to the State hospitals.

Dr. Alice Lin, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH) consultant, presented her report on the *Implementation of Local Management Entities*. Dr. Lin discussed immediate, short-term, and mid-term recommendations.

Kory Goldsmith, Research Division, reviewed the process for the closure of Dorothea Dix and John Umstead Hospitals. According to Session Law 2007-323 Section 10.49.(t), the Secretary may close Dorothea Dix and John Umstead Hospitals provided certain conditions are met.

Jim Osberg, Chief of State Operated Services, DMH, discussed the closure plan for Dorothea Dix and John Umstead Hospitals pursuant to the opening of Central Regional Hospital (CRH) in Butner. Mr. Osberg provided a timeline for the design, construction, and operation of CRH.

Several updates were presented by staff concerning legislative actions from the 2007 Session. Andrea Poole, Fiscal Research Division, and Melanie Bush, Fiscal Research Division, provided a review of budgetary actions. Kory Goldsmith, Research Division, summarized substantive legislation enacted. Shawn Parker, Research Division, gave an update on Local Management Entities (LMEs) including historic and current LME configurations.

Trish Amend, NC Housing Finance Agency, and Julia Bick, DHHS, discussed the Housing 400 Initiative. Ms. Amend announced that financing for housing for persons with disabilities had been awarded for 425 units in 33 counties.

Jim Osberg, Chief of State Operated Services, DMH, provided an update to the LOC on the hospital utilization pilot. Mr. Osberg discussed the distribution of funding and the timeline for implementation of services to reduce utilization of State psychiatric hospitals.

Phillip Hoffman, Chief of Resource and Regulatory Management, DMH, reported on data collection of consumer income data. He also explained that DMH established a workgroup to examine the collection of county funds utilization data.

Bonnie Morrell, Team Leader for Best Practice, DMH, reported on crisis services implementation. In SFY 2006-2007, $7 million was expended for local inpatient services, facility based crisis, detoxification, and mobile crisis resulting in a decrease of admissions to the State psychiatric hospitals.

Flo Stein, Chief of Community Policy Management, DMH, discussed performance indicators. Ms. Stein reported LMEs that provided continuity of services saw significant improvement in mental health and substance abuse clients in every measurable indicator.

October 31, 2007

The LOC convened its second meeting of the interim on Wednesday, October 31, 2007, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Dr. Thomas McLellan, CEO of the Treatment Research Institute, discussed the State's role in the improvement of effectiveness and accountability for the treatment of addiction. Dr. McLellan explained the chronic care model in the treatment of addiction. Goals to measure success included: retaining patients at an appropriate level of care and monitoring, preparing patients to do well in the next level of care, and evaluating effectiveness during treatment instead of post-discharge.

Dr. Mandy Chalk, Director, Center for Performance Based Policy, Treatment Research Institute, provided information on funding treatment networks and contracting for substance abuse treatment services.

Kim Johnson, Network for the Improvement of Addiction Treatment, presented factors to consider regarding performance based contracting. Ms. Johnson suggested key elements to consider: a good data collection system, clear definitions for data elements, and agreed upon performance standards.

November 15, 2007

The LOC convened its third meeting of the interim on Thursday, November 15, 2007, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Andrea Poole, Fiscal Research Division, reviewed Section 10.49.(s1)-(s4) of Session Law 2007-323 regarding the hospital utilization pilot.

Laura White, Team Leader, State Psychiatric Hospitals, DMH, explained the selection process for the LMEs participating in the hospital utilization pilot.

Don Herring, Director of Service Management, Western Highlands Network, described plans for increasing crisis services and hospital diversion systems to decrease State hospital utilization.

Betty Taylor, CEO, CenterPoint Human Services, reviewed existing crisis services offered by CenterPoint and plans for expansion. Goals under the pilot included: reserving bed days for patients requiring longer stays, increasing enhanced psychiatric services, diverting clients from the legal system and the ER, and increasing adult transitional housing.

Tom McDevittt, LME Director, Smoky Mountain Center, presented a proposal to reduce hospital utilization by increasing local crisis services especially inpatient psychiatric beds through public/private partnerships with two hospitals in the area.

Tom Galligan, Deputy Director for Budget and Finance, Division of Medical Assistance (DMA), gave an update on community supports financial status. Mr. Galligan reported that approximately 45% of the 2007 budget for community supports was spent during the first 4 months of the fiscal year.

Leza Wainwright, Deputy Director, DMH, and Tara Larson, Acting Deputy Director for Clinical Affairs, DMA, gave an update on community support services. Ms. Wainwright and Ms. Larson provided background and reviewed the revised comprehensive plan that included clarification of service definitions, suspending new provider endorsements until new rules and provider qualifications are developed, monitoring and review of LMEs, and changing the authorization process.

Ms. Wainwright then presented an update on single stream funding and reviewed the criteria necessary for LMEs participation.

Next, Ms. Wainwright discussed the independent evaluation of LME performance. Ms. Wainwright explained that the Department contracted with Mercer Consulting for independent reviews to determine LME performance, possible consolidation of functions, and requirements for LMEs to perform utilization review.

Senator Nesbitt, Co-Chair, called on members of the audience for public comment.

December 5, 2007

The LOC convened its fourth meeting of the interim on Wednesday, December 5, 2007, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Grayce Crockett, Director, Mecklenburg Local Management Entity (LME), explained the Mecklenburg hospital utilization pilot to reduce bed days at Broughton hospital.

Tom Galligan, Deputy Director for Budget and Finance, Division of Medical Assistance (DMA), gave an update on community supports services.

Andrea Poole, Fiscal Research Division, reviewed the 2007-2008 FY LME service dollars allocation.

Leza Wainwright, Deputy Director, DMH, discussed the current allocation of community based services funds and explained the allocation of continuation funds.

Kory Goldsmith, Research Division, reviewed an information packet provided to committee members in response to questions from the previous meeting.

Mike Mosley, Director, DMH, and Leza Wainwright, Deputy Director, DMH, presented the revised plan for the closure of Dorothea Dix and John Umstead hospitals. Mr. Mosley reviewed the timeline for transition to the new hospital. Mr. Mosely also announced the development of an additional 60 bed unit on the Dorothea Dix campus.

Representative Insko, Co-Chair, called on members of the audience for public comment.

January 23, 2008

The LOC convened its fifth meeting of the interim on Wednesday, January 23, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Shawn Parker, Research Division, and Andrea Poole, Fiscal Research, reviewed an information packet provided to committee members in response to questions from the previous meeting.

Dempsey Benton, Secretary of the Department of Health and Human Services (DHHS), presented an update on the State psychiatric hospitals and community support services. Secretary Benton also discussed initiatives to establish committees of external experts to help with mental health issues.

Andrea Poole, Fiscal Research Division, and Denise Harb, Fiscal Research, reviewed a new report, the MH/DD/SA System Indicators report.

Shawn Parker, Research Division, provided background on the development of local crisis services plans.

Anthony Ward, Provider Relations Manager, Guilford Center, described the area's implementation of crisis services and discussed the successes and challenges of the implementation.

Art Constantini, Director, Southeastern Center for MH/DD/SAS, reviewed the crisis services in place at Southeastern Center. Mr. Constantini described the plan as continuum consisting of prevention measures, crisis response services, and post-crisis services.

Terry Hatcher, Director, Division of Property and Construction, DHHS, gave an update on construction projects.

Andrea Poole, Fiscal Research Division, reviewed Session Law 2007-323, Section 10.51(b) that directs DHHS to develop a revised service dollar allocation methodology to equalize funding to LMEs across the State.

Leza Wainwright, Deputy Director, discussed the revised service dollars allocation and explained a combination of two formulas was used to develop the methodology.

February 27, 2008

The LOC convened its sixth meeting of the interim on Wednesday, January 23, 2008, at 10:00 A.M. in Room 643 of the Legislative Office Building.

Andrea Poole, Fiscal Research Division, reviewed an information packet provided in response to questions from the previous meeting. Next, Ms. Poole explained the monthly MH/DD/SA system indicators report and gave an update on construction projects.

Dan Coughlin, Area Director/CEO, Pam Shipman, Deputy Area Director, and Dr. Craig Hummel, Medical Director of Piedmont Behavioral Healthcare (PBH) discussed PBH's use of a 1915(b)/1915(c) combination Medicaid waiver. The waiver allowed PBH to restrict the freedom of choice of providers and to determine the size and scope of the provider network.

Gann Watson, Bill Drafting Division, explained the process for appealing a decision made by a State agency.

Emery Milliken, General Counsel, DHHS, provided information regarding the Medicaid appeals process, both formal and informal appeals.

Tara Larson, Deputy Director for Clinical Affairs, DMA, addressed the status of applications for additional Medicaid waivers. Ms. Larson highlighted options available through the waiver process with CMS. Leza Wainwright, Deputy Director, DMH, explained that DMH was working with LMEs to examine different waivers.

Flo Stein, Chief of Community Policy Management, DMH, presented an update on regionally funded and locally hosted substance abuse programs.

Leza Wainwright, Deputy Director, DMH, explained a technical amendment to the Community Alternatives Program (CAP) MR/DD waiver that allows family members or guardians to act as providers and provide personal care services to adult children.

Representative Insko, Co-Chair, called on members of the audience for public comment.

February 28, 2008

The LOC convened its seventh meeting of the interim on Thursday, February 28, 2008, at 9:00 A.M. in Room 643 of the Legislative Office Building.

As a follow-up on the appeals process, Representative Insko, Co-Chair, welcomed Judge Julian Mann, Director and Chief Administrative Law Judge of the Office of Administrative Hearings (OAH). Administrative Law Judge Don Overby, and Chief Clerk, Kim Housing were also in attendance. Judge Mann provided an overview of the OAH and addressed questions regarding the impact

of the community support appeals cases on the OAH. Judge Mann suggested that for cases that are *pro se*, the State file instead of the petitioner and that pre trial motions that interfere with getting to the merit of the case be eliminated.

Representative Insko asked Vicky Smith, Executive Director of Disabilities Rights of North Carolina, to respond to comments. Ms. Smith suggested that a clearly articulated, easily understood bill of rights for people with disabilities receiving services was needed whether the services were federally funded or State funded.

Next, Phillip Hoffman, Chief of Resources/Regulatory Management, DMH, gave an update on data collection and county funds utilization. He explained that DMH's reporting requirements were modified to include information on family size. Currently, the amount of county funds budgeted and received through the LMEs is reported but not how the funds are utilized.

Flo Stein, Chief of Community Policy Management, DMH, gave a presentation on crisis services for the developmentally disabled. Ms. Stein described barriers to receiving service and explained the importance of a functional assessment, training, and technical assistance. She explained several proven models in detail. Ms. Stein stated that DMH recommended that the Systematic Therapeutic Assessment Respite and Treatment (START) Program be implemented on a regional basis.

Next, Carol Donin, Developmental Center Team Leader, DMH, addressed downsizing at the developmental centers. Ms. Donin reported that most consumers moved to community residential settings such as Intermediate Care Facilities (ICF/MR) group homes and live-in group homes supported by the Community Alternatives Program (CAP) MR/DD waiver. Ms. Donin also mentioned the ICF-MR bed transfer initiative.

Tara Larson, Acting Deputy Director of Clinical Affairs, DMA, addressed cost-sharing under CAP. She explained that the Department looking at families currently on the CAP/MR and CAP/C waiver programs and developing a process by which families would pay for part of their care.

Rose Burnette, Tiered Waiver Project Manager, DMH, gave an update on the CAP-MR/DD waiver development. She explained that DHHS requested an extension from CMS to develop the four tiered waivers and projected implementation for the tiered waivers between January and June 2009.

Andrea Poole, Fiscal Research, reviewed a draft of recommendation options with committee members.

March 26, 2008

The LOC convened its eighth meeting of the interim on Wednesday, March 26, 2008, at 9:00 A.M. in Room 643 of the Legislative Office Building.

Shawn Parker, Research Division, reviewed an information packet provided to committee members in response to questions from the previous meeting.

Denise Harb and Andrea Poole, Fiscal Research Division, reviewed the monthly MH/DD/SA system indicators report.

Roman Rojano, Area Director, Wake County Human Services presented short and long term initiatives that addressed the closure of Dorothea Dix hospital.

Sharen Prevatte, Area Director, Southeastern Regional MH/DD/SA Services, discussed the status of the LME. Ms. Prevatte explained that Southeastern Regional utilized a combination of inpatient services at area hospitals, a mobile crisis team, a local crisis stabilization facility, and psychiatrists.

Andrea Poole, Fiscal Research Division, and Shawn Parker, Research Division, presented draft findings and recommendations to the LOC.

Trish Amend, NC Housing Finance Agency, and Julia Bick, DHHS, discussed the Housing 400 Initiative. Ms. Amend announced that over 1,300 units had been funded, 681 units completed, and 604 of those units were occupied.

Bonnie Morrell, Team Leader for Best Practice, DMH, gave a presentation on transitional residential treatment options for housing individuals with mental illness in the community.

Tara Larson, Acting Deputy Director for Clinical Affairs, DMA, explained issues surrounding the suspension of Medicaid eligibility for individuals in State institutions.

Denise Harb, Fiscal Research Division, and Gann Watson, Bill Drafting Division, continued the presentation of draft findings and recommendations to the committee members and incorporated proposals from members of the committee.

Dempsey Benton, Secretary of the Department of Health and Human Services, presented a report on the Department's recommendations.

April 17, 2008

The LOC convened its ninth meeting of the interim on Wednesday, April 17, 2008, at 9:00 A.M. in Room 544 of the Legislative Office Building.

Mike Watson, CEO, Sandhills Center for MH/DD/SAS, discussed single stream initiatives and hospital transition teams at Sandhills.

Roy Wilson, CEO, East Carolina Behavioral Health (ECBH), gave an overview of services at ECBH and explained that quality services are based on consumers' needs.

Tara Larson, Acting Deputy Director for Clinical Affairs, DMA, presented background on the Workforce Development Initiative. Ms. Larson then introduced John Morris, Annapolis Coalition on the Behavioral Health Workforce, and Dr. Amy Hewitt, University of Minnesota, Institute on Community Integrations.

Mr. Morris discussed goals and strategies for strengthening and supporting the workforce in the areas of behavioral health, developmental disabilities, and aging.

Dr. Hewitt, provided an overview of the direct support workforce in North Carolina and identified strategies to build systems that maximize support and development of direct support workers.

Leza Wainwright, Co-Director, Division of MH/DD/SAS, presented the findings and recommendations from the *Independent Evaluation of the Performance of Local Management Entities* report by Mercer.

Dempsey Benton, Secretary, Department of Health and Human Services (DHHS), announced priorities for DHHS including funding for additional staff at the State psychiatric hospitals, establishment of a statewide network of mobile crisis teams, procurement of additional community inpatient beds, and the voluntary development of regional LMEs.

Representative Insko, Co-Chair, called on members of the audience for public comment.

After lunch the LOC reconvened in Room 643 of the Legislative Office Building and Representative Insko, continued the public comment period.

Steve Hairston, Chief of Operations Support, DMH, reported on the Workforce Development Initiative.

Dr. Marvin Swartz, Chair, Commission for MH/DD/SAS presented an overview and the recommendations for the MH/DD/SAS Workforce Plan.

Pam Silberman, President/CEO, North Carolina Institute of Medicine, discussed the Substance Abuse Task Force draft findings and recommendations.

Andrea Poole, Fiscal Research, reviewed changes to the LOC draft report and incorporated proposals from members of the committee.

Gann Watson, Bill Drafting Division, explained the bill draft containing the LOC recommendations.

April 23, 2008

COMMITTEE FINDINGS AND RECOMMENDATIONS

INTRODUCTION

The LOC – and more recently the Department of Health and Human Services and the press – has identified problems concerning the administration of mental health, developmental disabilities, and substance abuse services at the State and local levels. Some of these problems and issues can be addressed in the 2008 Regular Session of the 2007 General Assembly. Others will require more review and scrutiny, and thus more time to identify and implement significant, long-term changes in the system at all levels of administration.

As a backdrop for the recommendations and legislative proposals contained in this report, it is important to understand the historical context and the fundamental policy behind MH/DD/SA System Reform enacted by the 2001 General Assembly in House Bill 381 and amendments enacted since that time.

During the mid to late-1990's, North Carolina's public system for delivering services to those with mental illness, developmental disabilities, and substance abuse addictions faced significant challenges. Several local agencies were in imminent danger of financial collapse and the State-run psychiatric hospitals were threatened with the loss of federal funding due to inadequate staffing and record-keeping violations. During this same period, the United States Supreme Court held that States have an obligation to provide community-based treatment for persons with mental disabilities when: (i) State medical professionals determine community placement is appropriate; (ii) placement would be less restrictive and is not opposed by the patient; and (iii) community placement can be reasonably accommodated, given resources available to the State and the needs of others with mental disabilities.[1] In response to these challenges, the General Assembly commissioned a series of studies and created the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) to make recommendations as to what should be done.

Policy enacted in Session Law 2001-487[2] set the framework for system reform. Specifically, it made significant changes addressing issues of State and local

[1] Olmstead v. L.C., 527 U.S. 581 (1999); Title II of the Americans with Disabilities Act.
[2] HB 381 - An Act to Phase in the Implementation of Mental Health System Reform at the State and Local Level (S.L. 2001-437).

governance and increased accountability. The act emphasized consumer-driven community-based services. It required that State and local governments provide certain core services to all individuals and required the development of enhanced services that targeted persons with the most severe disabilities. In addition, the act shifted the role of local public mental health agencies from being direct service providers to managing and coordinating services delivered by private providers. [3]

Policy of the State

"*The policy of the State is to assist individuals with needs for mental health, developmental disabilities, and substance abuse services in ways consistent with the dignity, rights, and responsibilities of all North Carolina citizens. Within available resources it is the obligation of State and local government to provide mental health, developmental disabilities, and substance abuse services through a delivery system designed to meet the needs of clients in the least restrictive, therapeutically most appropriate setting available and to maximize their quality of life…..State and local governments shall develop and maintain a unified system of services centered in area authorities or county programs. The public service system will strive to provide a continuum of services for clients while considering the availability of services in the private sector…*".[4]

Administration of the System

"*The Secretary shall administer and enforce the provisions of this Chapter and the rules of the Commission and shall operate State facilities. An area director or program director shall (i) manage the public mental health, developmental disabilities, and substance abuse services system for the area authority or county program according to the local business plan, and (ii) enforce applicable State laws, rules of the Commission, and rules of the Secretary. The Secretary in cooperation with area and county program directors and State facility directors shall provide for the coordination of public services between area authorities, county programs, and State facilities…*".[5]

"*Local management entities are responsible for the management and oversight of the public system of Mental Health, Developmental Disabilities, and Substance Abuse Services at the community level. An LME shall plan, develop, implement, and monitor services within a specified geographic area to ensure expected outcomes for consumers within available resources.*"[6]

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[3] N.C. Legislative Services Office, Research Division. *System Reform for Mental Health, Developmental Disabilities, and Substance Abuse Services.* 1 INFO BRIEF, no. 2 (Oct. 10, 2006).

[4] N.C.G.S. §122C-2

[5] N.C.G.S. §122C-111

[6] N.C.G.S. §122C-115.4

Systemwide Accountability

"Every county, through an area authority or county program, shall provide for the development, review, and approval of an LME business plan for the management and delivery of mental health, developmental disabilities, and substance abuse services."[7]

If an LME is not providing minimally adequate services the law authorizes the Secretary of DHHS to take certain actions after notice and time for correction by the LME. Those actions include suspension of funding, appointing a caretaker administrator or caretaker board of directors, and termination of an area director of program director when the Secretary appoints a caretaker administrator.[8]

Upon a determination by the Secretary that an area authority or county program is in imminent danger of failing financially and of failing to provide direct services to clients, the Secretary may assume control of the financial affairs of the area authority or county program and appoint an administrator to exercise the power assumed[9].

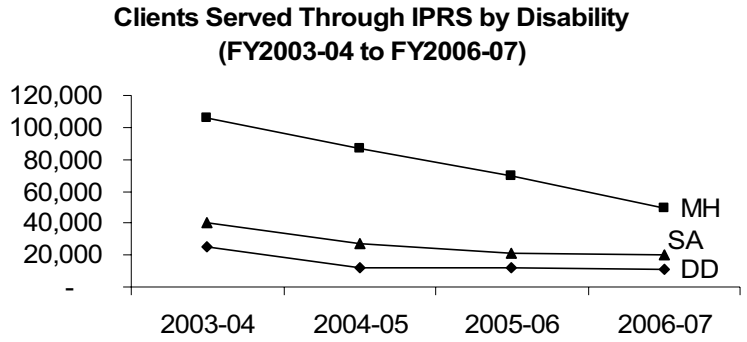
In light of the issues that have emerged regarding the implementation and administration of MH/DD/SA system reform, the LOC respectfully reports the following findings and recommendations for consideration by the 2007 General Assembly, Regular Session, 2008. The legislative proposal can be found in the Appendix to this report.

[7] N.C.G.S §122C-115.2
[8] N.C.G.S. §122C-124.1.
[9] N.C.G.S. §122C-125

FINDING ONE: EXPENDITURE OF SERVICE DOLLARS

State funds appropriated for services are not being fully expended for the intended purpose, especially in the areas of crisis services and substance abuse services. For example, in FY 2006-07, $47.7 million in State service dollars was unexpended. Of that, the 2007 General Assembly realigned $26.4 million for FY 2007-08 and the remaining funds were earmarked for LME systems administration for FY 2007-08. In FY 2007-08, it appears that service dollars will again be under-expended – particularly State funding for crisis services and substance abuse services.

Since FY 2003-04, the State has served fewer clients each year through the State IPRS system, the claims processing system for State-paid clients. The State served half as many clients in FY 2006-07 as it did in FY 2003-04[10]. The decline in clients served is particularly high for individuals with mental health and substance abuse services needs, as is shown in the chart below. While there was a corresponding increase in the number of persons with mental health needs served through Medicaid, more research is needed to determine if those services are reaching the same population that State-paid services are designed to help.



Additionally, there have anecdotal reports that providers are increasingly unwilling to provide services to State-paid clients and prefer to provide services to Medicaid-paid clients. A preliminarily review of available data suggests that this may be the case.

There are conflicting explanations available for the under-expenditure of funds, the decrease in services to State-paid individuals, and the lack of service providers available to treat State-paid clients. However, despite hearing from and meeting

[10] Measuring Trends in Public MHDDSA Payments and Persons Served, Medicaid and IPRS Aggregate Utilization Data by LME as presented at FARO in November, 2007: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm.

with LMEs, providers, and DHHS, the LOC has not been able to determine a full explanation of the problem.

Given the increased needs for these services seen in the community, the jails, State hospitals, and emergency rooms, it is vital that these funds are spent appropriately and that within those available resources, services be made available to individuals who do not qualify for Medicaid.

RECOMMENDATION ONE:

1. Adjust the timing and method by which each non-single-stream LME's services dollar allocations are distributed, in order to mitigate cash-flow problems that many LMEs experience at the beginning of the fiscal year. Specifically, distribute no less than one-twelfth of each non-single-stream LME's allocation to the respective LME at the beginning of the fiscal year, and subtract this amount from the LME's total reimbursements for the fiscal year.

2. Appropriate $6 million for DHHS to establish additional regionally-purchased and locally-hosted substance abuse programs.

3. Encourage the conversion of the remaining non-single-stream LMEs to single-stream funding as soon as possible.

   Appropriate to DHHS $675,000 for technical assistance to those LMEs not currently meeting the standards necessary for single-stream funding.

   Direct DHHS to develop standards for the removal of single-stream designation for those LMEs that do not continue to meet the single-stream standards once designated.

4. Direct DHHS to simplify the current State Integrated Payment and Reporting System (IPRS) to encourage more providers to serve State-paid clients.

5. Direct DHHS to create a reporting system for both single-stream funding and non-unit-cost-reimbursement funding that is readily comprehensible and integrates with payment systems.

6. Direct DHHS, in consultation with LMEs and providers, to determine why there have been over- and under-expenditures of State service dollars by LMEs and to take the actions necessary to address the

problem. Also direct DHHS to report to the General Assembly no later than January 1, 2009 on the actions taken.

7. Appropriate $1 million to the General Assembly to be used to retain the services of an independent consultant to perform a gap analysis of the Mental Health, Developmental Disabilities, and Substance Abuse Services System. The RFP should require the Independent Consultant to report its findings and recommendations by May 1, 2009.

   Also, recommend that the Joint Legislative Program Evaluation Oversight Committee include in the work plan for the Program Evaluation Division a thorough performance evaluation of the State's mental health agencies in the Department of Health and Human Services (the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Division of Medical Assistance) to be completed by May 1, 2009.

FINDING TWO: STATE-OPERATED SERVICES

The State psychiatric hospitals are admitting more clients than in prior years – approximately 2,600 more admissions in FY 2006-07 than in FY 2002-03.

In January 2007, due to increased admissions to the hospitals' acute units (particularly the adult acute units), the Department of Health and Human Services put a delayed admissions policy into effect: when a State psychiatric hospitals' acute units reach 110% capacity, no admissions are accepted until those units are once again below 110% capacity.

Three hospitals (Dix, Umstead, and Broughton) have been on delayed status[11]. The chart below shows the percent of days that each of those three hospitals have been on delayed status in the portion of FY 2006-07 that the policy was in effect and in FY 2007-08 as of February 2008. Broughton and Dix each have been at or above 110% capacity – and thus on delayed status – more than half the time.

Percent of Days on Delayed Status			
	Broughton	**Dix**	**Umstead**
January 2007 - June 2007	65%	49%	22%
July 2007 - February 2008	71%	59%	31%

Additionally, during SFY 2007-08, due in part to the absence of qualified permanent staff, State psychiatric hospitals were in jeopardy of losing their certification by the federal Centers for Medicaid and Medicare Services (CMS), and Broughton hospital did lose certification.

A hospital without CMS certification cannot bill Medicaid or Medicare for services, increasing the portion of the cost of hospital services that must be paid for by the State. Moreover, a non-certified hospital diminishes public confidence in our mental health system. The services and administrative practices at the State psychiatric hospitals need to be improved, to meet federal and State standards and to restore the public confidence. State institutions need the ability to hire and retain high-quality staff.

[11]As of February 2008, Cherry Hospital has not been on delayed status – the hospital has been over capacity, but has been able to divert referrals rather than delay admissions.

It is the policy of the State that the State hospitals be used only as a last resort: to be used for those individuals whose level of acuity prevents them from being served adequately by community service providers and for those individuals who local hospitals are unable to admit[12]. In the short-term, the increased demand for State hospital admissions needs be met to ensure the availability of that level of care when it is needed. However, this short-term increase in availability should not undermine the system's commitment to the previously stated policy. In the long-term, the demand needs to be reduced by providing alternative services in the community for individuals in crisis who can be adequately served in the community and by providing stabilizing services and supports to prevent crises from occurring.

In addition to issues relating to the State Hospitals, the Committee heard a report on downsizing at the State's Developmental Centers and found that the Centers have been unable to reduce the number of patients served. The General Assembly, in SL 2007-323, directed the State's Developmental Centers (the Caswell, Murdoch and Riddle centers) to reduce their number of residential patients and directed DHHS's budget to be reduced accordingly as the Centers censuses decreased. However, DHHS has informed the LOC that the Centers are not downsizing as expected, primarily because the patients living there are unable to be adequately and appropriately served in the community and due to increased demand from population increases. In order for the Centers to downsize effectively, consumers need supports for living, working, and participating in all aspects of community needs to be available. In addition to the direct supports, there also need to be affordable options for the actual residence.

RECOMMENDATION TWO:

1. Due to the high use of adult admissions unit beds, appropriate $5,274,000 on a one-time basis and authorize the temporary opening of the Central Regional Hospital Wake Unit on the Dorothea Dix Campus.

2. Require that all deaths occurring in State institutions be reported to the State Medical Examiner to determine if further investigation into the cause of death and circumstances surrounding the death is necessary and appropriate the necessary funds of $155,226 to DHHS for an

[12] North Carolina Department of Health and Human Services, *State Plan 2001: Blueprint for Change, (November 31, 2001).*

additional Public Health Nurse Consultant and other associated costs with the increased investigatory requirements.

3. Appropriate $30 million to expand the Hospital Utilization Pilot statewide, in a manner that maintains local control of funds and of bed utilization, with a goal of reducing the use of State psychiatric hospital beds for those individuals staying 2 weeks or less.

4. Appropriate $1,134,168 to implement the Transitional Residential Treatment Program in each of the 3 psychiatric hospital catchment areas.

5. Continue funding for the Housing 400 Initiative by appropriating $10 million to the Housing Trust Fund and $2.5 million to DHHS for recurring operating support for approximately 500 units. By providing stabilizing services and supports to prevent crises from occurring, appropriate housing will reduce the need for State Psychiatric hospitals in the long-term.

6. Provide for automatic re-enrollment in Medicaid for those individuals whose eligibility had been cancelled while in the hospital so that upon their release they will have access through Medicaid to care and medications.

7. Direct DHHS, within current available resources, to implement the tiered CAP-MR/DD waiver program as directed in SL 2007-323, Section 10.49(dd). The Department shall implement the program with four tiers: (i) up to $10,000; (ii) between $10,001 and $25,000; (iii) between $25,001 and $75,000; and (iv) greater than $75,000.

8. Direct the Institute of Medicine (IOM) to study and report on the best practices in transition for persons with developmental disabilities from one life setting to another, including barriers to transition and best practices in successful transitions. The Institute of Medicine should conduct this study using funds appropriated for IOM studies in the 2007 Session, and the study should encompass at least the following topics: (i) the transition for adolescents leaving high school, including adolescents in foster care and those in other settings; (ii) the transition for persons with developmental disabilities who live with aging parents; and (iii) the transition from the developmental centers to other settings.

9. Direct DHHS to review State-County Special Assistance rates to establish an appropriate rate for special care units for persons with a

mental health disability and to review the rules pertaining to special care units for persons with a mental health disability to determine if additional standards are necessary.

10. Support DHHS's recommendation for additional funds for hiring and retention of proper staffing in the State Hospitals.

FINDING THREE: SERVICES IN THE COMMUNITY

In March 2006, DHHS enacted new federally-approved "service definitions" for a variety of mental health services, including Community Support Services (CS). CS was designed to replace two former services (Community-Based Services and Case Management), and the State expected CS to cost approximately the same as what it replaced. However, in FY 2006-07, the service's State and Federal Medicaid cost was about $500 million higher than expected.

In the 2007 regular session, the General Assembly enacted Session Law 2007-323, of which Section 10.49(ee) implemented a number of changes to slow CS spending. DHHS also has taken steps to control the program's growth and expenses. But CS costs remain higher than anticipated in FY 2007-08, and spending is likely to exceed budget if it continues at the current rate.

The LOC believes that the overspending in the CS program has been caused by multiple factors, which are outlined below. It is the LOC's belief that not only have these factors caused the current problems with Community Support, but they leave the system vulnerable to similar problems in other MHDDSA areas.

The CS Reimbursement Rate Encourages Low-Qualified Providers
The State- and federally-approved CS definition allows for CS to be provided by paraprofessionals, associate professionals and qualified professionals – all of whom are reimbursed at the same rate. This "blended rate" has resulted in a rapid increase in the number of CS providers and in the service's costs, without administrative control over the necessity for the service, the type of service, and the qualifications of the service provider.

Service Providers Have a Conflict of Interest In Performing Assessments
Before receiving services or treatment, clients are evaluated and assessed to determine their diagnosis and treatment needs. However, these assessments are often conducted by a provider who also offers the services or treatments to which the client is referred. This creates a potential conflict of interest on the part of the provider and can lead to non-objective client assessments.

DHHS Has Undercut the LMEs' Ability to Perform Statutory Core Functions
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. However, the DHHS has transferred this function from LMEs to an

outside vendor for Medicaid-funded services. The outside vendor's performance of utilization review has been ineffective and inconsistent in its application, due in part to the absence of uniform review standards.

One function that has remained with the LMEs is provider endorsement. In order to provide Medicaid services, providers must first be endorsed by an LME as being qualified to provide the service. However, LMEs are not State agencies and have not been given sufficient authority to implement, monitor, and effectively enforce provider endorsement requirements in order to hold providers accountable. As a result, some endorsed providers are performing below standards required by State law and federal law.

Poor provider performance has given rise to concerns about the level, volume, and quality of services by providers, particularly with respect to community support services. In response to these concerns, LMEs have begun to deny, suspend, or refuse to renew provider endorsements; this has caused a spike in the number of provider appeals.

The Appeals Process Should be Streamlined to Address a Substantial Backlog in Appeals Pending, and Should Be Simplified to Address Issues of Fairness
The appeals process for Medicaid applicants and recipients needs to be streamlined, simplified, and balanced. Federal law requires a "fair hearing" when Medicaid services are reduced or denied and also requires resolution of the case within 90 days. Recent actions taken by the DHHS to reduce or eliminate services has caused a substantial increase in the volume of appeals, which in turn has caused a very large backlog of appeals pending. The result has created an increase in State Medicaid expenditures, case resolution far in excess of the time allowed under federal law, and a lawsuit recently filed raising due process issues. Last session the General Assembly provided for simplified appeals of Department of Revenue decisions by taxpayers, G.S. 105-241.15, and authorized the Chief Administrative Law Judge (OAH) to limit and simplify the procedures that apply to a contested tax case involving a taxpayer who is not represented by an attorney. G.S. 150B-31.1. A similar expedited process could be replicated for Medicaid contested cases. Changes to the appeals process to ensure that the interests of Medicaid clients are adequately represented may require additional funding to reduce the number of clients that appear pro se due to their financial situation.

The Ability to Control the Provider Network Can Contribute to LME Success
Piedmont Behavioral Health – the LME whose catchment area includes Davidson, Rowan, Cabarrus, Stanly and Union Counties – has a 1915 (b)/(c) combination Medicaid waiver that gives it flexibility in managing care. Among other features

the waiver allows Piedmont Behavioral Health (PBH) to control the size of its provider network. The LOC believes that this control has aided PBH's success.

RECOMMENDATION THREE:

1. Require that DHHS develop and implement a tiered rate structure for community support services to replace the current "blended" rate. Under the new tiered structure, services that are necessary but do not require the skill, education, or knowledge of a qualified professional should not be paid at the same rate as services provided by qualified skilled professionals**.**

2. Require DHHS to develop and implement a service authorization process that separates the assessment function from the service delivery function. In doing so, the Department should consider as an option LME assessment centers whose duties would include care coordination.

3. Direct DHHS to conduct a thorough study of the service authorization, utilization management, and utilization review processes and to develop a plan to return the service authorization, utilization review, and utilization management functions to LMEs for all clients.

   Direct DHHS to comply with the requirements of S.L. 2007-323, Section 10.49(ee). Prohibit DHHS from contracting with an outside vendor for service authorization, utilization review, or utilization management functions, or otherwise obligating the State for these functions beyond June 30, 2009. Direct DHHS to require LMEs to include in their service authorization, utilization management, and utilization review a review of assessments as well as person centered plans, and random or triggered audits of services and assessments.

   Also, require that the licensed professional who signs a medical order for services must indicate whether the licensed professional has (i) had contact with the consumer, and (ii) reviewed the consumer's assessment.

4. Direct DHHS to adopt guidelines for LME periodic review and re-endorsement of providers to ensure that only qualified providers are endorsed and that LMEs hold those providers accountable for the Medicaid and State-funded services they provide. Additionally, amend state law such that LMEs are acting as agents of the State when acting on provider endorsements.

5. Authorize the Office of Administrative Hearings (OAH) to develop a simplified procedure to streamline the process for hearing appeals of Medicaid recipients, applicants, and providers (including an automatic appeal for recipients and applicants). In developing the process the OAH should consult with DHHS to ensure that the streamlined and simplified process complies with federal "fair hearing" requirements. The process should be as simple and straightforward as possible, especially for appellants appearing without an attorney, without compromising the purpose of the Administrative Procedure Act, G.S. 150B-2, et seq., and allowing for a complete record of the hearing to be maintained by the presiding administrative law judge.

   Also, require DHHS, in its written notice of the reduction, termination, or denial of services, to provide information clearly explaining the opportunities for appeal and the reasons for the decision.

6. Direct DHHS to study Medicaid waivers, including 1915(b) and (c) waivers, for all LMEs. Recognizing that waivers may not be appropriate for all LMEs, direct the Department to study what would be needed to increase LMEs flexibility for innovation.

7. Direct DHHS to develop a plan for General Assembly review that would merge, consolidate, or provide for regional arrangements or consortia with respect to LME structure. The Secretary should consult with LMEs in the development of the plan and should submit the plan to the General Assembly for review. Further, require that the Secretary take no action to merge or consolidate LMEs before January 1, 2009.

8. Support the recommendation of the *MH/DD/SAS Workforce Plan* to appropriate the necessary funds to DHHS to establish a Workforce Development Specialist position within the Division of MH/DD/SAS. This specialist should have expertise in assessing workforce issues and will serve as the project manager for implementing the Division's workforce development initiatives, particularly the recommendations identified in the *MH/DD/SAS Workforce Plan*.

APPENDIX

[Attached as a Separate Document]