MINUTES

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

February 27, 2008
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Wednesday, February 27, 2008 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Charlie Dannelly, James Forrester, Vernon Malone, William Purcell and Representatives Martha Alexander, Beverly Earle, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members Senator Larry Shaw, Representatives Van Braxton and William Brisson were present. Also in attendance were Senator John Snow and Representative Pat Hurley.

Gann Watson, Shawn Parker, Ben Popkin, Andrea Poole, 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)

Senator Martin Nesbitt, Co-Chair, called the meeting to order and welcomed members and guests. He asked for a motion to approve the minutes from the January 23, 2008 meeting. Representative Braxton made the motion and the minutes were approved.

Senator Nesbitt then asked Andrea Poole, Fiscal Research, to review the information packet responding to questions asked by members during the January 23rd meeting. (See Attachment No. 2)

Next, Ms. Poole reviewed the MH/DD/SA system indicators and gave an update on construction projects. (See Attachment No. 3) She explained that the revised sheet for January contained changes requested at the last meeting in order for members to be able to compare changes to the February sheet. Also, chart 4 had been calculated incorrectly showing the calendar year percentage rather that the fiscal year percentage. It was suggested that chart 1 needed to indicate funding based on type of provider (paraprofessional, associate professional, qualified professional, etc.). Tara Larson from the Division of Medical Assistance said that modifiers put into place in the Division's IT system in December would provide that information. Ms. Poole was questioned about the small amount of money used for substance abuse in chart 2. Flo Stein with the Division of MH/DD/SAS responded that the realigned money, almost $6 million, was earmarked to go out next week. Regarding chart number 6, Leza Wainwright, Deputy Director from the Division of MH/DD/SAS, said that one of the reasons for increasing the acute capacity at the ADATC was to try to divert some of the 1-7 day stay in the psychiatric hospitals where that is for a primary substance abuse admission. Once staffing is addressed and all of the transfer protocols are worked out the occupancy rate at the

acute units will increase. It was noted that there may not be enough sub-acute beds. It was requested that staff provide information from the LMEs regarding substance abuse providers: 1) number of substance abuse providers under contract; 2) number of clients served with that same number of providers; 3) number of people on the waiting lists; 4) the number of substance abuse providers needed across the State. Ms. Poole also reviewed the status update of the construction project, and the cost of each of the projects including the repairs and renovations.

The next agenda item was a review of Piedmont Behavioral Healthcare and Medicaid waivers. Representative Insko asked Dan Coughlin, Area Director/CEO, Pam Shipman, Deputy Area Director and Dr. Craig Hummel, Medical Director of Piedmont Behavioral Healthcare (PBH), to make the presentation. (See Attachment No. 4) Mr. Coughlin stated that PBH was a demonstration project, going about reform uniquely different from the rest of the system in that PHB has Medicaid waivers, and a managed care model. Mr. Coughlin explained that PBH had a 1915(b)/1915(c) combination waiver. The 1915(b) waiver is for mental health and substance abuse, and the 1915(c) waiver is for developmental disabilities, and is recognized as a best practice model. The waiver was granted in April, 2005.

Dr. Hummel explained that his focus was to see that a person received the right care at the right time. He said that there must be a plan and a structure, a good data system, and the ability to track a patient to see that they were receiving services. He addressed outcomes explaining easy access, advanced access, and the broad array of care which focuses on delivering all types of care, allowing and designing the network so that patients can get out-patient treatment, substance abuse treatment, ACT treatment, and psychiatric treatment. Dr. Hummel reviewed the PBH comprehensive crisis plan, and said that with utilization management PBH was able to manage the high cost, and the high risk of community support service. He also said PBH had contracted with local hospitals in order to decrease hospitalization at the state hospitals. State hospital admissions were down 36% from SFY 06-07 to SFY 07-08. He then reviewed a readmission rate chart proving that the quality of care at PBH surpassed the national average, and the State average for significantly lower readmission rates.

Pam Shipman reviewed the impact of reinvestment dollars which reduced the DD waiting list with the addition of respite and supported employment. Because of the structure of the waiver, Medicaid funding can be used to buy ICF/MR beds, or a person can be taken out of the ICF/MR placement, and moved to a group home or their own home. She gave examples of how PBH moved the money with the people and created solutions for those who needed services. Ms. Shipman said that Comprehensive Community Providers (CCP's) were the foundation of the PBH network. She said that there were now 4 CCP's that were the clinical home for individuals with mental health or substance abuse needs. This is a new model offering services previously done by LMEs through case management. She added that case management remained within the LME with a special department handling DD. Ms. Shipman reiterated the importance of a state-of-the-art technology system processing over 50,000 claims each month, and an average of $11 million per month.

Concluding, Mr. Coughlin said that in the beginning, PBH worked out an agreement with state officials to try a different route to reform. After weighing options and much consideration, PBH decided that the 1915(b) waiver was the best way to achieve reform. He said one of the greatest challenges PBH had to overcome was an inadequate information system, but were able overcome the problem by developing their own software. Mr. Coughlin said the model works because it is fully integrated using a financial model, a business model, and a state-of-the-art information system. He added that all LMEs could benefit from having the same information system, and the ability to communicate with one another.

Mr. Coughlin was asked if psychiatrists were paid on a capitation basis. He responded that they were paid on a fee for service basis. PBH had the waiver capitative program authorizing PBH to reset the rate for psychiatrists. Capitation takes place from Medicaid to PBH as an agency.

Dr. Hummel was asked if all hospitals participate in PBH's in-patient care, and who provides in-patient psychiatric service. He responded that there were 2 geriatric hospitals, 3 hospitals contracted to take state funded patients, and other hospitals take Medicaid patients. Psychiatrists are paid on a fee for service basis, or the rate is folded into the contract of one or two hospitals. He was also asked if substance abuse patients were admitted. Dr. Hummel said that substance abuse patients were admitted, but most go to the facility based crisis which is a non-hospital medical detox.

Senator Nesbitt reminded members that when community support first started, PBH only allowed providers with appropriate staff to engage in community support. PBH controlled how much service could be received. PBH was successful by knowing the providers, knowing the patients, and working case-by-case. He said the LOC went on record opposing transferring Medicaid to Value Options because members were concerned that the LMEs needed to make those individual decisions. In order to obtain the waiver, Medicaid must grant approval. He said that if community support and Medicaid Utilization Review were moved back to the LMEs, it could be controlled on a case-by-case basis or the LMEs could get waivers to draw dollars back in to better control it and spend it in different ways. Senator Nesbitt added that there were trade offs since the system is not as open to providers. According to Medicaid, other LMEs can not exclude providers, but they could control providers through Utilization Management. LMEs did Utilization Management of Medicaid prior to community services without any problems. Ms. Shipman added that there was not a lot of provider driven, profit driven behavior because providers have a healthy market share. PBH must ensure choice but providers have to have a lot of infrastructure to provide services well. If providers only had a tenth of the market place it would be difficult to have the oversight and control needed to provide the Medicaid services well. She said it was much easier to have an open dialogue with providers so everyone knew what to expect.

Next, Gann Watson, Bill Drafting Division, explained the appeals process. She said that Secretary Benton recently raised the issue of the appeals process, and the problems it

created for the Department. She explained that when a State agency makes a decision that affects the rights, duties, or privileges of an individual or entity, that person then has a statutory right to appeal that decision. This does not pertain to local agencies. The Department (DHHS) will try to conduct an informal conference but if there is no resolution, it can go to Office of Administrative Hearing (OAH). OAH would then appoint a hearing officer. The Chief Administrative Law Judge (ALJ) can send the case to a mediated settlement conference but that conference does not impair the right of the party to have a full formal hearing at OAH. If there is no resolution, the party has 60 days to appeal to OAH. OAH must notify the party 15 days before the hearing date. The APA is very specific on what an ALJ must do to reach a final decision. The ALJ must do findings of fact, review evidence, and make a decision based on a preponderance of the evidence. The OAH decision then goes back to the agency for a final decision. The agency has a high burden in order to deviate from the ALJ's decision. The Department is required by law to follow the ALJ's decision on appeal unless it can show by a preponderance of the evidence that that decision of the ALJ was contrary to statutory requirements. The result of this process has been a very lengthy timeline for the resolution of appeals. Moreover, an explosion in the number of appeals, especially those related to community services, has created a significant backlog of appeals at the Department level. Another concern is that pending the outcome of the appeal the State is paying for services it might not have had to pay for if the Department's decision is upheld. Ms. Watson added that statutorily the State could recover the cost if the decision is upheld.

There was concern that those appealing did not have attorneys representing them. It was requested that statistics be provided showing how many cases prevail without attorneys. It was also requested that information be provided stating the appeals process for a provider appealing to an LME. Also requested was a written explanation of the process and the amount of money paid to providers or clients in the backlog.

Emery Milliken, General Counsel for the DHHS, shared information regarding the Medicaid appeals process, both informal and formal appeals. Ms. Milliken said the informal appeal is heard at the agency. The agency has hearing officers who reconsider decisions, review decisions made, give the person appealing an opportunity at an informal forum to discuss the decision, and question the person at the agency who has made the decision. The formal hearings for DHHS, Medicaid, denials of recipient services or actions against providers, are held the Office of Administrative Hearings (OAH). The recipient must file pleadings, motions must be responded to, the rules of evidence apply, the recipient may have an attorney but does not have to have an attorney present, and the Administrative Law Judge (ALJ) makes the decision. Once the decision is made, all the documents are sent to the agency for the agency's final decision. The agency must then review all documentation, give parties an opportunity to argue for or against the ALJ decision, and within 60 days make a final decision. The decision can be appealed to Superior Court. Those making appeals are either a recipient of a Medicaid service who have been denied service totally, or in-part. Providers appeal for action the Medicaid agency has taken against them which might include: an action for money to be repaid if the agency had been improperly paid; or an appeal if the agency has suspended

or terminated the provider from the Medicaid program. She then gave a brief description of the process a recipient would experience appealing a decision.

Ms. Milliken said that as of February 22, 2008 there were a total of 6,621 informal appeals pending at DMA. Of those, 5,751 are community support related. In June, 2006, there were 258 pending cases; in December, 2006 - 245 cases; in June, 2007 - 320 cases; and in December, 2007 there were 4, 422 pending cases. The majority of that surge was from community support services. Most recently, in June, 2007 the informal hearing section of DMA opened 87 community support cases. In July, 2007 there were 237 cases; in August, 2007 - 239 cases; and in November, 2007 - 1,673 cases. All of these appeals are VO decisions. Since February, 2008, 3,211 informal appeals had been opened of which 2,513 were community support cases. She said it was safe to assume that a good number of the cases were going to go to AOH, and the financial aspect was great since by law if someone appeals, they have the right to have their service continued during the appeals process.

Regarding the formal appeals, Ms. Milliken said the Attorney General represents State agencies defending the agencies in its cases at OAH. As of February 19, there were a total of 388 pending cases of which 349 are recipient cases and 39 are provider appeals. Most were community support appeals. Using previous years as an example, she said that in February, 2005, there were 59 cases; February, 2006 – 81 cases; and in February, 2007 – 107 cases.

Regarding provider appeals, the federal government does not set out what a State is required to do with respect to providers. That is based more on what property rights and interest the State recognizes a provider has in being a Medicaid provider, and what due process requirement a State has. As of February 22, 2008, the number of informal provider appeals received in 2008 was 252. Ms. Milliken said that DHHS had added contract positions to hire hearing officers, and is considering additional contract positions to help speed cases through the informal hearings. She expressed concern that the pipeline at OAH was narrow and cases would backup there. She said the Department was working on proposals for the LOC to streamline the appeals process, making it more expeditious and efficient, while respecting the rights of individuals.

Members were interested in the fairness of counsel not representing a recipient. It was requested that statistics be gathered on the number of cases won at OAH by those not represented, and the number of cases in which a recipient was not represented by counsel. It was also requested that the total number of dollars being appealed in community support be provided, the number of providers involved, and is the total amount of dollars involved in the provider appeals greater than or exceed the amount of going through the appeals process. There was also concern that people would appeal just to be able to continue services and providers continue to be paid. Ms. Milliken stated that the federal law requires the service be continued during the pending appeal. It also says that the agency in the event that it is successful at the hearing may recoup the money from the recipient based on the fact that the agency had correctly decided the case. That has not happened to date.

After lunch, Tara Larson, Deputy Director for Clinical Affairs, DMA, addressed the status of applications for additional Medicaid waivers and she highlighted options available through the waiver process with CMS. (See Attachment No. 5) Ms. Larson said that the waiver process for PBH became effective in 2005 but the process actually began in 2002-2003. She said the planning, the writing of the waiver, the negotiations, and the work with CMS was a lengthy process. She explained how "waiving" allowed states to waive parts of the rules that Medicaid operates under Fee for Service, and she explained the CMS approval process. She described the different types of waivers and Deficit Reduction Act, a relatively new process.

Leza Wainwright addressed how the Department was working with LMEs to examine different waivers. Ms. Wainwright said the special provision last year directed the Department to work with up to three LMEs (Smoky Mountain, Mecklenburg, and Guilford Center) to pursue a similar type of Piedmont LME. The three LMEs were interested in entering into a behavioral health reform, Medicaid waiver pilot project. One difference from PBH was the three LMEs planned to create an Administrative Services Organization (ASO) as an entity of local government, as a joint interlocal cooperative agency. The ASO would perform all of the administrative functions for the 3 LMEs. The LMEs would be responsible for functions at the local level such as care coordination, provider monitoring, and consumer and family complaints, appeals, and grievances. The type of waiver has yet to be decided. She said the ASO would be operational by October 1, 2008. The first function would be Screening, Triage, and Referral for Smoky Mountain and the Guilford Center starting July 1, 2008. The target date for the waivers is July 1, 2009.

Flo Stein, Chief of Community Policy Management, Division of MH/DD/ SAS, gave an update on regionally funded and locally hosted substance abuse programs. (See Attachment No. 6) She explained the proposal directed the State to issue RFP's to purchase a certain kind of substance abuse program, select providers, and find an LME to host that program. She listed the types of programs to be provided. Ms Stein said the programs were residential programs to increase capacity, and that there had been quite a number of applications. She indicated each covered multi-county, multi-LME areas. The charts showed the LME hosting the program, and the amount of money funded for 2008 and 2009. All programs receive patients from across the State. She said that with the new program, hundreds more people could be treated.

Leza Wainwright, Division of MH/DD/SAS, gave an update on the technical amendment to the CAP MR/DD waiver dealing with family members, and guardians acting as providers for their adult children. She said that in September it was announced that CMS had approved a technical amendment to the waiver which placed a limitation on the number of hours of service that family members and guardians could provide to adult recipients under the waiver. The waiver allowed a family member to provide 50 hours a week or 217 hours per month, and family members not living in the home could provide an additional 50 hours of service. CMS required an implementation plan as part of the approval of the technical amendment. It was determined by CMS that compliance should

be met within 6 months, February 22nd. Ms. Wainwright reported as of February 22nd, 645 families were in compliance with the requirement. An additional 6 month extension was allowed by CMS for the 20 families statewide who had not successfully transitioned or identified alternative care providers. She said that no one had been admitted to a State developmental center as a result of the change in policy, and no one had gone into an ICF/MR. In general operation of the waiver, there are an average of 3 people a month that move from the waiver to an ICF/MR and there are an average of 2 people that move from an ICF/MR to the waiver. She explained the Department's concern over the quality of care a family member could provide if that family member was fatigued.

Representative Insko said that Phillip Hoffman's update on data collection would be heard the next day, February 28th. She then asked members of the audience, who had signed up previously, to address their comments to the committee. Concerns and statements expressed by the audience included: The success of TROSA, a residential mental health and substance abuse program - recurring funding needed to continue support for community needs; problems concerning Implementation #35 & #40 – questioning the number of families qualifying for the extension, likely much higher; concern voiced over closure of Dix hospital; create a leadership team establishing goals so everyone can move in the same direction; fix what is not working; let LMEs run community based walk-in crisis facilities/clinics; restore public safety net; put incentives in place to see that the right treatments are provided; simplify getting the money out and get more money out; and fund community inflationary needs.

Regarding the meeting on February 28th, Andrea Poole announced that Judge Julian Mann from the Office of Administrative Hearings would speak to the committee at 9:00.

There being no further business, the meeting adjourned at 4:05 PM.

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

Rennie Hobby, Committee Assistant