Overview of Mental Health, Developmental Disability, and Substance Abuse Services-Related Legislation

Agenda Item #2: Review of 2008 Legislative Actions

All Deaths in State Facilities Reported

S.L. 2008-131 (SB 1770) directs the Secretary to report all deaths occurring in State facilities listed in G.S. 122C-181 to the local medical examiner and expands the medical examiners' jurisdiction to include these facilities.

The act directs the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to study the current death reporting requirements under G.S. 122C-26(5)c and assess the need for any additional reporting requirements or modifications to existing rules. The Commission is required to report its findings to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by November 1, 2008.

This act became effective July 28, 2008.

Note: S.L. 2008-107 (HB 2431) appropriates $158,326 to the Office of the Chief Medical Examiner for one position and increased operating costs associated with this change.

Children with Disabilities in Residential Treatment Programs

S.L. 2008-174 (HB 2306) requires the State Board of Education (State Board) and the Department of Health and Human Services (DHHS) to determine the agency responsible for providing special education and related services, as required under Article 9 (Education of Children with Disabilities) of Chapter 115C and the federal IDEA statutes and regulations, to children with disabilities placed in private psychiatric residential treatment facilities by public agencies other than the local educational agency.

The State Board and DHHS shall report the determination of the responsible agency and any recommended legislation or policy changes to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by January 1, 2009.

This act became effective August 4, 2008.

National Instant Criminal Background Check System Reporting/Restoration

S.L. 2008-210 (SB 2081) requires the clerk of superior court to report to the National Instant Criminal Background Check System (NICS) any individual who:

- Is involuntarily committed for either inpatient or outpatient mental health treatment.
  - If the person has been involuntarily committed to outpatient mental health treatment, the person must be reported only if the individual is found to be a danger to himself, herself, or others.
- Is acquitted of a crime by reason of insanity.
- Is found mentally incompetent to proceed to criminal trial.

The act also provides a restoration procedure to remove the mental commitment bar to purchasing, possessing, or transferring firearms. This restoration procedure is not available to a person who has been found not guilty by reason of insanity. The petition must be filed in the district court in the county in which the commitment took place or the county in which the person resides. The burden is on the petitioner to establish by a preponderance of the evidence that the petitioner no longer suffers from the condition that resulted in commitment and no longer poses a danger to himself, herself, or others for purposes of the purchase, possession, or transfer of firearms. The district attorney presents evidence to the contrary. The hearing is closed to

the public unless the court finds that the public interest is better served by conducting the hearing in public. The decision of the district court may be appealed to superior court for a hearing de novo. If the superior court issues a denial, the applicant must wait a minimum of one year before reapplying. If a petition is granted, the clerk of superior court must forward the order to NCIS. If a person succeeds in a restoration proceeding, the disqualifications from receiving a purchase permit and a concealed carry permit because of involuntary commitment are removed.

This act becomes effective December 1, 2008.

The Studies Act of 2008.

S.L. 2008-181, Secs. 10.1-10.2 (HB 2431, Secs. 10.1-10.2) authorizes the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services to study the involuntary commitment statutes in Chapter 122C of the General Statutes and determine if the supervision requirements during the examination are adequate to protect the health and safety of the individual and others. The Committee may report its findings, together with any recommended legislation, to the 2009 General Assembly on its convening.

This part became effective August 4, 2008.

Modify Appropriations Act of 2007

S.L. 2008-107 (HB 2431) – Chart incorporates changes from S.L 2008-118 (HB 2438), marked with *.

Section	Description
10.15(b)*	Directs the Department to allocate eight million dollars ($8,000,000) to support LMEs in establishing regionally purchased locally hosted substance abuse services. The provision requires LMEs to report to the Department on their use of these funds.
10.15(f)	Directs the Department to perform a service gap analysis of the MH/DD/SAS system and report by January 1, 2010. The provision directs the Department to involve LMEs and to not contract with an independent entity to perform the analysis.
10.15(o)	Directs that independent and supportive living apartments for persons with disabilities constructed with funds appropriated in this act shall be affordable to persons with incomes at the SSI level.
10.15(s)	Directs the NCIOM to study and report by March 1, 2009 the barriers to and best practices in successful transitions for persons with developmental disabilities from one life setting to the next.
10.15(t)	Directs the Department to assist LMEs in using 5% of specific funds to help successfully transition individuals from developmental disability centers into the community. The provision directs the Department to report on the progress of this provision by March 1, 2009.
10.15(u)	Directs the Department to review State County Special Assistant rules and rates to develop an appropriate rate for special care units for persons with a mental health disability including Traumatic Brain Injury and report by January 1, 2009.
10.15(v)	Directs the Department to include veterans and their families as target populations within the MH/DD/SAS system.
10.15(w)	Directs the Department to develop a service authorization process that requires a comprehensive clinical assessment to be completed by a licensed clinician prior to non-crisis service deliveries. The provision requires licensed professionals to indicate on medical orders whether the person has had contact with the consumer and has reviewed the consumer's assessment. The Department shall report to the proper occupational licensing board when a licensed professional fails to comply with this provision. The Department shall report on this process by October 1, 2009 and must notify the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services and the LOC 15 days prior to implementation.

Overview of Mental Health, Developmental Disability, and Substance Abuse Services-Related Legislation

Agenda Item #3: Community Support Services

Improve and Strengthen Fiscal Oversight of Community Support Services

S.L. 2008-107 (HB 2431) – Chart incorporates changes from S.L 2008-118 (HB 2438), marked with *.

Section	Description
10.15A* (Subsections relating to providers)	Improves and strengthens fiscal oversight of community support services by: ➢ Requiring DHHS to revise the community support service definitions and to submit the new definitions for federal approval. The revised definitions are to focus on rehabilitative services and minimizing over-expenditures. ➢ Requiring DHHS to replace the current "blended rate" for community support services with a tiered rate structure that reimburses providers based on their levels of skills, education, or professional knowledge. Once the tiers are implemented: within sixty days, at least 35% of community support services must be delivered by qualified professionals and within six months, at least 50% must be provided by qualified professionals. ➢ Allowing the Secretary of DHHS to designate MH/DD/SA services that require national accreditation, and providing timeframes within which providers of those services must achieve the national accreditation. ➢ Requiring DHHS to implement a community support provider appeals process for certain providers on a temporary basis (to expire July 1, 2010). The appeal process is to be conducted on a timely basis by a hearings officer within DHHS, and providers may appeal the final decision to Wake County Superior Court. Any petition pending hearing at the Officer of Administrative Hearings is to be transferred to DHHS. Finally, DHHS may suspend a Medicaid provider's endorsement pending a final agency decision. ➢ Requires the Department to adopt guidelines for local management entities to follow to ensure only qualified providers are endorsed and are held accountable. ➢ Requiring that providers obtain prior authorization for all Community Support services, and that providers may not bill for more than 8 hours of Community Support per consumer per week. These subsections became effective July 1, 2008.

10.15A(h1)* Note: S.L 2008-118 also added sections 10.15A(h2) -10.15A(h6)	Improves and strengthens fiscal oversight of community support services by: ➢ Establishing a temporary appeals process for Medicaid applicants and recipients who have been denied, terminated, suspended or reduced benefits. The Department must notify the recipient at least 30 days before the adverse determination is effective and must let the recipient know of his/her right to appeal. The recipient has 30 days to appeal, and if appealed, the appeal is a contested case under Chapter 150B of the General Statutes, to be heard by an administrative law judge. Prior to hearing before the administrative law judge, mediation is to be offered to the recipient. If mediation is successful, the mediator is to so indicate to the administrative law judge. If mediation is unsuccessful, the administrative law judge is to hear the case and make a determination. The burden of proof in the hearing is on the Department if the adverse determination being appealed is imposing a penalty or is reducing, terminating, or suspending a benefit previously granted. The final agency decision is to be made within 90 days of the notice of the adverse determination to the recipient. This section became effective July 1, 2008 and expires July 1, 2010.

Agenda Item #4: State Psychiatric Hospitals

S.L. 2008-107 (HB 2431) – Chart incorporates changes from S.L 2008-118 (HB 2438), marked with *.

Section	Description
10.15(g)	Prohibits DHHS from transferring patients to the new Central Regional Hospital until the Secretary provides a written report to the Governor that on the day of its opening and thereafter, Central Regional Hospital will be operated in a manner that provides a safe and secure environment for its patients and staff. Allows DHHS to transfer patients from Dorothea Dix Hospital to the new Central Regional Hospital after patients have been transferred from John Umstead Hospital if the Secretary has determined that an inspection of Central Regional Hospital indicates no findings of noncompliance with conditions of participation from the Centers for Medicare and Medicaid Services (CMS), and if the Secretary finds that Central Regional Hospital is in compliance with Joint Commission on the Accreditation of Healthcare Organizations standards for accreditation.
10.15(h)	Permits DHHS to open and operate on a temporary basis up to 60 beds at the Central Regional Hospital Wake Unit on the Dorothea Dix Campus.
10.15(i)	Specifies that one-time funds appropriated for the Dorothea Dix Hospital overflow unit shall be used to support the temporary opening and operation of the Central Regional Hospital Wake Unit on the Dorothea Dix Campus; that the General Assembly intends to fund the Wake Unit for three years; and that the Office of State Budget and Management shall establish the positions for the Central Regional Hospital Wake Unit on the Dorothea Dix campus as time-limited positions for up to three years.

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Agenda Item #5: LME Administration

S.L. 2008-107 (HB 2431) – Chart incorporates changes from S.L 2008-118 (HB 2438), marked with *.

Section	Description
10.15(a)	Directs the Department to distribute to non-single stream LMEs at least 1/12 of the LMEs continuation allocation for service dollars at the beginning of the fiscal year and to subtract that amount from the LMEs total reimbursements for the year.
10.15(c)	Directs the Department to encourage the conversion of non-single stream into single stream LMEs and to develop prompt pay guidelines as part of the requirements of being designated as single stream and standards for removal of that designation.
10.15(d)	Directs the Department to simplify the current State Integrated Payment and Reporting System (IPRS) and to work with LMEs to develop billing codes currently lacking.
10.15(e)	Directs the Department to consult with LMEs and service providers to determine why there has been under and over expenditures of State service dollars by LMEs. The Department shall report on its activities relating to this provision by January 1, 2009.
10.15(x)*	Directs the Department to develop a plan to return service authorization, utilization review, and utilization management functions to LMEs and report on the plans development by February 1, 2009. The provision requires that by July 1, 2009, these functions shall be returned to as many LMEs necessary to represent 30% of the State's population. The section requires for LMEs to provide these functions they must be nationally accredited or have met certain application requirements and meet all requirements of the existing vendor contract. The Department shall not contract or otherwise obligate the State with an outside vendor for these functions beyond September 30, 2009. The provision authorizes the Department to develop a plan to return authorization for CAP-MR/DD slots to the LMEs.
10.15(y-z)	Direct the Division of MH/DD/SAS to study and report by March 1, 2009, the use Medicaid waivers for all LMEs and to recommend other strategies that would increase LME flexibility to provide case management assessments and to have more control over provider networks. Subsection z provides that the Piedmont Behavioral Health LME is deemed as a demonstrational model.
10.15(aa-bb)	Direct that the Secretary shall not take any action prior to January 1, 2010 that would result in a merger or consolidation of LMEs including establishing consortia or regional arrangements. This does not include LMEs that did not meet catchment area requirements as of January 1, 2008 (Foothills, Johnston) or the proposed administration service agreement under development as of March 1, 2008 (Guilford, Smoky Mountain, Mecklenburg).
10.15(cc-ee)	Amend the General Statutes relating to the Secretary's authority to remove or designate to another LME the primary functions of an LME as designated in G.S. 122C-115.4(b). The provision requires an LME to fail to achieve a satisfactory outcome on any critical performance measures on three consecutive months, but limits the amount of time with technical assistance provided by the Secretary to 3 months (was 6 months). The provision defines minimally adequate services and a level of service of generally accepted professional standards and principles required for compliance with all laws, rules, regulations, and policies of the State and federal government.

Overview of Mental Health, Developmental Disability, and Substance Abuse Services-Related Legislation

Agenda Item #6. Crisis Services

S.L. 2008-107 (HB 2431) – Chart incorporates changes from S.L 2008-118 (HB 2438), marked with *.

Section	Description
10.15(j)	Directs DHHS to adopt guidelines for LME periodic review and rules for endorsement and re-endorsement of providers.
10.15(k)	Specifies that of funds allocated to DHHS, $8,121,644 shall be allocated to purchase local inpatient psychiatric beds or bed days, and that these beds/bed days must be distributed across the State according to need as determined by the Department. Specifies the role of DHHS and LMEs in using the funds. Specifies that these funds cannot be used to supplant other funds for the purchase of psychiatric inpatient services under contract with community hospitals, including beds or bed days being purchased through Hospital Pilot funds appropriated in S.L. 2007-323. Requires DHHS to report back to the General Assembly on beds or bed days purchased (i) with local funds, (ii) from existing State appropriations, (iii) under the Hospital Utilization Pilot, and (iv) purchased using funds appropriated under this subsection.
10.15(l)	Specifies that of funds appropriated to DHHS, $1,876,243 must be allocated for the START crisis model for developmental disability services; that the funds must be distributed to LMEs to support six crisis teams; and that the new crisis teams must be distributed across the State according to need as determined by the Department.
10.15(m)	Specifies that the $1,080,992 allocated for start-up and ongoing support of respite beds for individuals with developmental disabilities must be distributed across the State by the Department according to need.
10.15(n)*	Specifies that of funds appropriated to DHHS, DMHDDSA, $6,113,947 shall be allocated for walk-in crisis and immediate psychiatric aftercare and shall be distributed to the LMEs according to need as determined by the Department to support 30 psychiatrists and related support staff. Specifies that of these funds, $1,650,000 shall be used for telepsychiatry equipment to be owned by the LMEs.

Overview of Mental Health, Developmental Disability, and Substance Abuse Services-Related Legislation

Agenda Item #7: CAP-MR/DD Tiered Waivers

S.L. 2008-107 (HB 2431) – Chart incorporates changes from S.L 2008-118 (HB 2438), marked with *.

Section	Description
10.15(p)	Directs DHHS to implement the tiered CAP-MR/DD waiver program in accordance with Section 10.49(dd) of S.L. 2007-323. Creates four tiers as follows: (i) up to $17,500; (ii) between $17,501 and $45,000; (iii) between $45,001 and $75,000; and (iv) between $75,001 and $100,000. Requires DHHS to review on a case-by-case basis tier funding exceeding $100,000 and allows DHHS to authorize the excess amount based on standards adopted by the Department.
10.15(q)	Specifies that a portion of the funds appropriated to DHHS for additional CAP-MR/DD slots shall be used to fund CAP-MR/DD slots statewide and must fund a combination of i) tier one slots managed under the North Carolina CAP-MR/DD 1915(c) Medicaid waiver and ii) slots managed under the North Carolina Piedmont Behavioral Health Care 1915(b) and (c) Medicaid waiver.
10.15(r)	Directs DHHS to implement a plan to catch up Piedmont Behavioral Health (PBH) CAP-MR/DD slots to the Statewide average. Directs that the catch-up plan must transfer 1% of the funds for turnover CAP-MR/DD slots each year to PBH until PBH CAP-MR/DD slots reach the State per capita average of slots.