2011-2012

SENATE
MENTAL HEALTH &
YOUTH SERVICES

MINUTES

MEMBERSHIP

Mental Health and Youth Services
2011 - 2012

Senator Fletcher Hartsell, Chairman
Room 300-C, LOB
733-7223

Senator Austin Allran, Vice Chair
Room 625, LOB
733-5876

Senator Tommy Tucker, Vice Chair
Room 311, LOB
733-7659

Senator Stan Bingham
Room 2117, LB
733-5665

Senator Jim Davis
Room 2111, LB
733-5875

Senator Warren Daniel
Room 411, LOB
715-7823

Senator James Forrester
Room 1028, LB
715-3050

Senator Brent Jackson
Room 525, LOB
733-5705

Senator Ed Jones
Room 518, LOB
715-3032

Senator Ellie Kinnaird
Room 628, LOB
733-5804

Senator Martin Nesbitt
Room 1129, LB
715-3001

Senator William Purcell
Room 517, LOB
733-5953

Senator Gladys Robinson
Room 1120, LB
715-3042

Committee Assistant:

Gerry Johnson

Research Staff:

Shawn Parker
Jan Paul
Patsy Pierce
Susan Barham

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0302	Earle	CHARITABLE LICENSING EXEMPTION CLARIFICATION.	*S	Ref To Com On Mental Health & Youth Services	04-20-11	
916	Barnhart	STATEWIDE EXPANSION OF 1915(B)/(C) WAIVER.	*S	Pres. To Gov. 6/ 14/2011	06-06-11	06-09-11
S0053=	Josh Stein	DISAPPROVE CLOSURE OF DOROTHEA DIX HOSPITAL.	S	Ref To Com On Mental Health & Youth Services	02-10-11	
S0167=	Fletcher L. Hart	ALLOW EXPANSION OF CAPITATED WAIVER.	S	Re-ref Com On Mental Health & Youth Services	03-10-11	
S0316=	Fletcher L. Hart	ADD'L SECTION 1915 MEDICAID WAIVER SITES.	*SR	Ch. SL 2011-102	03-17-11	03-24-11
S0325=	Martin L. Nesbit	FUNDS FOR STEP-DOWN UNIT FOR BART PROGRAM.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0326=	Martin L. Nesbit	EVALUATE DD RESIDENTIAL OPTIONS FOR CHILDREN.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0327=	Martin L. Nesbit	MODIFY MHDDSAS REPORTING REQUIREMENTS.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0328=	Martin L. Nesbit	REPORT ON TRANSFER OF CAP-MR/DD UR TO LMES.	S	Re-ref Com On Appropriations/ Base Budget	03-14-11	04-27-11
S0329=	Martin L. Nesbit	EVIDENCE-BASED PRACT. IN PSYCH. HOSPITALS.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0330=	Martin L. Nesbit	REPORT ON MH SERVICES PROVIDED BY HOSP. ER'S.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
331=	Martin L. Nesbit	EVALUATE EFFICACY OF CABHA MODEL.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0332=	Martin L. Nesbit	REPORT ON NC CLUBHOUSE PROGRAMS.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0333=	Martin L. Nesbit	REVISE DD WAITING LIST PROCESS.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
$ S0334=	**Martin L. Nesbit**	**EXPAND INPATIENT PSYCHIATRIC BEDS/ FUNDS.**	**S**	**Re-ref Com On Appropriations/ Base Budget**	**03-14-11**	**04-27-11**
S0335=	Martin L. Nesbit	APPLY FOR TBI MEDICAID WAIVER.	S	Re-ref Com On Appropriations/ Base Budget	03-14-11	04-27-11
S0336=	Martin L. Nesbit	DEVELOP PLAN FOR ALLOCATING DD RESOURCES.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0337=	Martin L. Nesbit	ALLOW EXPANSION OF CAPITATED WAIVER.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0401=	Stan Bingham	ACH PILOT ON CRISIS INTERVENTION TRAINING.	S	Ref To Com On Health and Human Services	03-24-11	04-27-11
S0421	Stan Bingham	GAST TRAINING PILOT.	S	Ref To Com On	03-28-11	04-27-11

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
				Health and Human Services		
465	Fletcher L. Hart	PED STUDY LME GOVERNANCE.	*S	Ref To Com On Health and Human Services	03-31-11	06-08-11
S0481=	Ed Jones	MENTAL HEALTH WORKERS' BILL OF RIGHTS.	S	Ref To Com On Mental Health & Youth Services	04-04-11	
S0524=	Tommy Tucker	STRENGTHENING RESIDENTIAL PLACEMENT.	*S	Re-ref Com On Finance	04-07-11	05-04-11
S0525=	Tommy Tucker	STREAMLINE OVERSIGHT/ DHHS SERVICE PROVIDERS.	*S	Ref To Com On Appropriations	04-07-11	05-12-11
S0578	Fletcher L. Hart	FACILITATE TRANSFER SPH BEDS COM. FACILITY.	*S	Passed 2nd & 3rd Reading	04-14-11	06-02-11
S0669	Bob Atwater	DIX PROPERTY-MENTAL HEALTH TRUST FUND.	*S	Ref To Com On Finance	04-20-11	05-04-11

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

SENATE MENTAL HEALTH & YOUTH SERVICES COMMITTEE
Wednesday, March 23, 2011 at 12:00 Noon
Room 414, Legislative Office Building

MINUTES

The Senate Mental Health & Youth Services Committee met at 12:00 Noon on March 23, 2011, in Room 414 of the Legislative Office Building with thirteen members of the committee present. Senator Hartsell, Chairman, presided.

Senator Hartsell recognized pages Mercedes Bright and Mickayla Bender and thanked them for their assistance. As this was the first meeting of the Committee, Senator Hartsell then asked each member to introduce themselves and give their district.

Senate Bill 316 – Add'l Section 1915 Medicaid Waiver Sites. As this was Senator Hartsell's bill, he asked Senator Tucker to chair. Senator Jones moved to consider the bill for purposes of discussion. All voted and the motion carried. Senator Hartsell offered an amendment and moved that it be adopted. All voted and the motion carried. Senator Hartsell then explained the bill. Mr. Shawn Parker, Staff Attorney, gave additional explanation. Questions from Senators Daniel, Kinnaird, Allran and Robinson were answered by Senator Hartsell and Mr. Parker. Ms. Pam Shipman, Director and COF of Piedmont Behavioral Health, spoke on the bill. Others who spoke were David Richard, of The Arc of North Carolina, Mr. Michael Watson of North Carolina Department of Health and Human Services, Ms. Yvonne Copeland, Executive Director of North Carolina Council of Community Programs and Mr. G. Peyton Maynard. Senator Nesbitt spoke on the historical background of LMEs.

Senator Jones moved to adopt the bill as amended, unfavorable to the original bill and rolled into a new Proposed Committee Substitute. All voted and the motion carried.

There being no further business, the meeting was adjourned.

W. Tommy Tucker
Presiding

Committee Clerk

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	March 23, 2011	12:00 Noon	414 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 316	Add'l Section 1915 Medicaid Waiver Sites.	Senator Hartsell

Senator Fletcher L. Hartsell, Jr., Chair

Senate Mental Health & Youth Services Committee
Wednesday, March 23, 2011, 12:00 Noon
414 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 316	Add'l Section 1915 Medicaid Waiver Sites.	Senator Hartsell

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

MENTAL HEALTH & YOUTH SERVICES COMMITTEE REPORT
Senator Fletcher L. Hartsell, Jr., Chair

Thursday, March 24, 2011

Senator HARTSELL, JR.,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **316** Add'l Section 1915 Medicaid Waiver Sites.

Draft Number:	85113
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE BILL 316*

Short Title:	Add'l Section 1915 Medicaid Waiver Sites.	(Public)
Sponsors:	Senators Hartsell; and Pate.	
Referred to:	Health Care.	

March 14, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE DHHS TO IMPLEMENT ADDITIONAL 1915(B)(C) MEDICAID WAIVER SITES AND THIRD-PARTY BILLING FOR STATE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. Section 10.24 of S.L. 2010-31 is repealed.

SECTION 2. The Department of Health and Human Services shall implement additional capitated 1915(b)(c) Medicaid waivers during the 2011-2012 fiscal year through a Request for Application (RFA) process for LME applicants who prove readiness. The waiver program shall include all Medicaid-covered mental health, developmental disabilities, and substance abuse services. Expansion of the waiver is contingent upon approval by the Centers for Medicare and Medicaid Services.

SECTION 3. G.S. 122C-55(g) reads as rewritten:

"(g) Whenever there is reason to believe that the client is eligible for financial benefits through a governmental agency, a facility may disclose confidential information to State, local, or federal government agencies. Except as provided in ~~G.S.122C-55(a3),~~ subsections (a3) and (g1) of this section, disclosure is limited to that confidential information necessary to establish financial benefits for a client. ~~After~~ Except as provided in subsection (g1) of this section, after establishment of these benefits, the consent of the client or his legally responsible person is required for further release of confidential information under this subsection."

SECTION 4. G.S. 122C-55 is amended by adding a new subsection to read:

"(g1) A facility may disclose confidential information for the purpose of collecting payment due the facility for the cost of care, treatment, or habilitation."

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S D

SENATE BILL 316*
PROPOSED COMMITTEE SUBSTITUTE S316-CSSQ-5 [v.3]

3/22/2011 6:06:25 PM

Short Title: Add'l Section 1915 Medicaid Waiver Sites. (Public)

Sponsors:

Referred to:

March 14, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE DHHS TO IMPLEMENT ADDITIONAL 1915(B)(C) MEDICAID WAIVER SITES AND TO ALLOW A FACILITY TO DISCLOSE CERTAIN INFORMATION FOR PURPOSES OF COLLECTING PAYMENT AND TO DIRECT THE DISTRIBUTION OF A FUND BALANCE UPON THE DISSOLUTION OF AN AREA AUTHORITY.

The General Assembly of North Carolina enacts:

SECTION 1. Section 10.24 of S.L. 2010-31 is repealed.

SECTION 2. The Department of Health and Human Services shall implement additional capitated 1915(b)(c) Medicaid waivers during the 2011-2012 fiscal year through a Request for Application (RFA) process for LME applicants who prove readiness. The waiver program shall include all Medicaid-covered mental health, developmental disabilities, and substance abuse services. Expansion of the waiver is contingent upon approval by the Centers for Medicare and Medicaid Services.

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SECTION 4. G.S. 122C-55 is amended by adding a new subsection to read:

"(g1) A facility may disclose confidential information for the purpose of collecting payment due the facility for the cost of care, treatment, or habilitation."

SECTION 5. G.S. 122C-115.3(e) reads as rewritten:

"(e) Any ~~budgetary surplus~~fund balance available to an area authority at the time of its dissolution shall be distributed to those counties comprising the area authority on the same pro rata basis that the counties appropriated and contributed funds to the area authority's budget during the current fiscal year. Distribution to the counties shall be determined on the basis of an audit of the financial record of the area authority. The area authority board shall select a certified public accountant or an accountant who is subsequently certified by the Local Government Commission to conduct the audit. The audit shall be performed in accordance with

G.S. 159-34. The same method of distribution of funds described in this subsection shall apply when one or more counties of an area authority withdraw from the area authority.

SECTION 6. This act is effective when it becomes law.

SENATE BILL 316:
Add'l Section 1915 Medicaid Waiver Sites

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	March 23, 2011
Introduced by:	Sen. Hartsell	**Prepared by:**	Shawn Parker
Analysis of:	Amendment to First Edition S316-ASQ-20		Committee Counsel

SUMMARY:

The effect of the amendment is to authorize only the following facilities to disclose confidential information for the purposes of collecting payment due:

(1) Psychiatric Hospitals:
- a. Cherry Hospital.
- a1. **(Contingent effective date, see Editor's note)** Central Regional Hospital.
- b. **(Contingent repeal date, see Editor's note)** Dorothea Dix Hospital.
- c. **(Contingent repeal date, see Editor's note)** John Umstead Hospital.
- d. Broughton Hospital.

(2) Developmental Centers:
- a. Caswell Developmental Center.
- b. Repealed by Session Laws 2007-177, s. 1, effective July 5, 2007.
- b1. J. Iverson Riddle Developmental Center.
- c. Murdoch Developmental Center.
- d. through e. Repealed by Session Laws 2007-177, s. 1, effective July 5, 2007.

(3) Alcohol and Drug Treatment Centers:
- a. Walter B. Jones Alcohol and Drug Abuse Treatment Center.
- b. Repealed by Session Laws 2007-177, s. 1, effective July 5, 2007.
- c. Julian F. Keith Alcohol and Drug Abuse Treatment Center.
- d. R.J. Blackley Alcohol and Drug Treatment Center.

(4) Neuro-Medical Treatment Centers:
- a. through c. Repealed by Session Laws 2007-177, s. 1, effective July 5, 2007.
- d. Black Mountain Neuro-Medical Treatment Center.
- e. O'Berry Neuro-Medical Treatment Center.
- f. Longleaf Neuro-Medical Treatment Center.

(5) Residential Programs for Children:
- a. Whitaker School.
- b. Wright School.

The term facility in the original bill and proposed committee substitute is a defined term which means-

"Facility" means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers, and includes:

a. An "area facility", which is a facility that is operated by or under contract with the area authority or county program. For the purposes of this subparagraph, a contract is a contract, memorandum of understanding, or other written agreement whereby the facility agrees to provide services to one or more

clients of the area authority or county program. Area facilities may also be licensable facilities in accordance with Article 2 of this Chapter. A State facility is not an area facility;

b. A "licensable facility", which is a facility that provides services to individuals who are mentally ill, developmentally disabled, or substance abusers for one or more minors or for two or more adults. These services shall be day services offered to the same individual for a period of three hours or more during a 24-hour period, or residential services provided for 24 consecutive hours or more. Facilities for individuals who are substance abusers include chemical dependency facilities;

c. A "private facility", which is a facility that is either a licensable facility or a special unit of a general hospital or a part of either in which the specific service provided is not covered under the terms of a contract with an area authority;

d. The psychiatric service of the University of North Carolina Hospitals at Chapel Hill;

e. A "residential facility", which is a 24-hour facility that is not a hospital, including a group home;

f. A "State facility", which is a facility that is operated by the Secretary;

g. A "24-hour facility", which is a facility that provides a structured living environment and services for a period of 24 consecutive hours or more and includes hospitals that are facilities under this Chapter; and

h. A Veterans Administration facility or part thereof that provides services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 316*

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S316-ASQ-20 [v.2]

Comm. Sub. [YES]
Amends Title [YES]
First Edition

Date _____ ,2011

Senator Hartsell

moves to amend the bill on page 1, line 4, by deleting the phrase "A FACILITY" and substituting the phrase "STATE FACILITIES";

and on page 1, line 25, by rewriting the line to read:

"'(g1) A State facility operated under the authority of G.S. 122C-181 may disclose confidential information for the purpose of collecting".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

VISITOR REGISTRATION SHEET

Mental Health & Youth Services

~~Senate Committee on Education/Higher Education~~ Wednesday, March 23, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pam Shipman	
Joe Lanier	Nelson Mullins
Mary Powell	NC SA Federation
Rose Linsey	Youth Villages
Cliff Parker	Youth Unlimited
Andrew Meehan	Capstrat
Sarah Davis	DCD
Kay Paksoy	NASW-NC
Penny Hufstetler	School of Gov.
Bob Hall	McGuire Woods
Peyton Boland	Spencer Gup
Fred Walker	Eastern Seals UCP NC & VA

VISITOR REGISTRATION SHEET

mental health Youth Services

~~Senate Committee on Education/Higher Education~~ Wednesday, March 23, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Erica Nelson	NCCCP
Will Woodell	Value Options
Yvonne Copeland	NC Council of Comm Prog
Amy Whited	NC Med Soc.
Liza Wannamaker	ECBH
Dave Richard	The Arc
Julia Adams	The Arc of NC
John McMillan	NFFS
John Mercer	Policy Group.
Annaliese Dolph	DRNC
M. Wilson	DHHS

VISITOR REGISTRATION SHEET

Mental Health & Youth Services

~~Senate Committee on Education/Higher Education~~ Wednesday, March 23, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sally Cameron	NC Psychological Assoc
Ken Melchi	Ben. Lucas
Beth Melchor	DHHS
Kelly Crosbie	DMA
Katherine Ross	PPAIB
Jennifer Mahan	ASNC
Kim Orcutt	NCBA
John Dervin	Governor's Office
Steve JORDAN	DMH DD SAS
Kelley Neal	NAMI NC
Mike Taylor	Michael W. Taylor, Attorney at Law, PLLC

VISITOR REGISTRATION SHEET

Mental Health & Youth Services

~~Senate Committee on Education/Higher Education~~ Wednesday, March 23, 2011

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nicole Fisher	John Locke Foundation
R. Clark	R. Clark & Assoc.
Bob Hedrick	NCPC
Hugh Tilson	NLGPA
Joel Maynard	GPMI; Assoc.
John Thaxton	Staff
Matt Wolfe	PPAB
Tara Larsen	DMA/DHHS

SENATE MENTAL HEALTH & YOUTH SERVICES COMMITTEE
Wednesday, April 27, 2011 at 12:00 Noon
Room 414, Legislative Office Building

MINUTES

The Senate Mental Health & Youth Services Committee met at 12:00 Noon on April 27, 2011, in Room 414 of the Legislative Office Building with thirteen members of the committee present. Senator Hartsell, Chairman, presided.

Senator Hartsell called the meeting to order at 12:04 pm. He then introduced pages Burrell Brown, Bailey Sherrill and Heather Green and thanked them for their service.

Senate Bill 401 - ACH Pilot on Crisis Intervention Training. Senator Bingham was recognized to explain the bill. Questions from Senators Allran, Kinnaird, Robinson and Tucker were answered by Ms. Lou Wilson, representing the North Carolina Long Term Care Facilities and Ms. Jeff Horton, COF of the Division of Health Service Regulation. Senator Jones moved for a favorable report. All voted and the motion carried.

Senate Bill 421 – GAST Training Pilot. Senator Bingham explained the bill and Ms. Patsy Pierce, Staff Attorney, gave additional explanation. Mr. Shawn Parker, Staff Attorney, answered questions from Senators Robinson and Tucker. Senator Purcell moved for a favorable report. All voted and the motion carried.

Senate Bill 328 – Report on Transfer of CAP-MR/DD UR to LMEs. Senator Nesbitt was recognized to explain the bill. Questions from Senators Davis, Jackson and Tucker were answered by Senator Nesbitt. Senator Davis moved for a favorable report with a referral to Appropriations. All voted and the motion carried.

Senate Bill 334 – Expand Inpatient Psychiatric Beds/Funds. Senator Nesbitt explained the bill. Questions from Senators Forrester, Robinson, Daniel, Kinnaird, Davis, Allran Tucker and Bingham were answered by Senator Nesbitt, Shawn Parker, Staff Attorney, Mr. Jeff Horton, of Health Services Regulation and Mr. Bill Scott of the Department of Health and Human Services. Senator Tucker moved for a favorable report with a referral to Appropriations. All voted and the motion carried.

Senate Bill 335 – Apply for TBI Medicaid Waiver. Senator Nesbitt explained the bill. Ms. Carol Ornitz of the North Carolina Brain Injury Advisory Council, spoke on the bill. Senator Robinson moved for a favorable report with a referral to Appropriations. All voted and the motion carried.

There being no further business, the meeting was adjourned at 12:50 pm

Sen. Fletcher L. Hartsell, Jr., Presiding

Gerry Johnson, Committee Clerk

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	April 27, 2011	12:00 Noon	414 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 328	Report on Transfer of CAP-MR/DD UR to LMEs.	Senator Nesbitt,
SB 334	Expand Inpatient Psychiatric Beds/Funds.	Senator Nesbitt,
SB 335	Apply for TBI Medicaid Waiver.	Senator Nesbitt,
SB 401	ACH Pilot on Crisis Intervention Training.	Senator Bingham
SB 421	GAST Training Pilot.	Senator Bingham

Senator Fletcher L. Hartsell, Jr., Chair

Senate Mental Health & Youth Services Committee
Wednesday, April 27, 2011, 12:00 Noon
414 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 328	Report on Transfer of CAP-MR/DD UR to LMEs.	Senator Nesbitt,
SB 334	Expand Inpatient Psychiatric Beds/Funds.	Senator Nesbitt,
SB 335	Apply for TBI Medicaid Waiver.	Senator Nesbitt,
SB 401	ACH Pilot on Crisis Intervention Training.	Senator Bingham
SB 421	GAST Training Pilot.	Senator Bingham

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

MENTAL HEALTH & YOUTH SERVICES COMMITTEE REPORT
Senator Fletcher L. Hartsell, Jr., Chair

Wednesday, April 27, 2011

Senator HARTSELL, JR.,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **328** Report on Transfer of CAP-MR/DD UR to LMEs.
Sequential Referral: None
Recommended Referral: Appropriations/Base Budget

S.B. **334** Expand Inpatient Psychiatric Beds/Funds.
Sequential Referral: None
Recommended Referral: Appropriations/Base Budget

S.B. **335** Apply for TBI Medicaid Waiver.
Sequential Referral: None
Recommended Referral: Appropriations/Base Budget

S.B. **401** ACH Pilot on Crisis Intervention Training.
Sequential Referral: None
Recommended Referral: None

S.B. **421** GAST Training Pilot.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 5

Committee Clerk Comments:

SENATE BILL 328*

Short Title:	Report on Transfer of CAP-MR/DD UR to LMEs.	(Public)
Sponsors:	Senators Nesbitt; Allran, Atwater, D. Berger, Blue, Dannelly, Forrester, Garrou, Jenkins, Jones, Mansfield, Purcell, Robinson, and White.	
Referred to:	Mental Health & Youth Services.	

March 14, 2011

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REPORT ON THE IMPLEMENTATION OF UTILIZATION REVIEW BY DESIGNATED LOCAL MANAGEMENT ENTITIES FOR SERVICES PROVIDED UNDER THE COMMUNITY ALTERNATIVES PROGRAM FOR PERSONS WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. By September 1, 2012, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services shall submit a report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the implementation of utilization review by designated local management entities for services provided under the CAP-MR/DD Medicaid Waiver. The report shall include at least all of the following:

(1) A comparison of the training, monitoring, and operating costs associated with (i) transferring the utilization review function to Crossroads Behavioral Health Center, Eastpointe, The Durham Center, and Pathways LME (the four designated LMEs) and (ii) maintaining the statewide vendor contract in effect for utilization review prior to the transfer of this function to the four designated LMEs.

(2) Information on the number of CAP-MR/DD recipients who received utilization review services from the four designated LMEs between January 1, 2011, and January 1, 2012.

(3) A description of the accountability measures used by the four designated LMEs to ensure the accuracy of utilization review decisions.

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

SENATE BILL 328: Report on Transfer of CAP-MR/DD UR to LMEs

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	April 27, 2011
Introduced by:	Sen. Nesbitt	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 328 directs the Department of Health and Human Services to report on the implementation of CAP –MR/DD utilization review being performed by local management entities.

CURRENT LAW: As of January 20, 2011, utilization review for CAP-MR/DD waiver services are the responsibility of LMEs. All LME counties were split between four LME UR vendors* selected (through an RFA process) to perform this function as follows:

Crossroads Behavioral Health Center
Buncombe, Davie, Forsyth, Henderson, Iredell, Madison, Mitchell, Polk, Rockingham, Rutherford, Stokes, Surry, Transylvania, Yadkin, Yancey
Eastpointe
Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Cumberland, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Hertford, Hyde, Johnston, Jones, Lenoir, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Robeson, Sampson, Scotland, Tyrrell, Washington, Wayne, Wilson
The Durham Center
Alamance, Anson, Caswell, Chatham, Durham, Franklin, Granville, Guilford, Halifax, Harnett, Hoke, Lee, Montgomery, Moore, Orange, Person, Randolph, Richmond, Vance, Wake, Warren
Pathways LME
Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Catawba, Cherokee, Clay, Cleveland, Gaston, Graham, Haywood, Jackson, Lincoln, Macon, McDowell, Mecklenburg, Swain, Watauga, Wilkes

BILL ANALYSIS: Senate Bill 328 directs the Division of MH/DD/SAS to report to the health and human services appropriations committees of each chamber, the fiscal research division, and the Joint Legislative Oversight Committee on MH/DD/SAS on the implementation of utilization review by LMEs. The report is due by September 1, 2012 and shall include:

- A comparison in training, monitoring, and operating costs associated with the transfer to the four selected LMEs versus utilizing a statewide vendor.
- Information on the number of CAP MR/DD recipients who receiving services during the period between January 1, 2011 and January 1, 2012.
- A description of accountability measures used by the four designated LMEs to ensure accuracy of UR decisions.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: LME core functions, as defined by General Statute 122C-115, include utilization management, utilization review, and determination of the appropriate level and intensity of services to ensure that services are needed and appropriately provided. In recent years these functions have been transferred to an outside vendor-Value Options. The 2008 General Assembly directed the Department to return utilization management (of Medicaid services) to LMEs representing at least 30% of the State's population. Currently EastPointe, Durham and PBH perform UM/UR of Medicaid dollars for the counties in their catchment area and these 3 LMEs along with Crossroads and Pathways perform UR functions for CAP MR/DD services covering all counties in the State.

SENATE BILL 334*

Short Title:	Expand Inpatient Psychiatric Beds/Funds.	(Public)
Sponsors:	Senators Nesbitt; Allran, Atwater, D. Berger, Dannelly, Forrester, Garrou, Jenkins, Jones, Purcell, and White.	
Referred to:	Mental Health & Youth Services.	

March 14, 2011

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE ADDITIONAL FUNDS FOR THE EXPANSION OF LOCAL INPATIENT PSYCHIATRIC BEDS OR BED DAYS, AS RECOMMENDED BY THE LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division), the sum of thirty-nine million one hundred twenty-one thousand six hundred forty-four dollars ($39,121,644) for the 2011-2012 fiscal year for the purchase of 50 additional local inpatient psychiatric beds or bed days. These beds or bed days shall be distributed across the State in LME catchment areas and according to need as determined by the Department. The Department shall enter into contracts with the LMEs and community hospitals for the management of these beds or bed days. The Department shall work to ensure that these contracts are awarded equitably around all regions of the State. Local inpatient psychiatric beds or bed days shall be managed and controlled by the LME, including the determination of which local or State hospital the individual should be admitted to pursuant to an involuntary commitment order. Funds shall not be allocated to LMEs but shall be held in a statewide reserve at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to pay for services authorized by the LMEs and billed by the hospitals through the LMEs. LMEs shall remit claims for payment to the Division within 15 working days of receipt of a clean claim from the hospital and shall pay the hospital within 30 working days of receipt of payment from the Division. If the Department determines (i) that an LME is not effectively managing the beds or bed days for which it has responsibility, as evidenced by beds or bed days in the local hospital not being utilized while demand for services at the State psychiatric hospitals has not reduced or (ii) the LME has failed to comply with the prompt payment provisions of this subsection, the Department may contract with another LME to manage the beds or bed days, or, notwithstanding any other provision of law to the contrary, may pay the hospital directly. The Department shall develop reporting requirements for LMEs regarding the utilization of the beds or bed days. Funds appropriated in this section for the purchase of local inpatient psychiatric beds or bed days shall be used to purchase additional beds or bed days not currently funded by or through LMEs and shall not be used to supplant other funds available or otherwise appropriated for the purchase of psychiatric inpatient services under contract with community hospitals, including beds or bed days being purchased through Hospital Utilization Pilot funds appropriated in S.L. 2007-323. Not later than March 1, 2011, the Department shall report to the House of Representatives Appropriations

Subcommittee on Health and Human Services, the Senate, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on a uniform system for 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 section.

SECTION 2. This act becomes effective July 1, 2011.

SENATE BILL 334:
Expand Inpatient Psychiatric Beds/Funds

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	April 27, 2011
Introduced by:	Sen. Nesbitt	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 334 appropriates $39,121,644 to the Department of Health and Human Services to be used to purchase 50 additional local inpatient psychiatric beds or bed days.***

BILL ANALYSIS: Senate Bill 328 appropriates $39,121,644 from the General Fund to the Department to purchase 50 additional local inpatient psychiatric beds or bed days to be distributed across the State. The bill provides that these beds shall be distributed across the State according to need as determined by the Department. The Department shall enter into contracts with LMEs and community hospitals for the management of beds or bed days and requires that local inpatient psychiatric beds or bed days are managed and controlled by the LME. The bill provides these fund are not to be allocated to LMEs but will be held in a statewide reserve controlled by the Division. Funds used are not to supplant other funds available or otherwise appropriated 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 SL 2007-323.

The Department is directed to develop reporting requirements for LMEs regarding the utilization of the beds or bed days, and may contract with another LME to manage the beds if the beds are not properly being utilized or the LME fails to comply with the prompt payment requirement provided in the act.

The bill directs the Department to report, by March 1, 2011, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on a uniform system for 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 provision.

EFFECTIVE DATE: This act becomes effective July 1, 2011.

BACKGROUND: From the 2010 LOC report to the General Assembly:

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

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

SENATE BILL 335*

Short Title:	Apply for TBI Medicaid Waiver.	(Public)
Sponsors:	Senators Nesbitt; Allran, Atwater, D. Berger, Blue, Dannelly, Forrester, Jenkins, Jones, Mansfield, Purcell, and White.	
Referred to:	Mental Health & Youth Services.	

March 14, 2011

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO APPLY FOR A TRAUMATIC BRAIN INJURY MEDICAID WAIVER, AS RECOMMENDED BY THE LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, in consultation with the North Carolina Traumatic Brain Injury Advisory Council, shall develop and apply to the Centers for Medicare and Medicaid Services (CMS) for a 1915(c) waiver to permit persons who sustain traumatic brain injuries to access home and community-based Medicaid services. The Department shall not submit the application to CMS unless the General Assembly identifies a source of funding sufficient to provide the match for this proposed waiver from State appropriations earmarked for persons with traumatic brain injury. In determining the number of slots and the slot allocation formula for this proposed waiver, the Department shall consider the amount of funding identified by the General Assembly for this purpose.

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

- The CAP-C (Children) waiver is limited to serving young children with chronic medical conditions.

How many states currently operate a TBI Waiver?

Twenty-one states currently operate a TBI waiver. The first waiver was developed by the state of Kansas in 1991. By 1999, 75% of the TBI waivers currently in operation had already been implemented. [vi]

How many persons could benefit from a TBI waiver?

States have the discretion to choose the number of consumers to serve in a HCBS waiver program. Once approved by CMS, a state is held to the number of persons estimated in its application but has the flexibility to serve greater or fewer numbers of consumers by submitting an amendment to CMS for approval.[vii] But the amount of financial resources available to meet matching fund requirements will largely dictate the number of persons who can initially access this waiver.

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[i] Centers for Disease Control and Prevention, www.cdc.gov
[ii] Centers for Disease Control and Prevention, www.cdc.gov
[iii] Centers for Medicare and Medicaid Services, www.cms.hhs.gov
[iv] Centers for Medicare and Medicaid Services, www.cms.hhs.gov
[v] Centers for Medicare and Medicaid Services, www.cms.hhs.gov
[vi] Hendrickson, L. and Blume, R.,"A Survey of Medicaid Brain Injury Programs" , Rutgers Center for State Health Policy, March, 2008
[vii] Centers for Medicare and Medicaid Services, www.cms.hhs.gov

In late 2007, the Center for State Health Policy surveyed 23 states that operate Medicaid waivers targeted to individuals with brain injuries. Providing HCBS to individuals with brain injury is less expensive than providing services in nursing homes, hospitals, and similar institutions. Data from 17 of the surveyed states indicate that when compared to institutional costs, a total of almost $273 million was saved by Medicaid through the use of these brain injury waivers. On average $30,000 per person was saved

Issue Brief: Survey of Medicaid Brain Injury Programs
Rutgers Center for State Health Policy (2008)

The TBI Medicaid Waiver

House Bill 77

Senate Bill 335

The North Carolina Traumatic Brain Injury Advisory Council
Created 2003 by NC Session Law 2003-114

The Need for a Medicaid Waiver for Persons with Brain Injury

The Centers for Disease Control and Prevention (CDC) estimate that 180,000 persons in NC are already living with the long-term effects of traumatic brain injury (TBI). [i] Studies have shown that approximately 20% of the 5,000 – 6,000 new individuals hospitalized in NC each year from a TBI can be expected to require extensive rehabilitative services.[ii]

Persons with TBI present a wide range of needs due to loss of physical capabilities such as mobility, speech, hearing, and vision; impaired judgment; short-term memory loss; and behavior problems. Very few community-based service options are available in NC for those who have significant long-term needs.

The North Carolina Traumatic Brain Injury Advisory Council believes that one of the most cost-effective ways to serve individuals who have significant long-term needs in a non-institutional setting is through Home and Community Based Services (HCBS) Waiver.

What is a Home and Community Based Services (HCBS) Waiver?

An HCBS waiver provides the Secretary of Health and Human Services the authority to waive Medicaid provisions in order to allow Long-term care services to be delivered in community settings rather than in institutional settings. [iii]

What is the process by which a state is approved for an HCBS Waiver?

- The State Medicaid Agency and/or the agency intending to manage the waiver must first request approval from the NC General Assembly to apply for a waiver because matching funds are required.
- The state must identify the source of the matching funds.
- The State Medicaid agency must submit an application for a HCBS waiver to the Centers for Medicare and Medicaid Services (CMS) for review and approval. The State Medicaid Agency has the ultimate responsibility for a HCBS waiver program, although it may delegate the day-to-day operation of the program to another entity. Initial HCBS waivers are approved for a three-year period, and waivers are renewed for five-year intervals.[iv]
- CMS has 90 days in which to review and approve a waiver application. If CMS has questions about the application, the clock stops on the 90-day turn-around requirement until those questions are satisfactorily addressed. Once the waiver is approved, it may take 6 months to implement the waiver.

What are the federal requirements that the managing entity must follow when implementing the HCBS waiver?

- Demonstrate that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution.
- Ensure that measures will be taken to protect the health and welfare of consumers
- Provide adequate and reasonable provider standards to meet the needs of the target population
- Ensure that services are provided in accordance with an individualized Plan of Care.[v]

What is the financial advantage of a Medicaid Waiver?

The federal Medicaid program will provide $.64 for every $.36 that the state/county contributes in matching funds. This enables the state to maximize the use of state funds and serve more individuals.

Why can't persons with brain injury access one of the state's existing HCBS waivers?

- Only persons injured before the age of 22 are eligible for the CAP-MR/DD (Mental Retardation/Developmental Disabilities) waiver under federal guidelines.
- Persons served under the CAP-DA (Disabled Adult) waiver are restricted to receiving services in a private residence rather than a group home or other small supervised community setting. The CAP-DA waiver services menu is not broad enough to incorporate all the service needs of persons with brain injury.

SENATE BILL 335:
Apply for TBI Medicaid Waiver

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	April 25, 2011
Introduced by:	Sen. Nesbitt	**Prepared by:**	Janice Paul Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 335 would require the North Carolina Department of Health and Human Services (DHHS) to apply for a traumatic brain injury (TBI) Medicaid waiver, as recommended by the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.***

CURRENT LAW: Section 1915(c) of the Social Security Act, authorizes the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid statutory requirements. The waivers allow states to cover a broad array of home and community-based services for certain populations as an alternative to institutional care.

BILL ANALYSIS: Senate Bill 335 would direct DHHS to apply for a waiver from the Centers for Medicare and Medicaid Services to enable persons with traumatic brain injuries to access home and community-based services. DHHS would be prohibited from submitting the application unless the General Assembly identifies a sufficient funding source to provide the match for the waiver from state appropriations earmarked for persons with TBI.

EFFECTIVE DATE: This act is effective when it becomes law.

S335-SMTJ-26(e1) v3

SENATE BILL 401*

Short Title:	ACH Pilot on Crisis Intervention Training.	(Public)
Sponsors:	Senators Bingham; Allran, Atwater, Blake, Clary, Daniel, Preston, Rabon, Stevens, and Tucker.	
Referred to:	Mental Health & Youth Services.	

March 24, 2011

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO COORDINATE A PILOT PROGRAM TO EVALUATE THE EFFECTIVENESS OF CRISIS INTERVENTION TRAINING IN A LIMITED NUMBER OF ADULT CARE HOMES, BASED ON RECOMMENDATION 5.2 FROM THE NORTH CAROLINA INSTITUTE OF MEDICINE TASK FORCE ON THE CO-LOCATION OF DIFFERENT POPULATIONS IN ADULT CARE HOMES AND AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, shall coordinate a pilot program in 10 adult care homes to evaluate the effectiveness of crisis intervention training. The pilot program shall be conducted in adult care homes identified as having a significant percentage of residents with a primary diagnosis of mental health problems and where crisis management has been a concern in the past. The Division shall consider modification of the current North Carolina Interventions (NCI) Prevention training to a one-day training program appropriate for adult care home staff. The training shall be delivered to all direct care workers, including personal care aides, medication aides, and supervisors employed by the participants in the pilot program. The training shall include a competency evaluation component.

SECTION 1.(b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, shall evaluate the effectiveness of the crisis intervention training required by this section and report on or before March 1, 2012, to the North Carolina Study Commission on Aging and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include the number of adult care homes participating in the pilot, the criteria used to select the pilot participants, the number of staff that received training, the number of staff successfully completing the competency evaluation, the source that provided the training, the evaluation of training effectiveness, and a recommendation on whether the training should be expanded and how best to expand it to additional adult care homes.

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

SENATE BILL 401:
ACH Pilot on Crisis Intervention Training

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	April 26, 2011
Introduced by:	Sen. Bingham	**Prepared by:**	Susan Barham
Analysis of:	First Edition		Research Assistant

SUMMARY: ***Senate Bill 401 directs the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division of MH/DD/SAS) to coordinate a pilot program to evaluate the effectiveness of crisis intervention training in a limited number of adult care homes and report the findings to the NC Study Commission on Aging and the Joint Legislative Oversight Committee on MH/DD/SAS.***

BILL ANALYSIS:

Senate Bill 401, a recommendation from the NC Study Commission on Aging, requires the Division of MH/DD/SAS, Department of Health and Human Services to coordinate a pilot program to evaluate the effectiveness of crisis intervention training in adult care homes. The pilot program must be:

- Conducted in 10 adult care homes that have a large percentage of residents with a primary diagnosis of mental health problems and where crisis intervention has been a concern in the past.
- Delivered to all direct care workers including: personal care aides, medication aides, and supervisors employed by the participating adult care homes.
- Evaluated by including a competency component.

In addition, the Division of MH/DD/SAS must consider modifying NC Interventions (NCI) into a one-day training program. NCI is a standardized training program to prevent the use of restraints and seclusion, created and supported by the Division of MH/DD/SAS and used in all Division of MH/DD/SAS state facilities.[1]

Senate Bill 401 directs the Division of MH/DD/SAS to report on or before March 1, 2012 on the effectiveness of the training to the NC Study Commission on Aging and the Joint Legislative Oversight Committee on MH/DD/SAS. The report must include: (1) the number of adult care homes in the pilot, (2) the criteria used to select participants, (3) the number of staff that received training, (4) the number of staff that successfully completed the evaluation, (5) the source that provided training, (6) an evaluation of training, and (7) a recommendation on expansion of training to additional adult care homes.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND:

S.L. 2009-451, Section 10.78ff(3), required the NC Institute of Medicine (IOM) to study short term and long term strategies to address issues within adult care homes that provide residence to persons who are frail and elderly and to persons suffering from mental illness. The NCIOM Task Force on the Co-Location of Different Populations in Adult Care Homes met and released a report in January 2011.

In the 2011 Report to the Governor and the 2011 Regular Session of the General Assembly, the Study Commission on Aging supported many of the recommendations identified in the report of the NCIOM Task Force on the Co-Location of Different Populations in Adult Care Homes. The Commission recommended, in response to the Task Force recommendation 5.2., that the General Assembly enact Senate Bill 401.
S401-SMTE-6(e1) v2

[1] NC DHHS: North Carolina Interventions (NCI) website: http://www.ncdhhs.gov/mhddsas/training/nci.htm

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S 1

SENATE BILL 421*

Short Title:	GAST Training Pilot.	(Public)
Sponsors:	Senators Bingham; Allran, Atwater, D. Berger, Brown, Clary, Daniel, Dannelly, Forrester, Kinnaird, Mansfield, McKissick, Preston, Rabon, Stevens, Tucker, Vaughan, Walters, and White.	
Referred to:	Mental Health & Youth Services.	

March 28, 2011

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO ESTABLISH A PILOT TRAINING PROGRAM USING GERIATRIC/ADULT MENTAL HEALTH SPECIALTY TEAMS TO CONDUCT TRAINING IN ADULT CARE HOMES ON PREVENTING THE ESCALATION OF BEHAVIORS LEADING TO CRISIS, BASED ON RECOMMENDATION 5.1 FROM THE NORTH CAROLINA INSTITUTE OF MEDICINE TASK FORCE ON THE CO-LOCATION OF DIFFERENT POPULATIONS IN ADULT CARE HOMES AND AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, shall establish a pilot training program using the Geriatric/Adult Mental Health Specialty Teams (GAST) to provide training on preventing the escalation of behaviors leading to crisis. The training shall be piloted in a local management entity (LME) catchment area located within each of the three regions of the State. The pilot training program shall include all adult care homes located within the coverage area of the selected LMEs. Each adult care home shall be provided with at least three training opportunities per year. These three training opportunities shall be one and one-half hours each and shall cover preventing the escalation of behaviors leading to crisis.

Employees of adult care homes covered by the pilot training program must attend at least one training session per year. Adult care home employees specifically required to attend training include direct care workers, supervisors, and administrators, on all shifts. A list of employees, the type of training, and the date they attended training shall be maintained by the adult care home, and the list shall be available for inspection.

SECTION 1.(b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Department of Health and Human Services, shall evaluate the effectiveness of the pilot training program. The Division shall also determine whether the existing GASTs have the resources to expand this training statewide, the possibility of incorporating this training into the current training delivered by the teams, and any associated costs. On or before September 1, 2012, the Division shall report to the North Carolina Study Commission on Aging and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the effectiveness of the pilot and recommendations for expansion to all adult care homes licensed by the State.

SECTION 2. Part 2, Article 1, of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-4.9. Adult care home staff training.**

Adult care homes licensed pursuant to this Chapter shall permit Geriatric/Adult Mental Health Specialty Teams to conduct staff training.

SECTION 3. This act is effective when it becomes law.

SENATE BILL 421: GAST Training Pilot

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	April 27, 2011
Introduced by:	Sen. Bingham	**Prepared by:**	Patsy Pierce
Analysis of:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 421 would require MH/DD/SAS to conduct and evaluate a pilot program in adult care homes using Geriatric/Adult Mental Health Specialty Teams (GAST) to train direct care and administrative staff to prevent the escalation of behaviors leading to crisis. The GAST pilot training program was recommended in the 2011 report of the NC Study Commission on Aging.

CURRENT LAW: G.S. 131D-2.1 defines an adult care home as an assisted living residence with 24-hour scheduled and unscheduled personal care services for two or more residents. Direct or scheduled services are provided through a formal written agreement with licensed home care or hospice agencies. Some licensed adult care homes provide services to individuals with cognitive requirements requiring supervision.

BILL ANALYSIS: The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) in the Department of Health and Human Services (DHHS) would be required to conduct a pilot training program using Geriatric/Adult Mental Health Specialty Teams (GAST) to provide training on preventing the escalation of behaviors leading to crisis. The training would:

- Be piloted in a local management entity (LME) catchment area within each of the three State regions.
- Include all adult care homes located within the coverage area of the selected LME.
- Be offered at least three times per year and last for at least one and one-half hours.

Employees of the adult care homes participating in the pilot study must attend at least one of the offered sessions per year. Direct care workers, supervisors, and administrators on all shifts are required to attend the training. The adult care home would be required to maintain a list of employees, type of training, and date attended. The list would be available for inspection.

MH/DD/SAS would evaluate the effectiveness of the GAST pilot training program to determine if:

- Existing GASTs have the resources to expand the training statewide.
- GAST training could be incorporated into other, existing training provided by the teams.

The evaluation would also determine associated costs of training provision. Evaluation findings on effectiveness and recommendations for expansion of GAST training to all licensed adult care homes would be reported to the Joint Legislative Oversight Committee on MH/DD/SAS by September 1, 2012.

The bill would amend Part 2, Article 1, of Chapter 131D of the General Statutes by adding a new section allowing GASTs to conduct staff training in adult care homes.

EFFECTIVE DATE: The bill would become effective when it becomes law.

BACKGROUND: GASTs were initially funded in 2002 to increase community capacity to serve older adults and reduce reliance on State hospital services. Each team is composed of, at least, a nurse and a masters-level mental health clinician with geriatric expertise. Some teams that cover large areas have additional staff. In January 2007, another team member was added to address the needs of younger people with mental illness residing in long-term care facilities. GASTs do not provide direct services to individuals but rather provide consultation, education, training, and technical assistance to the staff and caregivers of the individuals.

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — April 27, 2011
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	DMHS-DHSR
Jessie Goodmon	DHHS/DHSR
Kerri Burke	MWC
Amy Whited	NCMS
[illegible]	LC
Paula Cox Fishman	Volunteer advocate and sister of adult DD woman
Louise Fisher	Volunteer Advocate for the Mentally Ill
CAROL ORNITZ	NC Brain Injury Advisory Council
[illegible]	Benchmarks
Annaliese Dolph	DRNC
Lon Walker	NCALTCF
Vincent Vegas	Pulp Fiction R US

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — **Name of Committee**

April 27, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	NCNA
	Brain Injury Association of NC
Betty Liljequist	Brain Injury Assoc of NC
Susan Fewell	Brain Injury Assoc of NC PO Box 10912, Raleigh, NC 27605
	NCHA
	NAMI NC

SENATE MENTAL HEALTH & YOUTH SERVICES COMMITTEE
Wednesday, May 4, 2011 at 12:00 Noon
Room 414, Legislative Office Building

MINUTES

The Senate Mental Health & Youth Services Committee met at 12:00 Noon on May 4, 2011, in Room 414 of the Legislative Office Building with twelve members of the committee present. Senator Fletcher Hartsell, chairman, presided. He then introduced pages April Smith and Grant Herndon and thanked them for their assistance.

Senator Hartsell noted that Senate Bills 465 and 525 would not be heard.

SB 524 – Strengthening Residential Placement - Senator Tucker was recognized to explain the bill. Questions from Senators Robinson, Purcell and Forrester were answered by Senator Tucker, Ms. Karen McLeod, President and CEO of Benchmarks , Ms. Patsy Pierce, Staff Attorney and Mr. Michael Watson, Deputy Secretary of DHHS. Ms. McLeod, Mr. Mark O'Donnell of DHHS, Ms. Catharine Goldsmith of DHHS, and Ms. Deby Dihoff, Executive Director of National Alliance on Mental Illness spoke on the bill. Senator Robinson presented and amendment. Senator Tucker accepted the amendment, all voted and the motion carried. Senator Davis moved for a favorable report as amended and rolled into a Proposed Committee Substitute with a referral to Finance. All voted and the motion carried.

SB 669 – Dix Property-Mental Health Trust Fund. Senator Hartsell presented the Proposed Committee Substitute for purposes of discussion. All voted and the motion carried. Senator Atwater was recognized to explain the bill. Questions from Senators Forrester, Purcell, Robinson, Allran and Kinnaird were answered by Senator Atwater. Senator Allran moved for a favorable report. All voted and the motion carried.

There being no further business, the meeting was adjourned at 12:55 pm.

Fletcher L. Hartsell, Jr, Presiding

Gerry Johnson, Committee Clerk

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	May 4, 2011	12:00 Noon	414 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 465	Behavioral Health Management.	Senator Hartsell
SB 524	Strengthening Residential Placement.	Senator Hartsell Senator Tucker
SB 525	Streamline Oversight/DHHS Service Providers.	Senator Hartsell Senator Tucker
SB 669	Dix Property-Mental Health Trust Fund.	Senator Atwater

Senator Fletcher L. Hartsell, Jr., Chair

Senate Mental Health & Youth Services Committee
Wednesday, May 4, 2011, 12:00 Noon
414 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 465	Behavioral Health Management.	Senator Hartsell
SB 524	Strengthening Residential Placement.	Senator Hartsell
SB 525	Streamline Oversight/DHHS Service Providers.	Senator Tucker Senator Hartsell
SB 669	Dix Property-Mental Health Trust Fund.	Senator Tucker Senator Atwater

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

MENTAL HEALTH & YOUTH SERVICES COMMITTEE REPORT
Senator Fletcher L. Hartsell, Jr., Chair

Wednesday, May 04, 2011

Senator HARTSELL, JR.,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **524** Strengthening Residential Placement.

Draft Number:	PCS 35240
Sequential Referral:	None
Recommended Referral:	Finance
Long Title Amended:	No

S.B. **669** Dix Property-Mental Health Trust Fund.

Draft Number:	PCS 85195
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comments:

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

SENATE BILL 465

Short Title:	Behavioral Health Management.	(Public)
Sponsors:	Senator Hartsell.	
Referred to:	Mental Health & Youth Services.	

March 31, 2011

A BILL TO BE ENTITLED

AN ACT TO ALLOW AREA AUTHORITIES ORGANIZED UNDER CHAPTER 122C OF THE GENERAL STATUTES THAT ARE OPERATING UNDER MEDICAID MANAGED CARE WAIVERS TO ORGANIZE UNDER CHAPTER 131E OF THE GENERAL STATUTES, THE HOSPITAL AUTHORITIES ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 2 of Chapter 131E of the General Statutes, the Hospital Authorities Act, is amended by adding a new section to read:

"**§ 131E-35. Organization under this Part by area authorities operating under Medicaid waivers.**

A behavioral health authority may be created under the provisions of this Part whenever a county board of commissioners finds and adopts a resolution finding that it is in the interest of the public health and welfare to create a behavioral health authority in order to operate a behavioral health program under a Medicaid 1915 (b)/(c) waiver program. A behavioral health authority shall be created in the same manner as a hospital authority pursuant to this Part and subject to the same provisions, except that G.S. 131E-20 does not apply to a behavioral health authority."

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

SENATE BILL 465:
Behavioral Health Management

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	April 28, 2011
Introduced by:	Sen. Hartsell	**Prepared by:**	Janice Paul
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 465 would enact a new section relating to health care facilities in Chapter 131E, the Hospital Authorities Act

CURRENT LAW: The North Carolina Hospital Authorities Act is set out in G.S. 131E, "Health Care Facilities and Services." The act provides oversight mechanisms for facilities; sets out the laws relating to constructing new facilities, borrowing money, and managing day-to-day operations; and provides hospitals with a legal and financial framework for treating patients who cannot pay for services. The stated purpose of G.S. 131E, Article 2 ("Public Hospitals"), Part 2 "(Hospital Authority"), is "to provide an alternate method for counties and cities to provide hospital, medical, and health care" in order to "protect the public health, safety and welfare, including that of low income persons."

Sections 1915(b) and(c) of the Social Security Act authorizes the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid statutory requirements. The waivers allow states to cover a broad array of home and community-based services for certain populations as an alternative to institutional care. Section 1915(b) waivers are commonly known as "freedom of choice" or managed care waivers. Section 1915(c) waivers allow the provision of home and community-based services in lieu of institutional care. Section 1915(b)/(c) waivers combine all Medicaid-funded mental health/developmental disability/substance abuse (MH/DD/SAS) services to allow a single capitated managed care system as a vehicle for service delivery to Medicaid recipients at the community level.

BILL ANALYSIS: Senate Bill 465 would add a new G.S. Section 131E-35 to permit a county to create a behavioral health authority (BHA) under a Medicaid 1915(b)/(c) waiver program. In order to create the BHA, the county board of commissioners must adopt a resolution finding that it is in the interest of public health and welfare to create the authority to operate a behavioral health program under a Section 1915(b)/(c) waiver. The bill requires that a BHA be created in the same manner as a hospital authority and be subject to the same provisions, except for G.S. 131E-20 (boundaries of the authority).

EFFECTIVE DATE: This act is effective when it becomes law.

S465-SMTJ-28(e1) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

SENATE BILL 524*

Short Title:	Strengthening Residential Placement.	(Public)
Sponsors:	Senators Tucker, Hartsell; Blake, Forrester, Hise, Hunt, Pate, Rabon, and Rouzer.	
Referred to:	Mental Health & Youth Services.	

April 7, 2011

A BILL TO BE ENTITLED

AN ACT STRENGTHENING MENTAL HEALTH RESIDENTIAL PLACEMENT UNDER THE MEDICAID PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Section 10.68A(a)(7) of S.L. 2009-451, as amended by Section 5A of S.L. 2009-575 and by Section 10.35 of S.L. 2010-31, reads as rewritten:

"**SECTION 10.68A.(a)** The Department of Health and Human Services, Division of Medical Assistance, may take the following actions, notwithstanding any other provision of this act or other State law or rule to the contrary and subject to the requirements of subsection (e) of this section:

...

(7) MH Residential. – The Department of Health and Human Services shall restructure the Medicaid child mental health, developmental disabilities, and substance abuse residential services to ensure that total expenditures are within budgeted levels. All restructuring activities shall be in compliance with federal and State law or rule. The Divisions of Medical Assistance and Mental Health, Developmental Disabilities, and Substance Abuse Services shall establish a team inclusive of providers, LMEs, and other stakeholders to assure effective transition of recipients to appropriate treatment options. The restructuring shall address all of the following:

a. Submission of the therapeutic family service definition to CMS.

b. The Department shall reexamine the entrance and continued stay criteria for all residential services. The revised criteria shall promote least restrictive services in the home prior to residential placement. During treatment, there must be inclusion in community activities and parent or legal guardian participation in treatment.

c. Require all existing residential providers or agencies to be nationally accredited within one year of enactment of this act. Any providers enrolled after the enactment of this act shall be subject to existing endorsement and nationally accrediting requirements. In the interim, providers who are nationally accredited will be preferred providers for placement considerations.

d. Before a child can be admitted to Level III or Level IV placement, an assessment shall be completed to ensure the appropriateness of placement, and one or more of the following shall apply:

1. Placement shall be a step down from a higher level placement such as a psychiatric residential treatment facility or inpatient; or
2. Multisystemic therapy or intensive in-home therapy services have been unsuccessful; or
3. The Child and Family Team has reviewed all other alternatives and recommendations and recommends Level III or IV placement due to maintaining health and safety; or
4. Transition or discharge plan shall be submitted as part of the initial or concurrent request.

e. Length of stay is limited to no more than ~~120~~180 days. Any exceptions granted will require for non-CABHAs an independent psychological or psychiatric assessment, for CABHAs, a psychological or psychiatric assessment that may be completed by the CABHA, and for both Child and Family Team review of goals and treatment progress, family or discharge placement setting are actively engaged in treatment goals and objectives and active participation of the prior authorization of vendor. ~~The Department shall study the effectiveness of the length of stay limitation imposed pursuant to this sub-subdivision, and the number of children staying in Level II, III, and IV facilities, and report its findings to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before January 1, 2011, and shall provide update reports on the number of children in these facilities to this same committee every six months thereafter, for the following three year period.~~

f. Submission of discharge plan is required in order for the request to be considered ~~complete.~~ complete, but the authorization approval is not conditional upon all signatures. The LME will designate appropriate individuals who can sign the discharge plan within 24 hours of receipt. Failure to submit a complete discharge plan will result in the request being returned as unable to process.

g. Any residential provider that ceases to function as a provider shall provide written notification to DMA, the Local Management Entity, recipients, and the prior authorization vendor 30 days prior to closing of the business.

h. Record maintenance is the responsibility of the provider and must be in compliance with record retention requirements. Records shall also be available to State, federal, and local agencies.

i. Failure to comply with notification, recipient transition planning, or record maintenance shall be grounds for withholding payment until such activity is concluded. In addition, failure to comply shall be conditions that prevent enrollment for any Medicaid or State-funded service. A provider (including its officers, directors, agents, or managing employees or individuals or entities having a direct or indirect ownership interest or control interest of five percent (5%) or more as set forth in Title XI of the Social Security Act) that fails to comply with the required record retention may be subject to sanctions, including exclusion from further participation in the Medicaid program, as set forth in Title XI.

j. On or before October 1, 2009, the Department shall report on its plan for transitioning children out of Level III and Level IV group homes. The Department shall submit the reports to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

...."

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

SENATE BILL 524:
Strengthening Residential Placement

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	May 4, 2011
Introduced by:	Sens. Tucker, Hartsell	**Prepared by:**	Patsy Pierce*
Analysis of:	First Edition		Legislative Analyst

SUMMARY: ***Senate Bill 524 makes changes to the Department of Health and Human Services restructuring of the Medicaid child mental health, developmental disabilities, and substance abuse residential services. The changes include (1) requiring an assessment prior to admitting a child to a Level III or Level IV placement, (2) increasing the maximum length of stay from 120 to 180 days, (3) requiring assessments for exceptions to 180 day limitation, (4) deleting the continuing reporting requirement on numbers of children in residential facilities, and (5) amending the requirement for a discharge plan to provide that the authorization approval is not conditional upon all signatures. The LME is to designate appropriate individuals who can sign the discharge plan within 24 hours of receipt.***

CURRENT LAW: In 2009, the General Assembly enacted S.L. 2009-451, Section 10.68A(a)(7) relating to Level III and Level IV residential treatment services for children. This section was amended by S.L. 2010-31, Section 10.35(7)e. The provisions of the Session Laws require the Department of Health and Human Services to reduce expenditures and to restructure the Medicaid child mental health, developmental disabilities, and substance abuse residential services to keep within budgeted levels. Among the changes were (1) the addition of requirements for reviewing entrance and continued stay criteria and promotion of the least restrictive services, (2) establishing criteria for admission into a Level III or Level IV facility, (3) limiting length of stay to 120 days unless an independent psychiatric assessment and a Child and Family Team review of goals and treatment progress indicates the need for additional time, (4) DHHS to report to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before January 1, 2011 on the effectiveness of the length of stay limitations, and to report every 6 months for 3 years on the number of children in Level II, Level III, and Level IV facilities, and (5) requiring a discharge plan prior to authorization for residential treatment.

BILL ANALYSIS: House Bill 377 amends S.L. 2009-451, Section 10.68A as amended by S.L. 2010-31, Section 10.35, to do the following:

(1) In addition to the criteria set out in S.L. 2009-451, Section 10.68A(a)(7)d. for admission to a Level III or Level IV facility, the bill would require an assessment prior to admission to ensure the appropriateness of placement.

(2) The maximum length of stay is increased from 120 to 180 days.

(3) Assessments for exceptions to 180 day limitation are modified to reflect the implementation of the new category of provider agency, a Critical Access Behavioral Health Agency (CABHA,) and to allow psychological assessments as well as psychiatric assessments be used in determining the need for the extension. Non-CABHA's must obtain an independent psychological or psychiatric assessment. A CAHBA may itself complete the psychological or psychiatric assessment.

(4) The requirement for continued reporting by DHSS on numbers of children in Level II, Level III and Level IV residential facilities is deleted.

(5) Authorization approval is not conditional upon receipt of all signatures on the required discharge plan. The LME is to designate appropriate individuals who can sign the discharge plan within 24 hours of receipt of the discharge plan.

EFFECTIVE DATE: The act is effective when it becomes law.

S524-SMTL-27(e1) v4

*Research Division (919) 733-2578 *Barbara Riley, House Health and Human Services Counsel, developed this summary.*

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 5-4-11

S. B. No. 524 Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE _____

Rep.)
Sen.) Robinson

moves to amend the bill on page 2, lines 18-26

( ) WHICH CHANGES THE TITLE

by ~~deleting~~ removing the redlining.

SIGNED Shirley D. Robinson

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

SENATE BILL 525*

Short Title:	Streamline Oversight/DHHS Service Providers.	(Public)
Sponsors:	Senators Tucker, Hartsell; Allran, Daniel, Goolsby, Gunn, Newton, Pate, and Rabon.	
Referred to:	Mental Health & Youth Services.	

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO STREAMLINE DUPLICATE OVERSIGHT OF DHHS SERVICE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Findings. – Over the years, State and legislative actions intended to improve safety and quality of care have resulted in multiple, redundant reviews of Department of Health and Human Services (DHHS) service providers by various State and local agencies. This duplicative bureaucracy has led to wasted resources on the part of the monitoring agencies and the service provider, along with interrupted services to the consumer.

SECTION 2. The Secretary of Health and Human Services (hereinafter "the Secretary") shall establish a task force made up of division staff and providers to objectively compare the tools and checklists, currently in place, to look for redundancies and review items as to service provider monitoring that are not value added by August 1, 2011. The Secretary shall instruct this team to remove and streamline any duplication that is identified by December 31, 2011.

SECTION 3.(a) The Secretary of Health and Human Services shall create one regulatory body within the DHHS responsible for oversight review for service providers across all DHHS divisions to reduce duplication May 1, 2012. The Secretary shall instruct the new regulatory body to combine the multitude of reviews into a single annual review process. The creation of this regulatory body ensures objectivity in oversight and removes the conflict and undue influences upon decisions that may be prevalent in a local area. It also increases the likelihood of consistency in feedback and findings based on narrowing the variability around rule interpretation. The regulatory body shall aid in the reduction of excessive and unnecessary control over private enterprise. The regulatory body will include and comply with requirements of the national accrediting bodies for oversight management entities (NCQA, URAC) that pertain to provider agencies to avoid duplicative parallel reviews or monitoring of provider agencies by the oversight management entities.

SECTION 3.(b) The Secretary shall instruct the regulatory body to select a multidisciplinary team from staff and resources already in place from the various departments to allow for one streamlined annual review of service provider agencies by the team of the facility, compliance to rules, record assurances, clinical integrity, and staff training. The Secretary shall eliminate endorsement and all tools and checklists (ex. Provider Monitoring Tool-PMT and Frequency and Extent of Monitoring Tool-FEM) associated with Local Management Entity monitoring and oversight and replace with service licensure at an agency level, as opposed to a site-specific service license, that the multidisciplinary team issues. The

multidisciplinary team may conduct additional reviews as indicated through Program Integrity flagged data, or a complaint or grievance. The annual review shall be agency specific not site-specific. The Secretary shall ensure that the multidisciplinary team includes specialized reviewers, with knowledge and experience specific to the services provided by the agency undergoing the annual review and rules applicable to those specific services and facilities. The Secretary will direct the multidisciplinary team to cross-walk the new annual review with the National Accreditation review to eliminate wasteful duplication. The Secretary shall direct the new regulatory body to create "core" multidisciplinary teams in locations across the state. For agencies with specialized services outside of the "core," the multidisciplinary team shall include specialized reviewers, with knowledge and experience specific to the services provided by the agency undergoing the annual review. When regular annual reviews are positive and meet compliance expectations for two consecutive years, the multidisciplinary team review shall be completed every two years pending any problems indicated through Program Integrity data, or a complaint or grievance. Such periodic review shall not necessarily require a return to annual monitoring for the service provider. The regulatory body shall have the power and authority to issue a request for corrective action, approve and monitor the corrective action, suspend and/or withdraw the billing process (contract, license, Medicaid enrollment for a specific service, etc.) for the service provider agency based on results from the annual or biennial review. The regulatory body shall have the discretion to determine whether infractions are site-specific or applicable to the agency as a whole. The regulatory body will be the central agency that responds to any complaints, abuse, neglect, and/or allegations.

SECTION 4. Chapter 143 of the General Statutes is amended by adding a new section to read:

"**§ 143B-139.6C. Coordination plan for the investigation of abuse or neglect complaints involving multiple agencies.**

For the purpose of avoiding duplication of effort and paperwork by service providers and the Department, to ensure a clear understanding and interpretation of compliance with applicable laws and rules, and to expedite the provision of effective services to clients, the Secretary of Health and Human Services shall direct the appropriate departmental divisions, in conjunction with providers and local oversight agencies, to establish a procedure for coordinating the investigation of complaints against licensed, certified, or accredited providers of services to recipients of social services or mental health, developmental disabilities, and substance abuse services through the regulatory body. When an abuse or neglect complaint is received by the Department and the complaint requires investigation by more than one division of the Department, the Secretary shall establish a coordination plan through the regulatory body to complete and share the results of the investigation with the appropriate bodies. The Secretary shall coordinate with the involved departmental divisions to review laws and rules that impact the investigation and to provide consistent and nonconflicting findings to the provider on what rules or laws have been violated and the corrections needed to comply with those laws and rules. The procedure shall provide for notice to service providers when a complaint is received. If a conflict arises among the departmental divisions concerning the interpretation of the law or rules, the conflict shall be resolved by the Secretary or, if necessary, by an amendment to rules or statutory clarification by the General Assembly. The provider shall not be deemed in violation of any rule, the interpretation of which is in conflict, until the conflict has been resolved and the provider informed of the decision."

SECTION 5.(a) The Secretary shall streamline the Medicaid enrollment process by directing the Division of Medical Assistance (DMA) to remove the requirement for annual reenrollment by September 1, 2011. Once a service provider is enrolled, the provider shall continue to maintain enrollment until the enrollment number has not been utilized for six consecutive months. The six-month tracking process shall be instituted if it is not currently in place, eliminating duplicative and unnecessary paperwork.

SECTION 5.(b) The Secretary shall mandate that each DHHS division, agency, or department provide a fiscal note for every change or adjustment in service definition, policy, rule, or statute upon enactment. This requirement shall minimize the creation of unfunded mandates for provider agencies.

SECTION 5.(c) The Secretary shall direct the Division of Mental Health Developmental Disabilities, and Substance Abuse Services to allow for data sharing from the Incident Response Improvement System (IRIS) with service providers and the regulatory body by June 30, 2012. The system currently prohibits providers' access to their data for analysis, internal monitoring, quality improvement, and quality assurance reports for various entities. Because access for providers is restrictive, it creates a duplicative process requiring providers to repopulate the incident report data sets again into their own systems.

SECTION 5.(d) The Secretary shall establish a task force made up of division staff and providers to objectively evaluate the North Carolina Treatment Outcomes Program Performance System (NC-TOPPS) to improve the way data is accessible across services rather than site-specific to reflect valid comparisons of program outcomes by August 1, 2011. The system does not allow data to be captured which is population-specific thus limiting the depth of data comparison and outcome identification.

SECTION 5.(e) The Secretary shall allow private sector development and implementation of an Internet-based, secure, and consolidated data warehouse and archive for maintaining corporate, fiscal, and administrative records of providers by September 1, 2011. Use of the consolidated data warehouse is optional. Providers that choose to utilize the data warehouse shall ensure that the data is up to date and accessible to the regulatory body. A provider shall submit any revised, updated information to the data warehouse within 10 business days after receiving the request. The regulatory body that conducts administrative monitoring must use the data warehouse for document requests. If the information provided to the regulatory body is not current or is unavailable from the data warehouse and archive, the regulatory body may contact the provider directly. A provider that fails to comply with the regulatory body's requested documents may be subject to an on-site visit to ensure compliance. Access to the data warehouse must be provided without charge to the regulatory body under this section.

SECTION 6. The language in this act will be reviewed annually for compliance with updates to policy made by the following national accrediting bodies: Council on Accreditation (COA), CARF International, Council on Quality and Leadership (CQL), and the Joint Commission.

SECTION 7. This act is effective when it becomes law.

S 1

SENATE BILL 669

Short Title:	Dix Property-Mental Health Trust Fund.	(Public)
Sponsors:	Senators Atwater; Allran, D. Berger, Dannelly, Kinnaird, Mansfield, McKissick, Robinson, Vaughan, Walters, and White.	
Referred to:	Mental Health & Youth Services.	

April 20, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE ALLOCATION OF THE PROCEEDS FROM ANY DISPOSITION OF THE DOROTHEA DIX HOSPITAL PROPERTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143C-9-2(c) reads as rewritten:

"(c) Notwithstanding G.S. 143C-1-2, any nonrecurring savings in State appropriations realized from the closure of any State psychiatric hospitals that are in excess of the cost of operating and maintaining a new State psychiatric hospital shall not revert to the General Fund but shall be placed in the Trust Fund and shall be used for the purposes authorized in this section. Notwithstanding G.S. 143C-1-2, recurring savings realized from the closure of any State psychiatric hospitals shall not revert to the General Fund but shall be credited to the Department of Health and Human Services to be used only for the purposes of subsections (b)(2) and (b)(3) of this section. Notwithstanding any other provision of law, all funds transferred into the Trust Fund from the disposition of the Dorothea Dix Hospital Property shall be used only to support the purposes of subdivisions (b)(1) and (b)(3) of this section that are related to persons with mental illness."

SECTION 2. G.S. 146-30 is amended by adding a new subsection to read:

"(b2) Notwithstanding the other provisions of this section or any other provision of law, no service charge into the State Land Fund shall be deducted from or levied against the proceeds of any disposition of the Dorothea Dix Hospital Property. The net proceeds of those dispositions shall be deposited in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs to be used for the purposes provided in G.S. 143C-9-2(c)."

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S D

SENATE BILL 669
PROPOSED COMMITTEE SUBSTITUTE S669-CSSQ-20 [v.1]

4/29/2011 9:31:35 AM

Short Title: Dix Property-Mental Health Trust Fund. (Public)

Sponsors:

Referred to:

April 20, 2011

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE ALLOCATION OF THE PROCEEDS FROM ANY DISPOSITION OF THE DOROTHEA DIX HOSPITAL PROPERTY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143C-9-2(c) reads as rewritten:

"(c) Notwithstanding G.S. 143C-1-2, any nonrecurring savings in State appropriations realized from the closure of any State psychiatric hospitals that are in excess of the cost of operating and maintaining a new State psychiatric hospital shall not revert to the General Fund but shall be placed in the Trust Fund and shall be used for the purposes authorized in this section. Notwithstanding G.S. 143C-1-2, recurring savings realized from the closure of any State psychiatric hospitals shall not revert to the General Fund but shall be credited to the Department of Health and Human Services to be used only for the purposes of ~~subsections (b)(2) and~~subsection (b)(3) of this section. Notwithstanding any other provision of law, all funds transferred into the Trust Fund from the disposition of the Dorothea Dix Hospital Property shall be used only to support the purposes of subdivisions (b)(1) and (b)(3) of this section that are related to persons with mental illness."

SECTION 2. G.S. 146-30 is amended by adding a new subsection to read:

"(b3) Notwithstanding the other provisions of this section or any other provision of law, no service charge into the State Land Fund shall be deducted from or levied against the proceeds of any disposition of the Dorothea Dix Hospital Property. The net proceeds of those dispositions shall be deposited in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs to be used for the purposes provided in G.S. 143C-9-2(c)."

SECTION 3. This act is effective when it becomes law.

SENATE BILL 669:
Dix Property-Mental Health Trust Fund

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	May 3, 2011
Introduced by:	Sen. Atwater	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition S669-CSSQ-20		Committee Counsel

SUMMARY: ***Senate Bill 669 directs all funds transferred from the disposition of the Dorothea Dix Hospital Property to the Trust Fund for Mental Health, Development Disabilities, and Substance Abuse Services and Bridge Funding Needs (Trust Fund) be used only to support services and programs intended for persons with mental illness and provides that a service charge to the State Land Fund shall not be deducted from the gross amount received from the disposition when determining net proceeds.***

CURRENT LAW:

Non-recurring savings from the closure of any State psychiatric hospital that are in excess of the cost of operating and maintaining a new State psychiatric hospital shall be placed in the Trust Fund and used to provide start-up funds and operating support for programs and services that provide more appropriate and cost effective community treatment alternatives and facilitate reform by expanding treatment and prevention services.

The net proceeds of any disposition shall be handled...as provided by act of the General Assembly. Net proceeds is the gross amount received from the sale, lease, or rental, less expenses incurred incident to the sale, lease, or rental and a service charge to be paid into the State Land Fund.

BILL ANALYSIS:

Senate Bill 669 directs that proceeds generated from the disposition of the Dorothea Dix Hospital (placed in the Trust Fund for MH/DD/SAS) shall be used only for programs and services that intended for persons with mental illness.

The bill removes the requirement that net proceeds include a deduction for a service charge to be paid to the State Land Fund.

EFFECTIVE DATE: This act is effective when it becomes law.

S669-SMSQ-23(CSSQ-20) v2

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — **Name of Committee**

May 4, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Angie Harris	Williams Mullen
Meredith Swindell	The Policy Group
Nicole Fisher	John Locke Foundation
BJ Miller	Moss Cove
Christine Crew	WakMed
Erica Nelson	NCCCP
Pam Shipman	PBH
Kristi Huff	NCHCFA
James Norment	Ward and Smith PA
Fred Walsh	East Seals UCP
Joe Lanier	Nelson Mullins

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — May 4, 2011
Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tara Ledford	MLC
Kathy Baker	Southeastern Regional LME
Jeanette Tarda-Hefner	Southeastern Regional LME
Don Clise	AYN
Jim Harrell	Benchmarks
Karen Mott	Benchmarks
Amy Whited	NCMS
Beth Melcher	DHHS
Lindsay Welch	DSOMF
Laura White	DSOHF
M. Watson	DHHS

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — May 4, 2011

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dawn Mishra	PSG
David Heiman	NC Center for Nonprofits
John Dorrin	Governor's Office

SENATE MENTAL HEALTH & YOUTH SERVICES COMMITTEE
Wednesday, May 11, 2011 at 12:00 Noon
Room 414, Legislative Office Building

MINUTES

The Senate Mental Health & Youth Services Committee met at 12:00 Noon on May 11, 2011, in Room 414 of the Legislative Office Building with seven members of the committee present. Senator Fletcher Hartsell, Chairman, presided.

Senator Hartsell introduced pages Ann Watkins and Ashton Herring and thanked them for their assistance.

SB 525 – Streamline Oversight/DHHS Service Providers. –Senator Hartsell presented a Proposed Committee Substitute. Senator Forrester moved to accept the Proposed Committee Substitute for purposes of discussion. All voted and the motion carried. Senator Tucker was recognized to explain the bill. Questions from Senators Kinnaird and Daniel were answered by Senator Tucker. Senator Jones moved for a favorable report, unfavorable to the original bill. All voted and the motion carried.

There being no further business the meeting was adjourned.

Sen. Fletcher L. Hartsell, Jr., Presiding

Gerry Johnson, Committee Clerk

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	May 11, 2011	12:00 Noon	414 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 525	Streamline Oversight/DHHS Service Providers.	Senator Hartsell Senator Tucker

Senator Fletcher L. Hartsell, Jr., Chair

Senate Mental Health & Youth Services Committee
Wednesday, May 11, 2011, 12:00 Noon
414 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 525	Streamline Oversight/DHHS Service Providers.	Senator Hartsell Senator Tucker

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

MENTAL HEALTH & YOUTH SERVICES COMMITTEE REPORT
Senator Fletcher L. Hartsell, Jr., Chair

Thursday, May 12, 2011

Senator HARTSELL, JR.,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **525** Streamline Oversight/DHHS Service Providers.

Draft Number:	75158
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE BILL 525*

Short Title:	Streamline Oversight/DHHS Service Providers.	(Public)
Sponsors:	Senators Tucker, Hartsell; Allran, Daniel, Goolsby, Gunn, Newton, Pate, and Rabon.	
Referred to:	Mental Health & Youth Services.	

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO STREAMLINE DUPLICATE OVERSIGHT OF DHHS SERVICE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Findings. – Over the years, State and legislative actions intended to improve safety and quality of care have resulted in multiple, redundant reviews of Department of Health and Human Services (DHHS) service providers by various State and local agencies. This duplicative bureaucracy has led to wasted resources on the part of the monitoring agencies and the service provider, along with interrupted services to the consumer.

SECTION 2. The Secretary of Health and Human Services (hereinafter "the Secretary") shall establish a task force made up of division staff and providers to objectively compare the tools and checklists, currently in place, to look for redundancies and review items as to service provider monitoring that are not value added by August 1, 2011. The Secretary shall instruct this team to remove and streamline any duplication that is identified by December 31, 2011.

SECTION 3.(a) The Secretary of Health and Human Services shall create one regulatory body within the DHHS responsible for oversight review for service providers across all DHHS divisions to reduce duplication May 1, 2012. The Secretary shall instruct the new regulatory body to combine the multitude of reviews into a single annual review process. The creation of this regulatory body ensures objectivity in oversight and removes the conflict and undue influences upon decisions that may be prevalent in a local area. It also increases the likelihood of consistency in feedback and findings based on narrowing the variability around rule interpretation. The regulatory body shall aid in the reduction of excessive and unnecessary control over private enterprise. The regulatory body will include and comply with requirements of the national accrediting bodies for oversight management entities (NCQA, URAC) that pertain to provider agencies to avoid duplicative parallel reviews or monitoring of provider agencies by the oversight management entities.

SECTION 3.(b) The Secretary shall instruct the regulatory body to select a multidisciplinary team from staff and resources already in place from the various departments to allow for one streamlined annual review of service provider agencies by the team of the facility, compliance to rules, record assurances, clinical integrity, and staff training. The Secretary shall eliminate endorsement and all tools and checklists (ex. Provider Monitoring Tool-PMT and Frequency and Extent of Monitoring Tool-FEM) associated with Local Management Entity monitoring and oversight and replace with service licensure at an agency level, as opposed to a site-specific service license, that the multidisciplinary team issues. The

multidisciplinary team may conduct additional reviews as indicated through Program Integrity flagged data, or a complaint or grievance. The annual review shall be agency specific not site-specific. The Secretary shall ensure that the multidisciplinary team includes specialized reviewers, with knowledge and experience specific to the services provided by the agency undergoing the annual review and rules applicable to those specific services and facilities. The Secretary will direct the multidisciplinary team to cross-walk the new annual review with the National Accreditation review to eliminate wasteful duplication. The Secretary shall direct the new regulatory body to create "core" multidisciplinary teams in locations across the state. For agencies with specialized services outside of the "core," the multidisciplinary team shall include specialized reviewers, with knowledge and experience specific to the services provided by the agency undergoing the annual review. When regular annual reviews are positive and meet compliance expectations for two consecutive years, the multidisciplinary team review shall be completed every two years pending any problems indicated through Program Integrity data, or a complaint or grievance. Such periodic review shall not necessarily require a return to annual monitoring for the service provider. The regulatory body shall have the power and authority to issue a request for corrective action, approve and monitor the corrective action, suspend and/or withdraw the billing process (contract, license, Medicaid enrollment for a specific service, etc.) for the service provider agency based on results from the annual or biennial review. The regulatory body shall have the discretion to determine whether infractions are site-specific or applicable to the agency as a whole. The regulatory body will be the central agency that responds to any complaints, abuse, neglect, and/or allegations.

SECTION 4. Chapter 143 of the General Statutes is amended by adding a new section to read:

"**§ 143B-139.6C. Coordination plan for the investigation of abuse or neglect complaints involving multiple agencies.**

For the purpose of avoiding duplication of effort and paperwork by service providers and the Department, to ensure a clear understanding and interpretation of compliance with applicable laws and rules, and to expedite the provision of effective services to clients, the Secretary of Health and Human Services shall direct the appropriate departmental divisions, in conjunction with providers and local oversight agencies, to establish a procedure for coordinating the investigation of complaints against licensed, certified, or accredited providers of services to recipients of social services or mental health, developmental disabilities, and substance abuse services through the regulatory body. When an abuse or neglect complaint is received by the Department and the complaint requires investigation by more than one division of the Department, the Secretary shall establish a coordination plan through the regulatory body to complete and share the results of the investigation with the appropriate bodies. The Secretary shall coordinate with the involved departmental divisions to review laws and rules that impact the investigation and to provide consistent and nonconflicting findings to the provider on what rules or laws have been violated and the corrections needed to comply with those laws and rules. The procedure shall provide for notice to service providers when a complaint is received. If a conflict arises among the departmental divisions concerning the interpretation of the law or rules, the conflict shall be resolved by the Secretary or, if necessary, by an amendment to rules or statutory clarification by the General Assembly. The provider shall not be deemed in violation of any rule, the interpretation of which is in conflict, until the conflict has been resolved and the provider informed of the decision."

SECTION 5.(a) The Secretary shall streamline the Medicaid enrollment process by directing the Division of Medical Assistance (DMA) to remove the requirement for annual reenrollment by September 1, 2011. Once a service provider is enrolled, the provider shall continue to maintain enrollment until the enrollment number has not been utilized for six consecutive months. The six-month tracking process shall be instituted if it is not currently in place, eliminating duplicative and unnecessary paperwork.

SECTION 5.(b) The Secretary shall mandate that each DHHS division, agency, or department provide a fiscal note for every change or adjustment in service definition, policy, rule, or statute upon enactment. This requirement shall minimize the creation of unfunded mandates for provider agencies.

SECTION 5.(c) The Secretary shall direct the Division of Mental Health Developmental Disabilities, and Substance Abuse Services to allow for data sharing from the Incident Response Improvement System (IRIS) with service providers and the regulatory body by June 30, 2012. The system currently prohibits providers' access to their data for analysis, internal monitoring, quality improvement, and quality assurance reports for various entities. Because access for providers is restrictive, it creates a duplicative process requiring providers to repopulate the incident report data sets again into their own systems.

SECTION 5.(d) The Secretary shall establish a task force made up of division staff and providers to objectively evaluate the North Carolina Treatment Outcomes Program Performance System (NC-TOPPS) to improve the way data is accessible across services rather than site-specific to reflect valid comparisons of program outcomes by August 1, 2011. The system does not allow data to be captured which is population-specific thus limiting the depth of data comparison and outcome identification.

SECTION 5.(e) The Secretary shall allow private sector development and implementation of an Internet-based, secure, and consolidated data warehouse and archive for maintaining corporate, fiscal, and administrative records of providers by September 1, 2011. Use of the consolidated data warehouse is optional. Providers that choose to utilize the data warehouse shall ensure that the data is up to date and accessible to the regulatory body. A provider shall submit any revised, updated information to the data warehouse within 10 business days after receiving the request. The regulatory body that conducts administrative monitoring must use the data warehouse for document requests. If the information provided to the regulatory body is not current or is unavailable from the data warehouse and archive, the regulatory body may contact the provider directly. A provider that fails to comply with the regulatory body's requested documents may be subject to an on-site visit to ensure compliance. Access to the data warehouse must be provided without charge to the regulatory body under this section.

SECTION 6. The language in this act will be reviewed annually for compliance with updates to policy made by the following national accrediting bodies: Council on Accreditation (COA), CARF International, Council on Quality and Leadership (CQL), and the Joint Commission.

SECTION 7. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S D

SENATE BILL 525*
PROPOSED COMMITTEE SUBSTITUTE S525-CSSQ-22 [v.5]

5/10/2011 2:38:49 PM

Short Title: Streamline Oversight/DHHS Service Providers. (Public)

Sponsors:

Referred to:

April 7, 2011

A BILL TO BE ENTITLED

AN ACT TO STREAMLINE DUPLICATE OVERSIGHT OF CERTAIN DHHS SERVICE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Findings. – Over the years, State and legislative actions intended to improve safety and quality of care have resulted in multiple, redundant reviews of Department of Health and Human Services (DHHS) service providers by various State and local agencies. This duplicative bureaucracy has led to wasted resources on the part of the monitoring agencies and the service provider, along with interrupted services to the consumer.

SECTION 2.(a) There is established within the Joint Legislative Oversight Committee on Health and Human Service or upon authorization of the Legislative Research Commission a Task Force to review and recommend a resolution to the duplicative regulatory oversight of DHHS services provided, regulated, or licensed under Chapters 122C or 131D of the General Statues, other than G.S. 131D-6 and Article 2 of Chapter 131D of the General Statutes.

SECTION 2.(b) The Task Force shall be comprised of 18 members appointed as follows:

(1) Eight members appointed by the President Pro Tempore of the Senate, as follows:
- (a) Three members of the Senate.
- (b) One member representing and recommended by the Benchmarks Association.
- (c) One member representing and recommended by the NC Association of Long Term Care Facilities.
- (d) One member representing and recommended by the Developmental Disabilities Consortium.
- (e) One member representing and recommended by the Friends of Residents in Long Term Care.
- (f) One member representing and recommended by the State Consumer and Family Advisory Committee.
- (g) One member representing and recommended by a Behavioral Health Managed Care Organization.

(2) Eight members appointed by the Speaker of the House of Representatives, as follows:
- (a) Three members of the House of Representatives

(b) One member representing and recommended by the Benchmarks Association
(c) One member representing and recommended by the NC Association of Long Term Care Facilities
(d) One member representing and recommended by Disability Rights NC
(e) One member representing and recommended by the local Consumer and Family Advisory Committees
(f) One member representing and recommended by the Council for Children's Rights.
(g) One member representing and recommended by a Behavioral Health Managed Care Organization

SECTION 2.(c) The Task Force shall meet monthly, beginning the first month after the conclusion of the 2011-12 session.

SECTION 2.(d) The Task Force shall have the following duties:

(1) Align National Accreditation required for providers and Behavioral Health Managed Care Organizations, licensing, state and federal regulatory functions and state policy to eliminate contradictory or duplicative requirements.

(2) Establish a consolidated review of DHHS oversight and regulatory functions, notwithstanding any complaint or grievance.

(3) Align complaint and grievance review process and policy.

(4) Establish coordination between DHHS divisions for abuse and neglect investigations to avoid current duplication.

(5) Ensure Compliance with CMS.

SECTION 2. (e) The Department shall provide monthly updates and reports to the Task Force related to

(1) Each division's regulatory functions

(2) Purpose of each of the identified regulatory functions

(3) Amount of fees charged for the identified regulatory functions, along with the date and amount of the most recent fee increase.

(4) Number of full-time equivalent positions dedicated to the identified regulatory functions, broken down by division

(5) Federal requirements for, or a federal component to, any of the identified regulatory functions.

(6) Areas of overlap among the divisions within the Department, and with other State agencies, with respect to the regulation of providers. For each area of overlap, the report shall specify all of the following:

(a) The name of each division and State agency that performs the regulatory function.
(b) How often each division or State agency that performs the regulatory function
(c) The total amount of funds expended by each division or State agency to perform the regulatory function.

SECTION 2.(f) The Task Force shall develop legislative recommendations to accomplish the four identified directives of the task force by April 2012.

SECTION 3. Effective January 1, 2012, the Department of Health and Human Services shall modify and consolidate LME endorsement, the Frequency and Extent of Monitoring Tool, and the Provider Monitoring Tool.

SECTION 4.(a) In order to minimize the creation of unfunded mandates, the Secretary shall direct a rate setting memorandum be prepared for every change or adjustment made by DHHS in service definition, policy, rule, or provider requirements that impacts services provided in accordance with this act.

SECTION 4.(b) The Secretary shall dissolve North Carolina Treatment Outcomes Program Performance System (NC-TOPPS) Advisory Committee and establish a task force made up of division staff, Behavioral Health Managed Care Organizations, consumers, and providers to objectively evaluate the North Carolina Treatment Outcomes Program Performance System (NC-TOPPS) to improve the way data is accessible across services rather than site-specific to reflect valid comparisons of program outcomes by August 1, 2011.

SECTION 4.(c) The Secretary shall allow private sector development and implementation of an Internet-based, secure, and consolidated data warehouse and archive for maintaining corporate, fiscal, and administrative records of providers by September 1, 2011. This data warehouse shall not be used to store consumer records. Use of the consolidated data warehouse by the service provider agency is optional. Providers that choose to utilize the data warehouse shall ensure that the data is up to date and accessible to the regulatory body. A provider shall submit any revised, updated information to the data warehouse within 10 business days after receiving the request. The regulatory body that conducts administrative monitoring must use the data warehouse for document requests. If the information provided to the regulatory body is not current or is unavailable from the data warehouse and archive, the regulatory body may contact the provider directly. A provider that fails to comply with the regulatory body's requested documents may be subject to an on-site visit to ensure compliance. Access to the data warehouse must be provided without charge to the regulatory body under this section.

SECTION 5. The Secretary shall review on an annual basis, updates to policy made by the following national accrediting bodies: Council on Accreditation (COA), CARF International, Council on Quality and Leadership (CQL), the Joint Commission, NCQA, and URAC and shall take actions necessary to ensure that DHHS policy or procedural requirements do not duplicate the updated accreditation standards.

SECTION 6. This act is effective when it becomes law.

SENATE BILL 525:
Streamline Oversight/DHHS Service Providers

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	May 10, 2011
Introduced by:	Sens. Tucker, Hartsell	**Prepared by:**	Shawn Parker Committee Counsel
Analysis of:	PCS to First Edition S525-CSSQ-22		

SUMMARY: ***The Proposed Committee Substitute for Senate Bill 525 establishes a task force to address duplicative regulatory oversight of certain DHHS service providers. The PCS directs DHHS to modify and consolidate monitoring tools, to prepare a rate setting memorandum for changes to provider requirements, to establish a new task force to evaluate the NC-TOPPS system, to allow private sector development of an Internet-based data archive for provider records and to annually review policy changes made by national accrediting bodies to avoid duplication of agency level policies and procedures.***

BILL ANALYSIS:

Section 1 provides the General Assembly finds that previous efforts to improve quality of care and safety have resulted in redundant service provider reviews wasting resources and interrupting consumer services.

Section 2(a) establishes within the Joint Legislative Oversight Committee on Health and Human Services (proposed in House Bill 595) or upon authorization of the Legislative Research Commission a task force (Task Force) to review and recommend a resolution to duplicative regulatory oversight of services provided, regulated or licensed under Chapter 122C (Mental Health, Developmental Disabilities, and Substance Abuse) and Chapter 131D (Adult Care Homes, Residential Child-Care facilities). The section exempts Adult Day Care (G.S. 133D-6) and local confinement facilities (Article 2 of Chapter 131D).

Section 2(b) sets the membership of the Task Force including members representing or recommended by the House of Representatives, the Senate, Benchmarks Association, the NC Association of Long Term Care Facilities, the Developmental Disabilities Consortium, Disability Rights NC, Friends of Residents in Long Term Care, State and Local Consumer and Family Advisory Committee, the Council for Children's Rights, and a Behavioral Health Managed Care Organization.

Section 2(c) directs the Task Force to meet monthly beginning the first month upon conclusion of the 2011-2012.

Section 2(d) provides the Task Force with the duty to align National accreditation standards with State and federal regulatory functions and policy to eliminate contradictive or duplicative requirements, align complaint and grievance review policy and process, establish a consolidated review of DHHS oversight and regulatory functions, and ensure compliance with CMS.

Section 2(e) directs DHHS to provide a variety of updates and reports to the Task Force.

Section 2(f) directs the Task Force to develop legislative recommendations to accomplish Task Force directives.

Section 3 directs the Department to modify and consolidate LME endorsement, the FEM tool, and provider monitoring tool by January 1, 2012.

Section 4(a) directs the Secretary to require a rate setting memorandum on changes in service definition, policy, rule, or provider requirements proposed by DHHS.

Section 4(b) directs the Secretary to establish a task force to evaluate the North Carolina Treatment Outcomes Program Performance System to improve data accessibility.

Section 4(c) authorizes the Secretary to allow private sector development of a consolidated data warehouse for maintaining provider's administrative records (optional at the provider level) and directs the regulatory body to use the warehouse prior to contacting the provider directly.

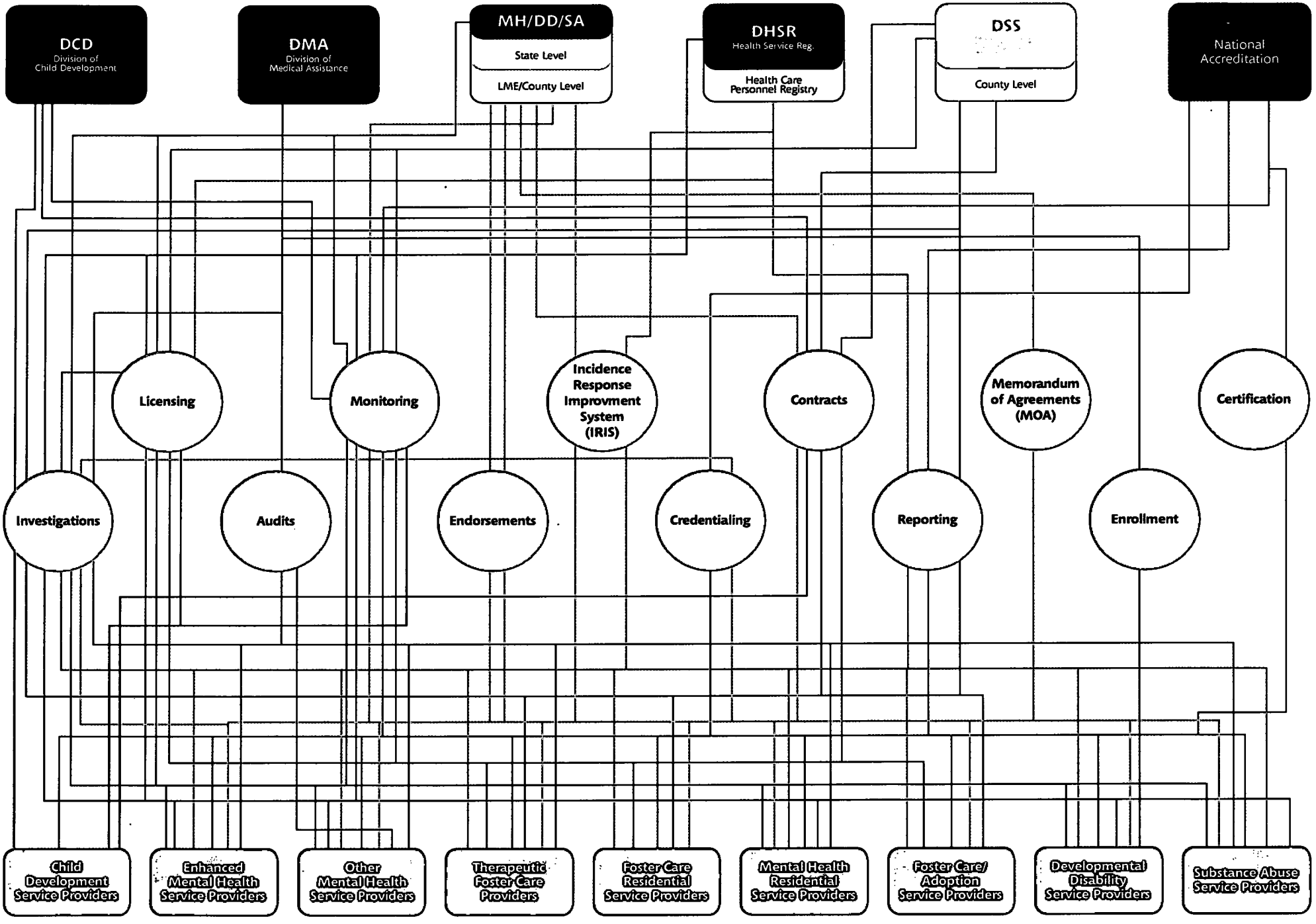
Section 5 directs the Secretary to annually review policy changes by specific national accrediting bodies and take appropriate action to avoid duplication of standards.

EFFECTIVE DATE: This act is effective when it becomes law.

S525-SMSQ-26(CSSQ-22) v1

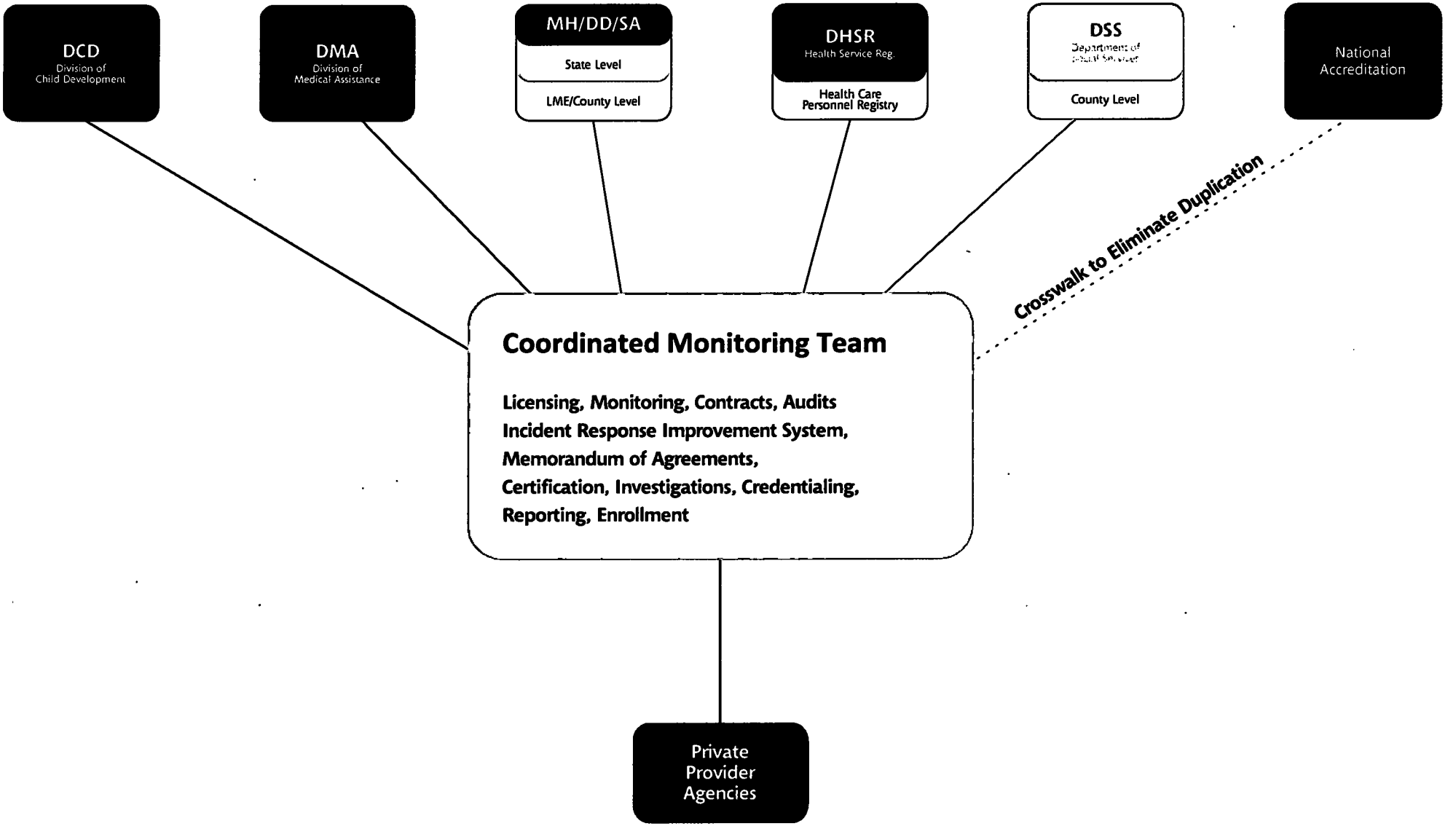
Current Duplicative Oversight Process

Senator [illegible] Tucker



Streamlined Oversight Process

Senator Tommy Tucker



VISITOR REGISTRATION SHEET

Mental Health & Youth Services — May 11, 2011

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathy S. Baker	Southeastern Regional LME 450 Country Club Road Lumberton, NC 28360
Louise G. Fisher	Volunteer Advocate for Mentally Ill
Jim Harrell	Benchmarks
[illegible]	Benchmarks
[illegible]	Benchmarks
[illegible]	Easter Seals UCP
Katherine Ross	PPAB
Brandy Barrett	PPAB
Jennifer Mahan	ASNC
Annaliese Dolph	DRNC
Holly Safi	DRNC
Doug Miskew	PSG

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — May-11-2011
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Dunn	Governor's Office
Jeff Horton	DHHS-DMH/DD/SAS
Jesse Goodman	DHHS/DMH/DD/SAS
Kris Horton	OMHS
Kay Paksoy	NASW-NC
David Heinen	NC Center for Nonprofits
Gina Boccelli	
Josh Manning	GPM & NSSC
Bob Hedrick	NC Providers Council
Joe Donovan	self
Lu-Ann Cheyne	CSS
Lora Wilson	NCAHTCF

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	[illegible]
[signature]	[illegible]
Meredith Swinder	Policy Group

SENATE MENTAL HEALTH & YOUTH SERVICES COMMITTEE
Wednesday, June 1, 2011 at 3:00 pm
Room 414, Legislative Office Building

MINUTES

The Senate Mental Health & Youth Services Committee met at 3:00 pm on June 1, 2011, in Room 414 of the Legislative Office Building with eight members of the committee present. Senator Fletcher Hartsell, Chair, presided.

Senator Hartsell called the meeting to order and introduced pages Holland Robinson, Ross Byrd, Jeremy Glover, Jonathan Glover, Charlotte Yarboro, Thomas Jarrell and Caroline Barwick and thanked them for their assistance.

SB 578 – LME Minimum Population. As this was Senator Hartsell's bill, he invited Senator Tucker to chair. Senator Jones moved to adopt the Proposed Committee Substitute for purposes of discussion. All voted and the motion carried. Senator Hartsell was recognized to explain the bill. Questions from Senators Jones. Bingham, Daniel, and Kinnaird were answered by Senator Hartsell, Senator Tucker, Shawn Parker. Staff Attorney and Ms. Martha Ann McConnell, Vice-President of Government Relations for Carolinas Medical. Ms. McConnell also gave additional information on the bill. Senator Jackson moved for a favorable report of the Proposed Committee Substitute, unfavorable to the original bill. All voted and the motion carried.

There being no further business, the meeting was adjourned.

Fletcher L. Hartsell, Jr., Presiding

Gerry Johnson, Committee Clerk

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	June 1, 2011	3:00 pm	414 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 578	LME Minimum Population.	Senator Hartsell

Senator Fletcher L. Hartsell, Jr., Chair

Senate Mental Health & Youth Services Committee
Wednesday, June 1, 2011, 3:00 pm
414 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 578	LME Minimum Population.	Senator Hartsell

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

MENTAL HEALTH & YOUTH SERVICES COMMITTEE REPORT
Senator Fletcher L. Hartsell, Jr., Chair

Thursday, June 02, 2011

Senator HARTSELL, JR.,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **578** LME Minimum Population.

Draft Number:	85208
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE BILL 578

Short Title:	LME Minimum Population.	(Public)
Sponsors:	Senator Hartsell.	
Referred to:	Mental Health & Youth Services.	

April 14, 2011

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE MINIMUM POPULATION THRESHOLD FOR LOCAL MANAGEMENT ENTITIES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 122C-115(a) reads as rewritten:

"**§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.**

(a) A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program established pursuant to G.S. 122C-115.1. The catchment area of an area authority or a county program shall contain either a minimum population of at least ~~200,000 or a minimum of six counties.~~300,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control."

SECTION 1.(b) G.S. 122C-115(a) reads as rewritten:

"**§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.**

(a) A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program established pursuant to G.S. 122C-115.1. The catchment area of an area authority or a county program shall contain either a minimum population of at least ~~200,000 or a minimum of six counties.~~500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control."

SECTION 2. This act is effective when it becomes law. Section 1(a) becomes effective July 1, 2012, and expires July 1, 2013. Section 1(b) becomes effective July 1, 2013.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 578
PROPOSED COMMITTEE SUBSTITUTE S578-CSSQ-38 [v.2]

6/1/2011 11:57:43 AM

Short Title: Facilitate Transfer SPH Beds Com. Facility. (Public)

Sponsors:

Referred to:

April 14, 2011

A BILL TO BE ENTITLED

AN ACT TO FACILITATE THE TRANSFER OF BEDS FROM A STATE PSYCHIATRIC HOSPITAL TO A COMMUNITY FACILITY WITHIN CERTAIN LMES.

The General Assembly of North Carolina enacts:

SECTION 1. The Secretary of the Department of Health and Human Services may transfer beds from a State psychiatric hospital to a community facility pursuant to the State Medical Facilities Plan Policy PSY-1 without a written memorandum of agreement between the local management entity serving the county where the beds are to be located and the facility submitting the proposal if all of the following conditions are met:

(1) The facility proposing to operate transferred beds submits an application to the Certificate of Need Section of the North Carolina Department of Health and Human Services

(2) The facility commits to serve the type of short-term patients normally placed at the State psychiatric hospital.

(3) The facility proposing to operate the beds is a provider created under G.S. 131E-17.

(4) The facility proposing to operate the beds is located in a single county area authority as defined in G.S. 122C-116.

SECTION 2. This act is effective when it becomes law and expires on December 31, 2011.

SENATE BILL 578:
Facilitate Transfer SPH Beds

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 1, 2011
Introduced by:	Sen. Hartsell	**Prepared by:**	Shawn Parker Committee Counsel
Analysis of:	PCS to First Edition S578-CSSQ-38		

SUMMARY: ***The Proposed Committee Substitute authorizes the Secretary to transfer beds from a State Psychiatric Hospital to community facility without a written memorandum of agreement if certain conditions are met.***

CURRENT LAW:

The State Medical Facilities Plan (Plan) is an annual document which contains policies and methodologies used in determining need for new health care facilities and services in North Carolina. Pursuant to G.S. 131E-77, the Plan is developed by the North Carolina Department of Health and Human Services, Division of Health Service Regulation, under the direction of the North Carolina State Health Coordinating Council, and approved by the governor. Each plan takes effect on January 1st and expires on December 31st.

Policy PSY-1 of the 2011 State Medical Facilities Plan provides that beds in the state psychiatric hospitals used to serve short-term psychiatric patients may be relocated to community facilities through the certificate of need process. The policy further provides that facilities proposing to operate transferred beds shall submit an application to the Certificate of Need Section of the North Carolina Department of Health and Human Services and commit to serve the type of short-term patients normally placed at the state psychiatric hospitals and that a proposal to transfer beds from a state hospital shall include a written memorandum of agreement between the local management entity serving the county where the beds are to be located, the secretary of the North Carolina Department of Health and Human Services, and the person submitting the proposal.

BILL ANALYSIS: The proposed committee substitute for Senate Bill 578 would authorize the Secretary to transfer beds without the written memorandum agreement between the LME and the facility submitting the proposal if the entity/facility proposing to operate the beds:

- Submits an application to the Certificate of Need Section within DHHS.
- Commits to serve the type of short-term patients normally placed at the state psychiatric hospital.
- Is hospital authority created pursuant to G.S. 131E-17.
- Is located in a single county area authority.

EFFECTIVE DATE: This act is effective when it becomes law and expires on December 31, 2011.

3578-SMSQ-34(CSSQ-38) v1

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — June 1, 2011
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Katherine Ross	PPAB
Annaliese Dolph	DR NC
Erica Nelson	NCCCP
Gene A Inscoe	A & A
Matthew McConnell	Carolinas HealthCare Sys.
Alissa Willett	NCACC
[illegible]	NCACC
[illegible]	[illegible]

SENATE MENTAL HEALTH & YOUTH SERVICES COMMITTEE
Wednesday, June 8, 2011 at 12:00 Noon
Room 414, Legislative Office Building

MINUTES

The Senate Mental Health & Youth Services Committee met at 12:00 Noon on June 8, 2011, in Room 414 of the Legislative Office Building with ten members of the committee present. Senator Fletcher Hartsell, Chair, presided.

Senator Hartsell called the meeting to order. He then introduced pages David Brooks, Johnathon Garwood, Ashley Gorman and Bethany Spivey and thanked them for their assistance to the committee.

SB 465 – Behavioral Health Management. Senator Tucker moved to adopt the Proposed Committee Substitute for purposes of discussion. All voted and the motion carried. Senator Hartsell then explained the bill. Senator Jones moved for a favorable report, unfavorable to the original bill. All voted and the motion carried.

HB 916 – Statewide Expansion of 1915(b)(c) Waiver. Representative Barnhart was recognized to introduce the bill. He then asked Mr. Shawn Parker, Committee Attorney, to give additional explanation of the bill. Representative Barnhart, Representative Insko, and Secretary Lanier Cansler, Secretary of the Department of Health and Human Services each spoke on the bill. Questions from Senators Purcell, Robinson and Tucker were answered by Representative Barnhart, Representative Insko and Secretary Cansler. Mrs. Mary Short from the audience also spoke.

Senator Hartsell noted that the hour was up and that the meeting would continue at 8:30, on the morning of June 9, 2010, in room 414. He then adjourned the meeting.

Fletcher L. Hartsell, Jr., Presiding

Gerry Johnson, Committee Clerk

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	June 8, 2011	12:00 Noon	414 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 465	Behavioral Health Management.	Senator Hartsell
HB 916	Statewide Expansion of 1915(b)/(c) Waiver.	Representative Barnhart Representative Dollar Representative Burr

Senate Mental Health & Youth Services Committee
Wednesday, June 8, 2011, 12:00 Noon
414 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 465	Behavioral Health Management.	Senator Hartsell
HB 916	Statewide Expansion of 1915(b)/(c) Waiver.	Representative Barnhart Representative Dollar Representative Burr Representative Insko

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

MENTAL HEALTH & YOUTH SERVICES COMMITTEE REPORT
Senator Fletcher L. Hartsell, Jr., Chair

Wednesday, June 08, 2011

Senator HARTSELL, JR.,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

S.B. **465** Behavioral Health Management.

Draft Number:	PCS 15178
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE BILL 465

Short Title:	Behavioral Health Management.	(Public)
Sponsors:	Senator Hartsell.	
Referred to:	Mental Health & Youth Services.	

March 31, 2011

A BILL TO BE ENTITLED

AN ACT TO ALLOW AREA AUTHORITIES ORGANIZED UNDER CHAPTER 122C OF THE GENERAL STATUTES THAT ARE OPERATING UNDER MEDICAID MANAGED CARE WAIVERS TO ORGANIZE UNDER CHAPTER 131E OF THE GENERAL STATUTES, THE HOSPITAL AUTHORITIES ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 2 of Chapter 131E of the General Statutes, the Hospital Authorities Act, is amended by adding a new section to read:

"**§ 131E-35. Organization under this Part by area authorities operating under Medicaid waivers.**

A behavioral health authority may be created under the provisions of this Part whenever a county board of commissioners finds and adopts a resolution finding that it is in the interest of the public health and welfare to create a behavioral health authority in order to operate a behavioral health program under a Medicaid 1915 (b)/(c) waiver program. A behavioral health authority shall be created in the same manner as a hospital authority pursuant to this Part and subject to the same provisions, except that G.S. 131E-20 does not apply to a behavioral health authority."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

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SENATE BILL 465
PROPOSED COMMITTEE SUBSTITUTE S465-CSSQ-46 [v.1]

6/7/2011 5:07:14 PM

Short Title: PED Study LME Governance. (Public)

Sponsors:

Referred to:

March 31, 2011

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE PROGRAM EVALUATION DIVISION TO STUDY THE CURRENT STRUCTURE OF GOVERNANCE AMONG AREA AUTHORITIES ORGANIZED UNDER CHAPTER 122C OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Program Evaluation Division of the General Assembly shall study the impact of Medicaid waivers, LME consolidation, and LME expansion on the current governance model for area authorities, single county programs, and multicounty programs established under Chapter 122C of the North Carolina General Statutes.

SECTION 1.(b) The Program Evaluation Division shall submit its findings and recommendations to the Joint Legislative Program Evaluation Oversight Committee no later than February 1, 2012.

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

SENATE BILL 465:
Behavioral Health Management

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 7, 2011
Introduced by:	Sen. Hartsell	**Prepared by:**	Janice Paul Committee Counsel
Analysis of:	PCS to First Edition S465-CSSQ-46		

SUMMARY: Senate Bill 465 would direct a study of the current structure of governance among area authorities organized under the Mental Health, Developmental Disabilities and Substance Abuse Act.

CURRENT LAW: G.S. Chapter 122C-3(20b) defines "Local Management Entity" (LME) as an area authority (the area mental health, developmental disabilities, and substance abuse authority), county program (a mental health, developmental disabilities, and substance abuse services program established, operated, and governed by a county) or consolidated human services agency (which has the responsibility to carry out the duties of a local health department and the authority to administer local public health programs in the same manner as a local health department). "LME" is a collective term that refers to functional responsibilities rather than governance structure.

BILL ANALYSIS: Senate Bill 465 would direct the Program Evaluation Division of the General Assembly to study the impact of Medicaid waivers, LME consolidation, and LME expansion on the current governance model for area authorities, single county programs, and multicounty programs established under G.S. Chapter 122C. The Program Evaluation Division would provide recommendations in a report to the Joint Legislative Program Evaluation Oversight Committee by February 1, 2012.

EFFECTIVE DATE: This act is effective when it becomes law.

S465-SMTJ-49(CSSQ-46) v1

HOUSE BILL 916
Committee Substitute Favorable 5/31/11
Third Edition Engrossed 6/1/11

Short Title: Statewide Expansion of 1915(b)/(c) Waiver. (Public)

Sponsors:

Referred to:

May 5, 2011

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH REQUIREMENTS FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND LOCAL MANAGEMENT ENTITIES WITH RESPECT TO STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services (Department) shall proceed with statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through expansion of the 1915(b)/(c) Medicaid Waiver. It is the intent of the General Assembly that expansion of the 1915(b)/(c) Medicaid Waiver will be completed by July 1, 2013, and will result in the establishment of a system that is capable of managing all public resources that may become available for mental health, intellectual and developmental disabilities, and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice, and all other public funding sources. In implementing the restructuring and expansion authorized in this section, the Department shall do all of the following:

(1) Establish accountability for the development and management of a local system that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for consumers in need of mental health, intellectual and developmental disabilities, and substance abuse services.

(2) Maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model, a proven system for the operation of all public resources for mental health, developmental disabilities, and substance abuse services.

(3) Designate a single entity to assume responsibility for all aspects of Waiver management. The following operational models are acceptable options for Local Management Entity (LME) applicants:

a. Merger model: A single larger LME is formed from the merger of two or more LMEs.

b. Interlocal agreement among LMEs: A single LME is identified as the leader for all Waiver operations, financial management, and accountability for performance measures.

(4) Use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid program while ensuring medically necessary care and deploy a system for

the allocation of resources based on the reliable assessment of intensity of need. The Department shall design these strategies to efficiently direct consumers to appropriate services and to ensure that consumers receive no more and no less than the amount of services determined to be medically necessary and at the appropriate funding level.

(5) As the 1915(b)/(c) Medicaid Waiver expands statewide, phase out the current CAP-MR/DD Waiver as well as the utilization management functions currently performed by public and private contractors.

(6) Design the Innovations Waiver in such a way as to serve the maximum number of individuals with intellectual and developmental disabilities within aggregate funding.

(7) Require LMEs approved to operate a 1915(b)/(c) Medicaid Waiver to do all of the following:

a. Maintain a local presence in order to respond to the unique needs and priorities of localities.

b. Implement a process for feedback end exchange of information and ideas to ensure communication with consumers, families, providers, and stakeholders regarding disability-specific and general Waiver operations.

c. Establish and maintain systems for ongoing communication and coordination regarding the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems such as local departments of social services, Community Care of North Carolina, hospitals, school systems, the Department of Juvenile Justice, and other community agencies.

d. Comply with the following operational requirements:

1. Maintain disability specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

2. Maintain administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.

3. Maintain full accountability for all aspects of Waiver operations and for meeting all contract requirements specified by the Department. The Department shall not require LMEs to subcontract any managed care functions or nonservice activities to other entities. However, LMEs that choose to subcontract managed care functions to other entities will be limited to the following:

I. Information systems.
II. Customer service (including call center) operations.
III. Claims processing.
IV. Provider, enrollment, credentialing, and monitoring.
V. Professional services.
VI. Treatment Plan development.
VII. Referral to services.

SECTION 1.(b) By August 1, 2011, the Department shall select LMEs that have been assessed to meet minimum criteria for Waiver operations according to the requirements of RFA #2011-261 issued on April 1, 2011.

SECTION 1.(c) The Department shall require LMEs that have not been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013, to merge with or be aligned through an interlocal agreement with an LME that has been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver. If any LME fails to comply with this requirement, the Department shall assign responsibility for management of the 1915(b)/(c) Medicaid Waiver on behalf of the noncompliant LME to an LME that is successfully operating the Waiver and successfully meeting performance requirements of the contract with the Department. Those LMEs approved to operate the 1915(b)/(c) Medicaid Waiver under an interlocal agreement must have a single LME entity designated as responsible for all aspects of Waiver operations and solely responsible for meeting contract requirements.

SECTION 1.(d) County governments are not financially liable for overspending or cost overruns associated with an area authority's operation of a 1915(b)/(c) Medicaid Waiver. County governments are not financially liable for overspending or cost overruns of Medicaid services associated with a county program or multicounty program's operation of a 1915(b)/(c) Medicaid Waiver beyond the county program or multicounty program's Medicaid risk reserve and Medicaid fund balance amounts.

SECTION 1.(e) Providers of targeted case management under the CAP-MR/DD Waiver are qualified to provide the 1915(c) service known as Community Guide under the Innovations Waiver. During the first year of assuming responsibility for Waiver operations, LMEs shall offer to contract with providers that were previously approved to provide targeted case management to individuals with intellectual and developmental disabilities under the CAP-MR/DD Waiver, for the provision of Community Guide services.

SECTION 1.(f) By December 31, 2011, the Department shall determine the feasibility of adding habilitation services to the State Medicaid Plan through the 1915(i) Option as a strategy to address the needs of Medicaid enrollees with IDD who are not enrolled in the Innovations Waiver and are not residing in an intermediate care facility for the mentally retarded (ICF-MR facility).

SECTION 1.(g) The Department shall consider the impact on ICF-MR facilities included in the 1915(b)/(c) Medicaid Waiver to determine and, to the extent possible, minimize potential inconsistencies with the requirements of G.S. 131E-176 and G.S. 131E-178 without negatively impacting the viability and success of the 1915(b)/(c) Medicaid Waiver programs.

SECTION 1.(h) The Department shall discontinue the pilot program to administer the Supports Intensity Scale to people with intellectual and developmental disabilities in non-Waiver LMEs.

SECTION 1.(i) The Department shall establish written policies ensuring alignment of objectives and operational coordination of the 1915(b)/(c) Medicaid Waiver and the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems under the auspices of the Department, including Community Care of North Carolina.

SECTION 1.(j) In the development of the budget for the 2013-2015 fiscal biennium and subsequent biennia, the General Assembly shall consider a reinvestment of at least fifteen percent (15%) of the total projected State savings for that biennium from the operation of the 1915(b)/(c) Waiver, for the purpose of expanding the number of consumers served by the Innovations 1915(c) Medicaid Waiver, or for the purpose of expanding other services that are designed to meet the needs of individuals with intellectual and developmental disabilities.

SECTION 1.(k) By October 1, 2011, the Department, in coordination with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the

Division of Medical Assistance, LMEs, PBH, and with stakeholder input, shall submit to the appropriate Oversight Committee of the General Assembly a strategic plan delineating specific strategies and agency responsibilities for the achievement of the objectives and deadlines set forth in this Act.

SECTION 1.(l) The Department shall submit status reports to the General Assembly on the restructuring and expansion authorized in this section on January 1, 2012, April 1, 2012, October 1, 2012, February 1, 2013, and October 1, 2013.

SECTION 2. G.S. 122C-115(a) reads as rewritten:

"(a) A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program established pursuant to G.S. 122C-115.1. ~~The catchment area of an area authority or a county program shall contain either a minimum population of at least 200,000 or a minimum of six counties.~~ Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control.

(a1) ~~Effective July 1, 2007, the Department of Health and Human Services shall reduce by ten percent (10%) annually the administrative funding for LMEs that do not comply with the catchment area requirements of subsection (a) of this section. However, an LME that does not comply with the catchment area requirements because of a change in county membership shall have 12 months from the effective date of the change to comply with subsection (a) of this section.~~ Effective July 1, 2012, the Department shall reduce the administrative funding for LMEs that do not comply with the minimum population requirement of 300,000 to a rate consistent with the funding rate provided to LMEs with a population of 300,000.

(a2) Effective July 1, 2013, the Department shall reassign management responsibilities for Medicaid funds and State funds away from LMEs that are not in compliance with the minimum population requirement of 500,000 to LMEs that are fully compliant with all catchment area requirements, including the minimum population requirements specified in this section.

(b) Counties shall and cities may appropriate funds for the support of programs that serve the catchment area, whether the programs are physically located within a single county or whether any facility housing a program is owned and operated by the city or county. Counties and cities may make appropriations for the purposes of this Chapter and may allocate for these purposes other revenues not restricted by law, and counties may fund them by levy of property taxes pursuant to G.S. 153A-149(c)(22).

(c) Except as authorized in G.S. 122C-115.1, within a catchment area designated in the business plan pursuant to G.S. 122C-115.2, a board of county commissioners or two or more boards of county commissioners jointly shall establish an area authority with the approval of the Secretary.

(d) Except as otherwise provided in this subsection, counties shall not reduce county appropriations and expenditures for current operations and ongoing programs and services of area authorities or county programs because of the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area authority or county program. Counties may reduce county appropriations by the amount previously appropriated by the county for one-time, nonrecurring special needs of the area authority or county program."

SECTION 3. G.S. 122C-115.3(a) reads as rewritten:

"(a) Whenever the board of commissioners of each county constituting an area authority determines that the area authority is not operating in the best interests of consumers, it may direct that the area authority be dissolved. In addition, whenever a board of commissioners of a county that is a member of an area authority determines that the area authority is not operating in the best interests of consumers of that county, it may withdraw from the area authority. An

area authority that does not meet the minimum population requirements specified in G.S. 122C-115 may dissolve at any time during a fiscal year. Dissolution of an area authority or withdrawal from the area authority by a county for other reasons shall be effective only at the end of the fiscal year in which the action of dissolution or withdrawal transpired."

SECTION 4. G.S. 150B-1(d) is amended by adding a new subdivision to read:

"(20) The Department of Health and Human Services in implementing, operating, or overseeing new 1915(b)/(c) Medicaid Waiver programs or amendments to existing 1915(b)/(c) Medicaid Waiver programs."

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 916:
Statewide Expansion of 1915(b)/(c) Waiver

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 7, 2011
Introduced by:	Reps. Barnhart, Dollar, Burr, Insko	**Prepared by:**	Shawn Parker Janice Paul Committee Co-Counsel
Analysis of:	Third Edition		

SUMMARY: House Bill 916 directs the Department of Health and Human Services to restructure the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders by expanding operation of a 1915(b)/(c) Medicaid Waiver statewide.

BILL ANALYSIS:

System change

House Bill 916 directs the Department of Health and Human Services (DHHS) to establish a system to deliver public services statewide to persons with mental illness, intellectual and developmental disabilities, and substance abuse disorders by expanding the 1915(b)/(c) Medicaid Waiver program. DHHS would complete restructuring of management responsibilities for all public resources for MH/DD/SAS programs by July 1, 2013, by:

- Becoming accountable for developing and managing a local system that provides easy access to care, makes available and delivers required services, and provides continuity of care;
- Adhering to the Piedmont Behavioral Health (PBH) system model;
- Within catchment areas, designating a single Local Management Entity (LME), either by merger or interlocal agreements (with one lead LME) to be responsible for all aspects of Waiver management;
- Employing specified managed care strategies, including care coordination and utilization management, to control costs while ensuring that consumers receive medically necessary care;
- Phasing out the current CAP-MR/DD and utilization management functions currently performed by other contractors;
- Designing the Innovations waiver to serve a greater number of qualified individuals within funding limits;
- Requiring 1915(b)/(c) Waiver-approved LMEs to maintain a community presence; implement a feedback and information exchange process to communicate with consumers, providers and others; create systems for communication and care coordination with other organized systems, such as local social service agencies, hospitals, schools, and other community agencies; and comply with specific operational requirements.

LMEs to operate 1915(b)/(c) waivers

The bill directs DHHS by August 1, 2011 to select LMEs which meet the minimum Waiver operations criteria according to the requirements of the RFA 2011-261 issued on April 1, 2011. The bill further directs DHHS to cause LMEs that fail to meet minimum operational requirements by Janaury 1, 2013 to merge or align an approved LME, and provides that under an interlocal agreement, a single LME would be responsible for all Waiver operations and contract requirements.

Local government limited liability

Under the act, county governments are not financially liable for cost overruns associated with the area authority's or single/multi-county program's Waiver operation beyond that entity's risk reserve and Medicaid fund balance amounts.

Services for persons with Intellectual and Developmental Disability (IDD)
Targeted Case Management (TCM) is a service available statewide that assists individuals with intellectual and developmental disabilities in gaining access to needed services described in the State Medicaid Plan, as well as needed medical, social, educational, and other services. During the first year of Waiver operations, LMEs are directed to contract with previously approved TCM providers under the CAP-MR/DD Waiver to provide Community Guide service.

A Section 1915(i) Option allows states to offer Home- and Community-Based Services (HCBS), and allows states to offer HCBS under a Medicaid state plan to individuals who are Medicaid-eligible. It limits eligibility to individuals with incomes up to 150 percent of poverty who, but for the program services, would need an institutional level of care. NC Innovations is a means of funding services and supports for people with mental retardation and other related developmental disabilities who are at risk for institutional care in an Intermediate Care Facility for Individuals with Mental Retardation (ICF-MR). Innovations also provides funding for people to return to their homes and communities from ICF-MRs. The bill directs DHHS to assess by December 31, 2011, the feasibility of adding habilitation services through the 1915(i) Option for Medicaid enrollees with intellectual and developmental disabilities (IDD) who are not enrolled in the Innovations Waiver and are not residing in an ICF-MR.

The bill further directs DHHS to consider impacts on ICF-MR facilities and evaluate and minimize possible inconsistencies between the certificate of need requirements and the viability and success of 1915(b)/(c) Waiver programs, and to discontinue for non-waiver LMEs the Supports Intensity Scale pilot program authorized in the 2010 Appropriations Act.

Managed Care Systems
The bill directs DHHS to adopt written policies to align objectives of the 1915(b)/(c) Waiver and the care of eligible consumers with other managed care systems, including Community Care of North Carolina.

Reinvestment of Projected Savings
The bill directs future General Assemblies to consider reinvesting 15% or more of the projected savings from operating the Waiver to increase the number of consumers served by the Innovations Waiver or to expand services for persons with intellectual and developmental disabilities.

Reporting requirements
The bill directs DHHS, in coordination with other specified agencies, to submit a strategic plan for implementing this act to a legislative oversight committee, by October 1, 2011, and to submit periodic status reports to the General Assembly as to the progress of the restructuring and expansion authorized in Section 1.

LME catchment population
By July 1, 2012 the minimum population of an area authority or county program must be at least 300,000. The Department will reduce administrative funding of LMEs which do not comply with the minimum population to a rate consistent with catchments of 300,000. By July 1, 2013 the minimum population of an area authority or county program must be at least 500,000. The Department will reassign management responsibilities for State and federal pass-through funding from LMEs which do not comply with the minimum population requirements. Further, the bill provides that the dissolution of an area authority not meeting minimum population requirements is effective at any time during the fiscal year.

Rules not subject to the APA
The bill exempts the Department from the rule making under Artcile 2A of Chapter 150B in implementing, operating, or overseeing new or amending existing Waiver programs.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND:

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: (1) State medical professionals determine community placement is appropriate; (2) placement would be less restrictive and is not opposed by the patient; and (3) community placement can be reasonably accommodated, given resources available to the State and the needs of others with mental disabilities.

In 2001, the General Assembly passed legislation which made significant policy changes addressing issues of State and local governance and increased accountability. It emphasized consumer-driven community-based services. It required that State and local governments provide certain core services to all individuals and also required the development of enhanced services that targeted persons with the most severe disabilities. It also shifted the role of local public mental health agencies from that of direct service providers to one of managing and coordinating services delivered by private providers.

In April 2005, DHHS began operating under two new waivers* as a pilot project: (1) the Piedmont Cardinal Health Plan, a pilot 1915 (b) Freedom of Choice waiver project; and (2) the Innovations Home and Community Based services (HCBS) 1915 (c) waiver. In this pilot project, Medicaid funded services for mental health, substance abuse and developmental disabilities are provided on a capitation basis in a five-county area through a prepaid inpatient health plan (PIHP). PBH (formerly known as Piedmont Behavioral Healthcare), a local management entity, operates the PIHP and manages state and federally funded mental health, substance abuse and developmental disabilities services.

A Medicaid waiver is the authority given to a state by the Centers for Medicare and Medicaid Services (CMS) to "waive" one or more federal Medicaid regulations in order to create non-traditional services, programs and delivery systems. Only certain Medicaid regulations can be waived depending on the type of the waiver requested.

H916-SMSQ-38(e3) v1

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee

June 8, 2011
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Terry Mutter	Parent PO Box 2711 Raleigh NC 27611
Janell Albany	daughter - CAP
Sean Webb	Advocate
Pat Wiegand	parent
Kay Paksoy	NASW-NC
Michelle Moody	NASW-NC
Meredith Swilden	The Policy Group
Mike Taylor	Michael W. Taylor, attys at law, PLLC
Katherine Jon	DPHB
John Dern	Governor's Office
Pamon Shipman	DBH

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — **Name of Committee**

June 8, 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JDELANIER	NELSON MULLINS
Erica Nelson	NCCLP
[illegible]	East Sd UCP
Julia Adams	The Arc of NC
[illegible]	[illegible]
Ken Melton	K. M. A.
[illegible]	Capitol
Bob Rickelman	NC DEVELOPMENTAL DISABILITIES COUNCIL
Beth Stalvey	NC Developmental Disability Council
[illegible]	[illegible]
Rachel Hause	NMHS-NC

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bowlish	Cabarrus
Michelle Brooks	UHS
Martha McCrea	Carolina HealthCare
Marian Trout	NCACC

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — June 8, 2011

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary K Short	Parent/Family/Advocate Taylorsville
Katie Short	CAP MR/DD Beneficiary Taylorsville
Paula Cox Fishman	Volunteer Advocate for sister with MR/DD - Greensboro NC
Beth Melcher	DHHS
Will Wardell	Value Options
Ellen Perry	consumer advocate
Kelly Crosbie	DMA
Holly Saft	DRNC
Annaliese Dolph	DRNC
Amy Whited	NC Med. Society
Michael Biesecker	N+O
Rob Lamme	[illegible]

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — **Name of Committee**

June 8 2011 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Louise Fisher	Volunteer Advocate for M. Lee
Whitney Christensen	Jordan Price
Kris Hicks	DHHS
W. Gardner Cyrus	DLC & Assoc
TARA FIELDS	Benchmarks
Karen McLeod	Benchmarks
Elise Bouchard	Sen. Bingham

SENATE MENTAL HEALTH & YOUTH SERVICES COMMITTEE
Thursday, June 9, 2011 at 8:30 am
Room 643, Legislative Office Building

MINUTES

The Senate Mental Health & Youth Services Committee met at 8:30 am on June 9, 2011, in Room 643 of the Legislative Office Building with nine members of the committee present. Senator Hartsell, Chair, presided.

Senator Hartsell recognized pages Ryder Smith, Nick Pruthi, Chris Brazier, Vincent Ragland, Randi Gibbs and Lizzy Sirkin and thanked them for their assistance. He then introduced the Sergeant-at Arms and thanked them.

This meeting was a continuation of the previous meeting of June 8, 2011. Senator Hartsell invited the individuals who had signed to speak but had not spoken at the June 8th meeting to speak. Those speaking were Ms. Terry Miller, Representative Verla Insko spoke on be-half of Ms. Ellen Perry, Ms. Pat Wiegand, Mr. Sean Webb, and Mrs. Carole Choate. Additional speakers were Mrs. Louise Fisher, volunteer advocate, Mr. Dave Richard representing the ARC, Ms. Pam Shipman, Deputy Area Director/Chief Operations Officer for PBH (Piedmont Behavioral Health), Ms. Erica Nelson, Ms. Mary Short and Ms. Paula Cox Fishman.

Representative Barnhart was recognized to speak again on the bill. Questions from Senators Robinson, Kinnaird, Purcell, Tucker, and Jackson were answered by Representative Barnhart, Ms. Kelly Crosby from Department of Health and Human Services and Ms. Pam Shipman of PBH.

Senator Jackson moved for a favorable report. All voted and the motion carried.

There being no further business, the meeting was adjourned.

Fletcher L. Hartsell, Jr, Presiding

Gerry Johnson, Committee Clerk

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Thursday	June 9, 2011	8:30 am	414 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 916	Statewide Expansion of 1915(b)/(c) Waiver.	Representative Barnhart Representative Dollar Representative Burr Representative Insko

Senator Fletcher L. Hartsell, Jr., Chair

Senate Mental Health & Youth Services Committee
Thursday, June 9, 2011, 8:30 am
414 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 916	Statewide Expansion of 1915(b)/(c) Waiver.	Representative Barnhart Representative Dollar Representative Burr Representative Insko

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

MENTAL HEALTH & YOUTH SERVICES COMMITTEE REPORT
Senator Fletcher L. Hartsell, Jr., Chair

Thursday, June 09, 2011

Senator HARTSELL, JR.,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS #1) **916** Statewide Expansion of 1915(b)/(c) Waiver.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

HB 916 -- Sen. Hartsell

HOUSE BILL 916
Committee Substitute Favorable 5/31/11
Third Edition Engrossed 6/1/11

Short Title: Statewide Expansion of 1915(b)/(c) Waiver. (Public)

Sponsors:

Referred to:

May 5, 2011

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH REQUIREMENTS FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND LOCAL MANAGEMENT ENTITIES WITH RESPECT TO STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services (Department) shall proceed with statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through expansion of the 1915(b)/(c) Medicaid Waiver. It is the intent of the General Assembly that expansion of the 1915(b)/(c) Medicaid Waiver will be completed by July 1, 2013, and will result in the establishment of a system that is capable of managing all public resources that may become available for mental health, intellectual and developmental disabilities, and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice, and all other public funding sources. In implementing the restructuring and expansion authorized in this section, the Department shall do all of the following:

(1) Establish accountability for the development and management of a local system that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for consumers in need of mental health, intellectual and developmental disabilities, and substance abuse services.

(2) Maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model, a proven system for the operation of all public resources for mental health, developmental disabilities, and substance abuse services.

(3) Designate a single entity to assume responsibility for all aspects of Waiver management. The following operational models are acceptable options for Local Management Entity (LME) applicants:

a. Merger model: A single larger LME is formed from the merger of two or more LMEs.

b. Interlocal agreement among LMEs: A single LME is identified as the leader for all Waiver operations, financial management, and accountability for performance measures.

(4) Use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid program while ensuring medically necessary care and deploy a system for

the allocation of resources based on the reliable assessment of intensity of need. The Department shall design these strategies to efficiently direct consumers to appropriate services and to ensure that consumers receive no more and no less than the amount of services determined to be medically necessary and at the appropriate funding level.

(5) As the 1915(b)/(c) Medicaid Waiver expands statewide, phase out the current CAP-MR/DD Waiver as well as the utilization management functions currently performed by public and private contractors.

(6) Design the Innovations Waiver in such a way as to serve the maximum number of individuals with intellectual and developmental disabilities within aggregate funding.

(7) Require LMEs approved to operate a 1915(b)/(c) Medicaid Waiver to do all of the following:

a. Maintain a local presence in order to respond to the unique needs and priorities of localities.

b. Implement a process for feedback end exchange of information and ideas to ensure communication with consumers, families, providers, and stakeholders regarding disability-specific and general Waiver operations.

c. Establish and maintain systems for ongoing communication and coordination regarding the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems such as local departments of social services, Community Care of North Carolina, hospitals, school systems, the Department of Juvenile Justice, and other community agencies.

d. Comply with the following operational requirements:

1. Maintain disability specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

2. Maintain administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.

3. Maintain full accountability for all aspects of Waiver operations and for meeting all contract requirements specified by the Department. The Department shall not require LMEs to subcontract any managed care functions or nonservice activities to other entities. However, LMEs that choose to subcontract managed care functions to other entities will be limited to the following:

I. Information systems.
II. Customer service (including call center) operations.
III. Claims processing.
IV. Provider, enrollment, credentialing, and monitoring.
V. Professional services.
VI. Treatment Plan development.
VII. Referral to services.

SECTION 1.(b) By August 1, 2011, the Department shall select LMEs that have been assessed to meet minimum criteria for Waiver operations according to the requirements of RFA #2011-261 issued on April 1, 2011.

SECTION 1.(c) The Department shall require LMEs that have not been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013, to merge with or be aligned through an interlocal agreement with an LME that has been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver. If any LME fails to comply with this requirement, the Department shall assign responsibility for management of the 1915(b)/(c) Medicaid Waiver on behalf of the noncompliant LME to an LME that is successfully operating the Waiver and successfully meeting performance requirements of the contract with the Department. Those LMEs approved to operate the 1915(b)/(c) Medicaid Waiver under an interlocal agreement must have a single LME entity designated as responsible for all aspects of Waiver operations and solely responsible for meeting contract requirements.

SECTION 1.(d) County governments are not financially liable for overspending or cost overruns associated with an area authority's operation of a 1915(b)/(c) Medicaid Waiver. County governments are not financially liable for overspending or cost overruns of Medicaid services associated with a county program or multicounty program's operation of a 1915(b)/(c) Medicaid Waiver beyond the county program or multicounty program's Medicaid risk reserve and Medicaid fund balance amounts.

SECTION 1.(e) Providers of targeted case management under the CAP-MR/DD Waiver are qualified to provide the 1915(c) service known as Community Guide under the Innovations Waiver. During the first year of assuming responsibility for Waiver operations, LMEs shall offer to contract with providers that were previously approved to provide targeted case management to individuals with intellectual and developmental disabilities under the CAP-MR/DD Waiver, for the provision of Community Guide services.

SECTION 1.(f) By December 31, 2011, the Department shall determine the feasibility of adding habilitation services to the State Medicaid Plan through the 1915(i) Option as a strategy to address the needs of Medicaid enrollees with IDD who are not enrolled in the Innovations Waiver and are not residing in an intermediate care facility for the mentally retarded (ICF-MR facility).

SECTION 1.(g) The Department shall consider the impact on ICF-MR facilities included in the 1915(b)/(c) Medicaid Waiver to determine and, to the extent possible, minimize potential inconsistencies with the requirements of G.S. 131E-176 and G.S. 131E-178 without negatively impacting the viability and success of the 1915(b)/(c) Medicaid Waiver programs.

SECTION 1.(h) The Department shall discontinue the pilot program to administer the Supports Intensity Scale to people with intellectual and developmental disabilities in non-Waiver LMEs.

SECTION 1.(i) The Department shall establish written policies ensuring alignment of objectives and operational coordination of the 1915(b)/(c) Medicaid Waiver and the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems under the auspices of the Department, including Community Care of North Carolina.

SECTION 1.(j) In the development of the budget for the 2013-2015 fiscal biennium and subsequent biennia, the General Assembly shall consider a reinvestment of at least fifteen percent (15%) of the total projected State savings for that biennium from the operation of the 1915(b)/(c) Waiver, for the purpose of expanding the number of consumers served by the Innovations 1915(c) Medicaid Waiver, or for the purpose of expanding other services that are designed to meet the needs of individuals with intellectual and developmental disabilities.

SECTION 1.(k) By October 1, 2011, the Department, in coordination with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the

Division of Medical Assistance, LMEs, PBH, and with stakeholder input, shall submit to the appropriate Oversight Committee of the General Assembly a strategic plan delineating specific strategies and agency responsibilities for the achievement of the objectives and deadlines set forth in this Act.

SECTION 1.(l) The Department shall submit status reports to the General Assembly on the restructuring and expansion authorized in this section on January 1, 2012, April 1, 2012, October 1, 2012, February 1, 2013, and October 1, 2013.

SECTION 2. G.S. 122C-115(a) reads as rewritten:

"(a) A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program established pursuant to G.S. 122C-115.1. ~~The catchment area of an area authority or a county program shall contain either a minimum population of at least 200,000 or a minimum of six counties.~~ Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control.

(a1) ~~Effective July 1, 2007, the Department of Health and Human Services shall reduce by ten percent (10%) annually the administrative funding for LMEs that do not comply with the catchment area requirements of subsection (a) of this section. However, an LME that does not comply with the catchment area requirements because of a change in county membership shall have 12 months from the effective date of the change to comply with subsection (a) of this section.~~ Effective July 1, 2012, the Department shall reduce the administrative funding for LMEs that do not comply with the minimum population requirement of 300,000 to a rate consistent with the funding rate provided to LMEs with a population of 300,000.

(a2) Effective July 1, 2013, the Department shall reassign management responsibilities for Medicaid funds and State funds away from LMEs that are not in compliance with the minimum population requirement of 500,000 to LMEs that are fully compliant with all catchment area requirements, including the minimum population requirements specified in this section.

(b) Counties shall and cities may appropriate funds for the support of programs that serve the catchment area, whether the programs are physically located within a single county or whether any facility housing a program is owned and operated by the city or county. Counties and cities may make appropriations for the purposes of this Chapter and may allocate for these purposes other revenues not restricted by law, and counties may fund them by levy of property taxes pursuant to G.S. 153A-149(c)(22).

(c) Except as authorized in G.S. 122C-115.1, within a catchment area designated in the business plan pursuant to G.S. 122C-115.2, a board of county commissioners or two or more boards of county commissioners jointly shall establish an area authority with the approval of the Secretary.

(d) Except as otherwise provided in this subsection, counties shall not reduce county appropriations and expenditures for current operations and ongoing programs and services of area authorities or county programs because of the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area authority or county program. Counties may reduce county appropriations by the amount previously appropriated by the county for one-time, nonrecurring special needs of the area authority or county program."

SECTION 3. G.S. 122C-115.3(a) reads as rewritten:

"(a) Whenever the board of commissioners of each county constituting an area authority determines that the area authority is not operating in the best interests of consumers, it may direct that the area authority be dissolved. In addition, whenever a board of commissioners of a county that is a member of an area authority determines that the area authority is not operating in the best interests of consumers of that county, it may withdraw from the area authority. An

area authority that does not meet the minimum population requirements specified in G.S. 122C-115 may dissolve at any time during a fiscal year. Dissolution of an area authority or withdrawal from the area authority by a county for other reasons shall be effective only at the end of the fiscal year in which the action of dissolution or withdrawal transpired."

SECTION 4. G.S. 150B-1(d) is amended by adding a new subdivision to read:

"(20) The Department of Health and Human Services in implementing, operating, or overseeing new 1915(b)/(c) Medicaid Waiver programs or amendments to existing 1915(b)/(c) Medicaid Waiver programs."

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 916:
Statewide Expansion of 1915(b)/(c) Waiver

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 7, 2011
Introduced by:	Reps. Barnhart, Dollar, Burr, Insko	**Prepared by:**	Shawn Parker Janice Paul Committee Co-Counsel
Analysis of:	Third Edition		

SUMMARY: ***House Bill 916 directs the Department of Health and Human Services to restructure the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders by expanding operation of a 1915(b)/(c) Medicaid Waiver statewide.***

BILL ANALYSIS:

System change

House Bill 916 directs the Department of Health and Human Services (DHHS) to establish a system to deliver public services statewide to persons with mental illness, intellectual and developmental disabilities, and substance abuse disorders by expanding the 1915(b)/(c) Medicaid Waiver program. DHHS would complete restructuring of management responsibilities for all public resources for MH/DD/SAS programs by July 1, 2013, by:

- Becoming accountable for developing and managing a local system that provides easy access to care, makes available and delivers required services, and provides continuity of care;
- Adhering to the Piedmont Behavioral Health (PBH) system model;
- Within catchment areas, designating a single Local Management Entity (LME), either by merger or interlocal agreements (with one lead LME) to be responsible for all aspects of Waiver management;
- Employing specified managed care strategies, including care coordination and utilization management, to control costs while ensuring that consumers receive medically necessary care;
- Phasing out the current CAP-MR/DD and utilization management functions currently performed by other contractors;
- Designing the Innovations waiver to serve a greater number of qualified individuals within funding limits;
- Requiring 1915(b)/(c) Waiver-approved LMEs to maintain a community presence; implement a feedback and information exchange process to communicate with consumers, providers and others; create systems for communication and care coordination with other organized systems, such as local social service agencies, hospitals, schools, and other community agencies; and comply with specific operational requirements.

LMEs to operate 1915(b)/(c) waivers

The bill directs DHHS by August 1, 2011 to select LMEs which meet the minimum Waiver operations criteria according to the requirements of the RFA 2011-261 issued on April 1, 2011. The bill further directs DHHS to cause LMEs that fail to meet minimum operational requirements by Janaury 1, 2013 to merge or align an approved LME, and provides that under an interlocal agreement, a single LME would be responsible for all Waiver operations and contract requirements.

Local government limited liability

Under the act, county governments are not financially liable for cost overruns associated with the area authority's or single/multi-county program's Waiver operation beyond that entity's risk reserve and Medicaid fund balance amounts.

Services for persons with Intellectual and Developmental Disability (IDD)
Targeted Case Management (TCM) is a service available statewide that assists individuals with intellectual and developmental disabilities in gaining access to needed services described in the State Medicaid Plan, as well as needed medical, social, educational, and other services. During the first year of Waiver operations, LMEs are directed to contract with previously approved TCM providers under the CAP-MR/DD Waiver to provide Community Guide service.

A Section 1915(i) Option allows states to offer Home- and Community-Based Services (HCBS), and allows states to offer HCBS under a Medicaid state plan to individuals who are Medicaid-eligible. It limits eligibility to individuals with incomes up to 150 percent of poverty who, but for the program services, would need an institutional level of care. NC Innovations is a means of funding services and supports for people with mental retardation and other related developmental disabilities who are at risk for institutional care in an Intermediate Care Facility for Individuals with Mental Retardation (ICF-MR). Innovations also provides funding for people to return to their homes and communities from ICF-MRs. The bill directs DHHS to assess by December 31, 2011, the feasibility of adding habilitation services through the 1915(i) Option for Medicaid enrollees with intellectual and developmental disabilities (IDD) who are not enrolled in the Innovations Waiver and are not residing in an ICF-MR.

The bill further directs DHHS to consider impacts on ICF-MR facilities and evaluate and minimize possible inconsistencies between the certificate of need requirements and the viability and success of 1915(b)/(c) Waiver programs, and to discontinue for non-waiver LMEs the Supports Intensity Scale pilot program authorized in the 2010 Appropriations Act.

Managed Care Systems
The bill directs DHHS to adopt written policies to align objectives of the 1915(b)/(c) Waiver and the care of eligible consumers with other managed care systems, including Community Care of North Carolina.

Reinvestment of Projected Savings
The bill directs future General Assemblies to consider reinvesting 15% or more of the projected savings from operating the Waiver to increase the number of consumers served by the Innovations Waiver or to expand services for persons with intellectual and developmental disabilities.

Reporting requirements
The bill directs DHHS, in coordination with other specified agencies, to submit a strategic plan for implementing this act to a legislative oversight committee, by October 1, 2011, and to submit periodic status reports to the General Assembly as to the progress of the restructuring and expansion authorized in Section 1.

LME catchment population
By July 1, 2012 the minimum population of an area authority or county program must be at least 300,000. The Department will reduce administrative funding of LMEs which do not comply with the minimum population to a rate consistent with catchments of 300,000. By July 1, 2013 the minimum population of an area authority or county program must be at least 500,000. The Department will reassign management responsibilities for State and federal pass-through funding from LMEs which do not comply with the minimum population requirements. Further, the bill provides that the dissolution of an area authority not meeting minimum population requirements is effective at any time during the fiscal year.

Rules not subject to the APA
The bill exempts the Department from the rule making under Artcile 2A of Chapter 150B in implementing, operating, or overseeing new or amending existing Waiver programs.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND:

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: (1) State medical professionals determine community placement is appropriate; (2) placement would be less restrictive and is not opposed by the patient; and (3) community placement can be reasonably accommodated, given resources available to the State and the needs of others with mental disabilities.

In 2001, the General Assembly passed legislation which made significant policy changes addressing issues of State and local governance and increased accountability. It emphasized consumer-driven community-based services. It required that State and local governments provide certain core services to all individuals and also required the development of enhanced services that targeted persons with the most severe disabilities. It also shifted the role of local public mental health agencies from that of direct service providers to one of managing and coordinating services delivered by private providers.

In April 2005, DHHS began operating under two new waivers* as a pilot project: (1) the Piedmont Cardinal Health Plan, a pilot 1915 (b) Freedom of Choice waiver project; and (2) the Innovations Home and Community Based services (HCBS) 1915 (c) waiver. In this pilot project, Medicaid funded services for mental health, substance abuse and developmental disabilities are provided on a capitation basis in a five-county area through a prepaid inpatient health plan (PIHP). PBH (formerly known as Piedmont Behavioral Healthcare), a local management entity, operates the PIHP and manages state and federally funded mental health, substance abuse and developmental disabilities services.

A Medicaid waiver is the authority given to a state by the Centers for Medicare and Medicaid Services (CMS) to "waive" one or more federal Medicaid regulations in order to create non-traditional services, programs and delivery systems. Only certain Medicaid regulations can be waived depending on the type of the waiver requested.

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee

June 9 2010
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary K Short	Parent/Advocate Taylorsville
Katie Short	CAP-MR/DD recipient TAYLORSVILLE
Terry Clarke	Raleigh - Parent
Ann Albany	My Daughter CAP
Paula Cox Fishman	volunteer advocate & guardian of adult MR/DD sister
Sean Webb	Sibling of DD. Advocate
Pat Wiegand	parent
Carol Cavato	A Caring Heart Case Mgmt.
Louise Fisher	Volunteer Advocate for the Ms. Sld
JOE LANIER	NELSON MULLINS
Pam Shipman	PBH

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee

6/9/11
Date

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Meredith Switzer	The Policy Group
Katherine Ross	PPAB
Michael Taylor	Michael W. Taylor, attyat law, PLLC
Dave Richard	The Arc
Elise Bouchard	Sen. Bingham
Kay Parsley	NASW-NC
John Murphy	Policy Group
Tara Heady	NCCDD
Heather Hayes	NMSS-NC
Jane Walden	Easter Seals UCP NC & VA
Tara FIELDS	Benchmarks

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — 6/9/11

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Annaliese Dolph	DRNC
Jennifer Mahan	ASNC
Erica Nelson	NCCCP
John Bowdish	AstraZeneca
Peyton Maynard	[illegible]
Greg Griggs	
Julia Adams	The Arc of NC
W. Gordon [illegible]	DLC + Assoc
[illegible]	NMSS-NC
Doug Miskew	PSG
[illegible]	CSS

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee

6/9/11
Date

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NAME	FIRM OR AGENCY AND ADDRESS
Andrew Meehan	Capstrat
Jarod Jos	NCHA
Jerry Hancock	EGH

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Kyle Hanny	NC Dems
Rebecca Trantham	NCACC
Alissa Willett	NCAEC
Ellen Russell	The Arc of NC
Robert Keeley	Sunovion Pharm.
[signature]	NAMI

MEMBERSHIP

Mental Health and Youth Services
2011 - 2012

Senator Fletcher Hartsell, Chairman
Room 300-C, LOB
733-7223

Senator Austin Allran, Vice Chair
Room 625, LOB
733-5876

Senator Tommy Tucker, Vice Chair
Room 311, LOB
733-7659

Senator Stan Bingham
Room 2117, LB
733-5665

Senator Chris Carney
Room 1928, LB
715-3050

Senator Warren Daniel
Room 411, LOB
715-7823

Senator Jim Davis
Room 2111, LB
733-5875

Senator Brent Jackson
Room 525, LOB
733-5705

Senator Ed Jones
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715-3032

Senator Ellie Kinnaird
Room 628, LOB
733-5804

Senator Martin Nesbitt
Room 1129, LB
715-3001

Senator William Purcell
Room 517, LOB
733-5953

Senator Gladys Robinson
Room 1120, LB
715-3042

Committee Assistant:

Gerry Johnson

Research Staff:

Shawn Parker
Jan Paul
Patsy Pierce
Susan Barham

2011-2012 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0302	Earle	CHARITABLE LICENSING EXEMPTION CLARIFICATION.	*SR	Ch. SL 2012-15	04-20-11	05-30-12
423=	Hurley	CHILD PROTECT. SERV/ CHILD CARE SUB./RENT EXEMPT.	*S	Re-ref Com On Rules and Operations of the Senate	05-23-12	06-07-12
H0916	Barnhart	STATEWIDE EXPANSION OF 1915(B)/(C) WAIVER.	*SR	Ch. SL 2011-264	06-06-11	06-09-11
H1055=	Burr	ELIMINATE LME PROVIDER ENDORSEMENT.-AB	SR	Ch. SL 2012-66	06-06-12	06-07-12
H1056=	Burr	PARTNERSHIP FOR CHILDREN PARTICIPANT RECORDS.	SR	Ch. SL 2012-67	06-06-12	06-07-12
H1075=	Dollar	LME/MCO GOVERNANCE.	*S	Re-ref Com On Mental Health & Youth Services	06-06-12	06-11-12
H1075=	Dollar	LME/MCO GOVERNANCE.	*S	Re-ref Com On Mental Health & Youth Services	06-26-12	
H1081=	Burr	PROVISIONAL LICENSURE CHANGES MEDICAID.-AB	SR	Ch. SL 2012-72	06-06-12	06-07-12
S0053=	Josh Stein	DISAPPROVE CLOSURE OF DOROTHEA DIX HOSPITAL.	S	Ref To Com On Mental Health & Youth Services	02-10-11	
S0167=	Fletcher L. Hart	ALLOW EXPANSION OF CAPITATED WAIVER.	S	Re-ref Com On Mental Health & Youth Services	03-10-11	
S0316=	Fletcher L. Hart	ADD'L SECTION 1915 MEDICAID WAIVER SITES.	*SR	Ch. SL 2011-102	03-17-11	03-24-11
325=	Martin L. Nesbit	FUNDS FOR STEP-DOWN UNIT FOR BART PROGRAM.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0326=	Martin L. Nesbit	EVALUATE DD RESIDENTIAL OPTIONS FOR CHILDREN.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0327=	Martin L. Nesbit	MODIFY MHDDSAS REPORTING REQUIREMENTS.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0328=	Martin L. Nesbit	REPORT ON TRANSFER OF CAP-MR/DD UR TO LMES.	S	Re-ref Com On Appropriations/ Base Budget	03-14-11	04-27-11
S0329=	Martin L. Nesbit	EVIDENCE-BASED PRACT. IN PSYCH. HOSPITALS.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0330=	Martin L. Nesbit	REPORT ON MH SERVICES PROVIDED BY HOSP. ER'S.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0331=	Martin L. Nesbit	EVALUATE EFFICACY OF CABHA MODEL.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0332=	Martin L. Nesbit	REPORT ON NC CLUBHOUSE PROGRAMS.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0333=	Martin L. Nesbit	REVISE DD WAITING	S	Ref To Com On	03-14-11	

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

2011-2012 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		LIST PROCESS.		Mental Health & Youth Services		
$ S0334=	**Martin L. Nesbit**	**EXPAND INPATIENT PSYCHIATRIC BEDS/ FUNDS.**	**S**	**Re-ref Com On Appropriations/ Base Budget**	**03-14-11**	**04-27-11**
S0335=	Martin L. Nesbit	APPLY FOR TBI MEDICAID WAIVER.	S	Re-ref Com On Appropriations/ Base Budget	03-14-11	04-27-11
S0336=	Martin L. Nesbit	DEVELOP PLAN FOR ALLOCATING DD RESOURCES.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0337=	Martin L. Nesbit	ALLOW EXPANSION OF CAPITATED WAIVER.	S	Ref To Com On Mental Health & Youth Services	03-14-11	
S0401=	Stan Bingham	ACH PILOT ON CRISIS INTERVENTION TRAINING.	S	Ref To Com On Health and Human Services	03-24-11	04-27-11
S0421	Stan Bingham	GAST TRAINING PILOT.	S	Ref To Com On Health and Human Services	03-28-11	04-27-11
S0465	Fletcher L. Hart	PED STUDY LME GOVERNANCE.	*S	Ref To Com On Health and Human Services	03-31-11	06-08-11
S0481=	Ed Jones	MENTAL HEALTH WORKERS' BILL OF RIGHTS.	S	Ref To Com On Mental Health & Youth Services	04-04-11	
S0524=	Tommy Tucker	STRENGTHENING RESIDENTIAL PLACEMENT.	*S	Re-ref Com On Finance	04-07-11	05-04-11
S0525=	Tommy Tucker	CRITICAL ACCESS BEHAVIORAL HEALTH AGENCIES.	*S	Pres. To Gov. 7/3/ 2012	04-07-11	05-12-11
S0578	Fletcher L. Hart	FACILITATE TRANSFER SPH BEDS COM. FACILITY.	*SR	Ch. SL 2011-275	04-14-11	06-02-11
S0669	Bob Atwater	DIX PROPERTY-MENTAL HEALTH TRUST FUND.	*S	Ref To Com On Finance	04-20-11	05-04-11
S0875=	Louis Pate	LME GOVERNANCE.	S	Ref To Com On Mental Health & Youth Services	05-24-12	

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SENATE MENTAL HEALTH & YOUTH SERVICES COMMITTEE
Wednesday, May 30, 2012 at 12:00 Noon
Room 414, Legislative Office Building

MINUTES

The Senate Mental Health & Youth Services Committee met at 12:00 Noon on May 30, 2012, in Room 414 of the Legislative Office Building, with twelve members of the committee present. Senator Fletcher Hartsell, Chair, presided.

Senator Hartsell introduced pages Leanne Gosey, Jennifer Quick, Tyler Coe, Melinda Hobbs, Max Britt, Sarah Ammond and Jeffrey Masar and the Sergeant-at-Arms and thanked them for their service to the Committee.

House Bill 302 – Charitable Licensing Exemption Clarification. Senator Bingham moved to adopt the Proposed Committee Substitute for purposes of discussion. All voted and the motion carried. Ms. Jan Paul, Staff Attorney, explained the Proposed Committee Substitute. Senator Allran moved for a favorable report to the proposed committee substitute, unfavorable to the original bill. Questions from Senators Nesbitt, Tucker, Kinnaird and Jackson were answered by Ms. Paul and Representative Dollar. All voted and the motion carried.

House Bill 423 – Enact First Evaluation Program. Senator Tucker moved to adopt the Proposed Committee Substitute for purposes of discussion. All voted and the motion carried. Representative Moffitt was recognized to explain the bill. Ms. Patsy Pierce gave additional explanation. Representative Moffitt noted that the bill was for discussion only at this time. Questions from Senators Bingham, Robinson, Carney and Tucker were answered by Representative Moffitt and Ms. Pierce. Comments were also given by Ms. Melcher and Ms. Barbara Ryan from Department of Health & Human Services and Senator Nesbitt. Senator Bingham moved to adopt the Proposed Committee Substitute, unfavorable to the original bill and referred to Finance. Senator Apodaca asked Ms. Melcher if she felt that adoption of this bill would impede her negotiations with the Department Of Justice. Senator Hartsell then asked, would the adoption of this bill, even preliminarily, impede the resolution of the matter with the Department Of Justice or not? After much discussion Senator Hartsell displaced the bill and the motion until next week and asked the Department of Health & Human Services to try to get an answer from the Federal Department of Justice.

Senate Bill 875 – LME Governance. Senator Hartsell noted that the Committee would begin discussion at this meeting. He also noted that there was a companion bill in the House that is sponsored by Representative Dollar. Representative Dollar was recognized to give general information on the bill. Questions from Senators Daniel and Purcell were answered by Representative Dollar. Senator Hartsell noted that the Committee would look into this in more detail at the meeting next week and would take up other issues related to the Waiver implementation as part of this in terms of both governance and the Waiver itself. He asked that any questions be forwarded to Mr. Shawn Parker or other members of the staff before the next meeting.

There being no further business, the meeting was adjourned.

Senator Fletcher L. Hartsell, Jr., Chair

Gerry Johnson, Committee Assistant

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	May 30, 2012	12:00 Noon	414 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 302	Charitable Licensing Exemption Clarification.	Representative Earle Representative Samuelson
HB 423 *	Enact First Evaluation Program.	Representative Hurley Representative Moffitt
SB 875	LME Governance.	Senator Apodaca Senator Pate

***HB 423 is a PCS – New Title: Adult Care Home Pilot/Buncombe County**

1. Discussion on the implementation of SL 2011-264 Statewide expansion of 1915(b)/(c) Waiver
2. Discussion on LME/MCO Hospital Contracts

Senator Fletcher L. Hartsell, Jr., Chair

Senate Mental Health & Youth Services Committee
Wednesday, May 30, 2012, 12:00 Noon
414 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 302	Charitable Licensing Exemption Clarification.	Representative Earle Representative Samuelson
HB 423 *	Enact First Evaluation Program.	Representative Hurley Representative Moffitt
SB 875	LME Governance.	Senator Apodaca Senator Pate

*HB 423 is a PCS – New Title: Adult Care Home Pilot/Buncombe County

Presentations

Other Business:

DISCUSSIONS:

1. The Implementation of SL 2011-264 Statewide Expansion of 1915(b)/(c) Waiver
2. LME/MCO Hospital Contracts

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

MENTAL HEALTH & YOUTH SERVICES COMMITTEE REPORT
Senator Fletcher L. Hartsell, Jr., Chair

Wednesday, May 30, 2012

Senator HARTSELL, JR.,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B. **302** Charitable Licensing Exemption Clarification.

Draft Number:	PCS 80371
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

Sen. Hartsell will present the bill on the Floor

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 302
Second Edition Engrossed 4/19/11
PROPOSED SENATE COMMITTEE SUBSTITUTE H302-CSSQ-78 [v.2]

5/28/2012 2:26:20 PM

Short Title: Charitable Licensing Exemption Clarification. (Public)

Sponsors:

Referred to:

March 10, 2011

A BILL TO BE ENTITLED

AN ACT TO BROADEN THE EXEMPTION FROM CHARITABLE LICENSING REQUIREMENTS FOR CERTAIN NONPROFIT ADULT RESIDENTIAL TREATMENT FACILITIES AND TO EXTEND THE SUNSET ON A WAIVER RELATING TO ALTERNATIVE STAFFING REQUIREMENTS FOR FACILITIES THAT USE ELECTRONIC SUPERVISION DEVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-22 reads as rewritten:

"**§ 122C-22. Exclusions from licensure; deemed status.**

(a) The following are excluded from the provisions of this Article and are not required to obtain licensure under this Article:

(1) Physicians and psychologists engaged in private office practice;

(2) General hospitals licensed under Article 5 of Chapter 131E of the General Statutes, that operate special units for the mentally ill, developmentally disabled, or substance abusers;

(3) State and federally operated facilities;

(4) Adult care homes licensed under Chapter 131D of the General Statutes;

(5) Developmental child care centers licensed under Article 7 of Chapter 110 of the General Statutes;

(6) Persons subject to licensure under rules of the Social Services Commission;

(7) Persons subject to rules and regulations of the Division of Vocational Rehabilitation Services;

(8) Facilities that provide occasional respite care for not more than two individuals at a time; provided that the primary purpose of the facility is other than as defined in G.S. 122C-3(14);

(9) Twenty-four-hour nonprofit facilities established for the purposes of shelter care and recovery from alcohol or other drug addiction through a 12-step, self-help, peer role modeling, and self-governance approach;

(10) Inpatient chemical dependency or substance abuse facilities that provide services exclusively to inmates of the Department of Correction, as described in G.S. 148-19.1; and

(11) A charitable, nonprofit, faith-based, adult residential treatment facility that does not receive any federal or State funding ~~and is part of an international~~

~~organization serving at least 50 countries that helps persons ages 18 through 40 overcome life controlling problems~~ and is a religious organization exempt from federal income tax under section 501(a) of the Internal Revenue Code.

...."

SECTION 2. Section 4 of S.L. 2009-490 is rewritten to read:

"**SECTION 4.** The Department of Health and Human Services, Division of Health Service Regulation shall establish a pilot program to study the use of electronic supervision devices as an alternative means of supervision during sleep hours at facilities for children and adolescents who have a primary diagnosis of mental illness and/or emotional disturbance. The pilot program shall be implemented at a facility currently authorized to waive the requirement set forth in 10A NCAC 27G .1704(c) or any related or subsequent rule or regulation by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services setting minimum overnight staffing requirements. The waiver shall remain in effect until ~~December 31, 2012;~~ December 31, 2015; however, the Division reserves the right to rescind the waiver if, at the time of the facility's license renewal, there are outstanding deficiencies that have remained uncorrected upon follow-up survey, that are related to electronic supervision.

SECTION 3. This act becomes effective July 1, 2012.

HOUSE BILL 302:
Charitable Licensing Exemption Clarification

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	May 29, 2012
Introduced by:	Reps. Earle, Samuelson	**Prepared by:**	Janice Paul
Analysis of:	PCS to Second Edition H302-CSSQ-78		Committee Counsel

SUMMARY: ***The proposed committee substitute for House Bill 302 would broaden the exemption from licensure requirements for charitable, nonprofit, faith-based, adult residential treatment facilities by not requiring them to be part of an international organization. It would also extend the sunset on a waiver to use electronic supervision in residential facilities for children and adolescents with mental illness or developmental disabilities.***

Section 1

CURRENT LAW: In order be exempt from licensing requirements of G.S. 122C-22, an adult residential treatment facility for the mentally ill, developmentally disabled, and substance abusers cannot receive any federal or state funding, and must be a tax-exempt religious organization. The facility must also be part of an international organization serving at least 50 countries helping people between the ages 18 through 40 overcome life-controlling problems.

BILL ANALYSIS: House Bill 302 would eliminate the requirement that, in order to be exempted from licensing requirements, an entity must be part of an international organization serving at least 50 countries and which assists persons aged 18 to 40 in addressing life-controlling problems. The proposed committee substitute changes the effective date to July 1, 2012.

Section 2

CURRENT LAW: The Department of Health and Human Services was directed in Session Law 2009-490 to establish a pilot program to study the use of electronic monitoring devices as an alternative means of supervising children and adolescents with mental illness or developmental disabilities during sleep hours at facilities authorized to waive the agency rule relating to minimum staffing requirements.

BILL ANALYSIS: The PCS would extend the sunset on the waiver from December 31, 2012, to December 31, 2015.

EFFECTIVE DATE: The act becomes effective July 1, 2012.

H302-SMTJ-63(CSSQ-78) v1

HOUSE BILL 302
Second Edition Engrossed 4/19/11

Short Title:	Charitable Licensing Exemption Clarification.	(Public)
Sponsors:	Representatives Earle and Samuelson (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Health and Human Services, if favorable, Finance.	

March 10, 2011

A BILL TO BE ENTITLED

AN ACT TO BROADEN THE EXEMPTION FROM CHARITABLE LICENSING REQUIREMENTS FOR CERTAIN NONPROFIT ADULT RESIDENTIAL TREATMENT FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-22 reads as rewritten:

"**§ 122C-22. Exclusions from licensure; deemed status.**

(a) The following are excluded from the provisions of this Article and are not required to obtain licensure under this Article:

(1) Physicians and psychologists engaged in private office practice;

(2) General hospitals licensed under Article 5 of Chapter 131E of the General Statutes, that operate special units for the mentally ill, developmentally disabled, or substance abusers;

(3) State and federally operated facilities;

(4) Adult care homes licensed under Chapter 131D of the General Statutes;

(5) Developmental child care centers licensed under Article 7 of Chapter 110 of the General Statutes;

(6) Persons subject to licensure under rules of the Social Services Commission;

(7) Persons subject to rules and regulations of the Division of Vocational Rehabilitation Services;

(8) Facilities that provide occasional respite care for not more than two individuals at a time; provided that the primary purpose of the facility is other than as defined in G.S. 122C-3(14);

(9) Twenty-four-hour nonprofit facilities established for the purposes of shelter care and recovery from alcohol or other drug addiction through a 12-step, self-help, peer role modeling, and self-governance approach;

(10) Inpatient chemical dependency or substance abuse facilities that provide services exclusively to inmates of the Department of Correction, as described in G.S. 148-19.1; and

(11) A charitable, nonprofit, faith-based, adult residential treatment facility that does not receive any federal or State funding ~~and is part of an international organization serving at least 50 countries that helps persons ages 18 through 40 overcome life-controlling problems~~ and is a religious organization exempt from federal income tax under section 501(a) of the Internal Revenue Code.

...."

SECTION 2. This act becomes effective July 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 423
Committee Substitute Favorable 4/20/11
Committee Substitute #2 Favorable 5/10/11
PROPOSED SENATE COMMITTEE SUBSTITUTE H423-CSSQ-75 [v.1]

5/23/2012 11:30:17 AM

Short Title: Adult Care Home Pilot/Buncombe Co. (Public)

Sponsors:

Referred to:

March 23, 2011

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH A PILOT PROGRAM IN BUNCOMBE COUNTY TO AUTHORIZE USE OF A MORE DETAILED ASSESSMENT TOOL FOR SCREENING ADULT CARE HOME RESIDENTS AND TO ALLOW BUNCOMBE COUNTY'S DEPARTMENT OF SOCIAL SERVICES TO DELEGATE BY CONTRACT ITS ROUTINE ADULT CARE HOME MONITORING DUTIES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services shall develop and implement a twelve-month pilot program in Buncombe County to begin no later than July 1, 2012, and to terminate June 30, 2013, regarding (i) the screening, placement, and care coordination of adult care home residents and (ii) the routine monitoring of adult care homes licensed under Article 1 of Chapter 131D of the General Statutes. Adult care homes in Buncombe County are not required to participate in this pilot program, but may elect to participate by notifying the Department of their intent to participate in the manner prescribed by the Department. The Secretary of Health and Human Services may waive any rule adopted under Article 1 or Article 3 of Chapter 131D of the General Statutes as necessary to protect the health and well-being of any individual admitted to an adult care home that elects to participate in this pilot program.

SECTION 1.(b) As part of this pilot program:

(1) Each adult care home shall evaluate whether it can meet the health needs of each individual who applies for admission and each individual who is currently residing in the adult care home, taking into consideration the information obtained from the administration of a uniform assessment instrument approved by the Department that enables the facility to do all of the following:

a. Develop appropriate and comprehensive service plans and care plans.

b. Determine the level and type of facility staff necessary to meet the needs of the residents.

c. Determine whether residents have been appropriately placed in the facility, taking into consideration the individual and group needs of the residents.

d. Determine a resident's level of functioning, including, but not limited to, cognitive status and physical functioning in activities of daily living. Activities of daily living are personal functions essential for the health and well-being of the resident.

e. Determine if the resident requires referral to the resident's physician or other appropriate licensed health care professional or community resource, including care coordination or care management activities available through the Medical Assistance Program.

(2) Each participating adult care home shall assist each resident with enrollment in any appropriate care coordination or care management activities available to the resident through the Medical Assistance Program, monitor the condition of the health and well-being of each resident, and take steps to coordinate the care needs of the resident with the resident's physician or other appropriate licensed health care professional or community resource.

(3) In consultation with the Department, the Buncombe County Department of Social Services may by contract delegate routine monitoring duties under G.S. 131D-2.11(b) to entities with specialized expertise in monitoring the health care needs of adult care home residents. This delegation is authorized solely for the purpose of assisting, and not replacing, adult care home specialists employed by the county department of social services. Notwithstanding any delegation of duties, the county department of social services shall remain accountable for its routine monitoring duties for the duration of this pilot program.

(4) Notwithstanding any law to the contrary, Chapter 132 of the General Statutes, the Public Records Law, applies to all written reports prepared by contractors to whom routine monitoring duties have been delegated pursuant to subdivision (3) of this section, but does not apply to information in the records that is confidential or privileged, including medical records, or that contains the names of residents or complainants.

SECTION 2. Not later than January 1, 2014, the Department of Health and Human Services shall report its findings and recommendations about the costs and benefits of the pilot program authorized by this act to the Joint Oversight Committee on Health and Human Services.

SECTION 3. This act is effective when it becomes law.

HOUSE BILL 423:
Enact First Evaluation Program

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	May 28, 2012
Introduced by:	Rep. Hurley	**Prepared by:**	Patsy Pierce
Analysis of:	PCS to Third Edition H423-CSSQ-75		Legislative Analyst

SUMMARY: ***The Senate Proposed Committee Substitute (PCS) completely rewrites House Bill 423 to direct the Department of Health and Human Services (DHHS) to develop and implement an Adult Care Home health care needs assessment pilot program in Buncombe County during the 2012-2013 fiscal year and authorize the Buncombe County Department of Social Services to contract with an outside agency to complete monitoring requirements during the pilot program. Findings of the pilot program would be reported to the Joint Oversight Committee on Health and Human Services not later than January 1, 2014.***

CURRENT LAW: G.S. 131D-2.15 directs Adult Care Homes to complete a DHHS-approved assessment of each resident within 72 hours of admitting the resident and annually thereafter. The assessment includes the resident's level of cognitive and physical functioning related to activities of daily living (ADL) and findings are used to a develop comprehensive service plan. DHHS reviews residents' assessments and service plans as a part of its inspection and licensing of Adult Care Homes.

G.S. 131D-2.11(b) directs DHHS to work with county departments of social services to complete routine monitoring of Adult Care Homes to ensure compliance with State and federal laws, rules and regulations in accordance with the policies and procedures of the Division of Health Service Regulation (Division). County departments of social services are directed to submit written reports on monitoring visits and complaint investigations to the Division within 20 days of the visit.

BILL ANALYSIS:

DHHS would be directed to develop and implement a twelve-month pilot program to assess Adult Care Home residents' health care needs in Buncombe County beginning July 1, 2012 and terminating on June 30, 2013. Participation in the pilot program would be wholly voluntary. During the pilot program, participating Adult Care Homes would evaluate current and potential residents using a uniform assessment instrument approved by DHHS. The assessment instrument would provide information to allow the pilot program participants to develop comprehensive service and care plans by determining (i) level and type of facility staff needed; (ii) appropriateness of placement; (iii) level of functioning including, but not limited to, ADLs, and (iv) referral needs, including care coordination activities available through the Medical Assistance Program. Adult Care Homes participating in the pilot program would assist residents with enrollment in care coordination activities and coordinate with the resident's physician, other licensed health care professionals, and community resources.

In consultation with DHHS, the Buncombe County Department of Social Services could delegate monitoring responsibilities described in G.S. 131D-2.11(b) to a contracting agency with specialized expertise in monitoring Adult Care Homes. The Buncombe County Department of Social Services would remain accountable for monitoring services during the pilot program. North Carolina Public Records Law would apply to written reports developed by the contractors, but would not apply to confidential resident or complainant information.

DHHS would report the findings about the costs and benefits of the pilot program to the Joint Oversight Committee on Health and Human Services on or before January 1, 2014.

EFFECTIVE DATE: This act is effective when it becomes law.

H423-SMTL-60(CSSQ-75) v3

H 3

HOUSE BILL 423
Committee Substitute Favorable 4/20/11
Committee Substitute #2 Favorable 5/10/11

Short Title: Enact First Evaluation Program. (Public)

Sponsors:

Referred to:

March 23, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ALLOW CERTAIN CERTIFIED PROVIDERS TO CONDUCT INITIAL (FIRST-LEVEL) EXAMINATIONS FOR INVOLUNTARY COMMITMENT OF INDIVIDUALS WITH MENTAL ILLNESS, IN A MANNER CONSISTENT WITH THE FIRST EVALUATION PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Part 7 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-263.1 Secretary's authority to waive requirement of first examination by physician or eligible psychologist; training of certified providers performing first examinations.**

(a) The Secretary of Health and Human Services may, upon request of an LME, waive the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a master's level psychiatric nurse, or a master's level certified clinical addictions specialist in accordance with subdivision (8) of this subsection to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this type of request, the LME shall specifically describe all of the following:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding all of the following:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(4) A waiver granted by the Secretary under this section shall be in effect for a period of up to three years and may be rescinded at any time within this period if the Secretary finds the LME has failed to meet the requirements of this section.

(5) In no event shall the substitution of a licensed clinical social worker, master's level psychiatric nurse, or master's level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level psychiatric nurse, or the master's level certified clinical addictions specialist.

(6) The Department shall require that individuals performing initial examinations under the waiver have successfully completed the Department's standardized training program and examination. The Department shall maintain a list of these individuals on its Web site.

(7) As part of its waiver request, the LME shall document the availability of a physician to provide backup support.

(8) A master's level certified clinical addiction specialist shall only be authorized to conduct the initial examination of individuals meeting the criteria of G.S. 122C-281(a).

(b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall expand its standardized certification training program to include refresher training for all certified providers performing initial examinations pursuant to subsection (a) of this section."

SECTION 2. Beginning January 1, 2012, each 24-hour residential facility that (i) falls under the category of non-hospital medical detoxification, facility-based crisis service, or inpatient hospital treatment, (ii) is not a State facility under the jurisdiction of the Secretary of Health and Human Services, and (iii) is designated by the Secretary of Health and Human Services as a facility for the custody and treatment of individuals under a petition of involuntary commitment pursuant to G.S. 122C-252 and 10A NCAC 26C .0101 shall submit a written report on involuntary commitments each January 1 and each July 1 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include all of the following:

(1) The number and primary presenting conditions of individuals receiving treatment from the facility under a petition of involuntary commitment.

(2) The number of individuals for whom an involuntary commitment proceeding was initiated at the facility, who were referred to a different facility or program.

(3) The reason for referring the individuals described in subdivision (2) of this section to a different facility or program, including the need for more intensive medical supervision.

SECTION 3. This act becomes effective October 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S 1

SENATE BILL 875*

Short Title:	LME Governance.	(Public)
Sponsors:	Senator Pate.	
Referred to:	Mental Health & Youth Services.	

May 24, 2012

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN GOVERNANCE OF LOCAL MANAGEMENT ENTITIES WITH RESPECT TO THE IMPLEMENTATION OF STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-115(a) reads as rewritten:

"§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.

(a) A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program established pursuant to ~~G.S. 122C-115.1.~~G.S. 122C-115.1 and in accordance with rules, policies, and guidelines adopted pursuant to statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver. Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control."

SECTION 2. G.S. 122C-116 reads as rewritten:

"§ 122C-116. Status of area authority; status of consolidated human services agency.

(a) An area authority is a local political subdivision of the ~~State except that a single county area authority is considered a department of the county in which it is located for the purposes of Chapter 159 of the General Statutes.~~State.

(b) A consolidated human services agency is a department of the county."

SECTION 3.(a) G.S. 122C-118.1 reads as rewritten:

"§ 122C-118.1. Structure of area board.

(a) ~~An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties may have up to 30 members. In a single county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by~~

~~adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include two individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.~~ An area board shall have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or the boards of county commissioners within the area, shall appoint members consistent with the requirements provided in subsection (b) of this section. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category. A member of the board may be removed with or without cause by the initial appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chairman of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) ~~Except as otherwise~~Within the maximum membership provided in ~~this subsection, not more than fifty percent (50%) of~~subsection (a) of this section, the ~~members~~membership of the area board shall reside within the catchment area and ~~represent the following:~~ be composed as follows:

(1) ~~A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.~~At least one member who is a current county commissioner.

(2) ~~A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.~~The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.

(3) At least one family member ~~or individual from a citizens' organization composed primarily of consumers or their family members,~~of the local CFAC, as recommended by the local CFAC, representing the interests of ~~individuals:~~the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~In~~Individuals in recovery from ~~addiction; or~~addiction, or

c. ~~With~~ Individuals with intellectual or other developmental disabilities.

(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~With~~Individuals with intellectual or other developmental ~~disabilities; or~~disabilities, or

c. ~~In~~ Individuals in recovery from addiction.

(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.
(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.
(8) An individual with insurance expertise consistent with the scale and nature of the managed care organization.
(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.
(10) An attorney with health care expertise.
(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.
(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member and shall only participate in Board activities that are open to the public.

~~An~~Except as provided in subdivision (12) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. Of the members described in subdivisions (2) through (4) of this subsection, the board of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than two categories of membership if the member has the qualifications or attributes of the two categories of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the member's service as a county commissioner. Any member of an area board who is a county manager serves on the board at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the duration of the member's employment as a county manager. The terms of ~~the other~~members on the area board shall be for three years, except that upon the initial formation of an area board in compliance with subsection (a) of this section, one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. ~~Members, other than county commissioners and county managers,~~ Members shall not be appointed for more than ~~two~~three consecutive terms. ~~Board members serving as of July 1, 2006, may remain on the board for one additional term. This subsection applies to all area authority board members regardless of the procedure used to appoint members under subsection (a) of this section.~~

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes."

SECTION 3.(b) All area boards shall meet the requirements of G.S. 122C-118.1, as amended by Section 3 of this act, no later than July 1, 2013.

SECTION 4.(a) G.S. 122C-119.1 reads as rewritten:

"§ 122C-119.1. Area Authority board members' training.

All members of the governing body for an area authority shall receive initial orientation on board members' responsibilities and annual training provided by the Department ~~in~~and shall include fiscal management, budget development, and fiscal accountability. A member's refusal to be trained shall be grounds for removal from the board."

SECTION 4.(b) The North Carolina Department of Health and Human Services, in cooperation with the School of Government and the local management entities, shall develop a standardized core curriculum for the training described in Section 4(a) of this act.

SECTION 5. G.S. 122C-170(b) reads as rewritten:

"Part 4A. Consumer and Family Advisory Committees.

"§ 122C-170. Local Consumer and Family Advisory Committees.

...

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than ~~two~~three consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, developmental disabilities, and substance abuse services.

(2) Family members of consumers of mental health, developmental disabilities, and substance abuse services.

...."

SECTION 6. Area authorities may add one or more additional counties to their existing catchment area by agreement of a majority of the existing member counties.

SECTION 7.(a) Beginning July 1, 2012, and for a period of two years thereafter, the Department of Health and Human Services shall not approve any county's request to withdraw from a multicounty area authority operating under the 1915 (b)/(c) Medicaid Waiver. Not later than January 1, 2014, the Secretary shall adopt rules to establish a process for county disengagement that shall at a minimum ensure the following:

(1) Provisions of service are not disrupted by the disengagement.

(2) The disengaging county is either in compliance or plans to merge with an area authority that is in compliance with population requirements provided in G.S. 122C-155(a).

(3) The timing of the disengagement is accounted for and does not conflict with setting capitation rates.

(4) Adequate notice is provided to the affected counties, the Department of Health and Human Services, and the General Assembly.

(5) Provisions for distribution of any real property no longer within the catchment area of the area authority.

SECTION 7.(b) G.S. 122C-112.1 is amended by adding a new subdivision to read:

"(38) Adopt rules establishing a procedure for single-county disengagement from an area authority operating under a 1915 (b)/(c) Medicaid Waiver."

SECTION 8. G.S. 122C-147(c) reads as rewritten:

"§ 122C-147. Financing and title of area authority property.

...

(c) All real property purchased for use by the area authority shall be provided by local or federal funds unless otherwise allowed under subsection (b) of this section or by specific capital funds appropriated by the General Assembly. The title to this real property and the authority to acquire it is held by the ~~county where the property is located. The authority to hold title to real property and the authority to acquire it, including the area authority's authority to finance its acquisition by an installment contract under G.S. 160A-20, may be held by the area authority or by the contracting governmental entity with the approval of the board or boards of commissioners of all the counties that comprise the area authority. The approval of a board of county commissioners shall be by resolution of the board and may have any necessary or proper conditions, including provisions for distribution of the proceeds in the event of disposition of the property by the area authority.~~ area authority. Real property may not be acquired by means of an installment contract under G.S. 160A-20 unless the Local Government

Commission has approved the acquisition. No deficiency judgment may be rendered against any unit of local government in any action for breach of a contractual obligation authorized by this subsection, and the taxing power of a unit of local government is not and may not be pledged directly or indirectly to secure any moneys due under a contract authorized by this subsection.

...."

SECTION 9.(a) G.S. 122C-117 reads as rewritten:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

...

(7) Appoint an area director in accordance with G.S. 122C-121(d). ~~The appointment is subject to the approval of the board of county commissioners except that one or more boards of county commissioners may waive its authority to approve the appointment. The appointment shall be based on a selection by a search committee of the area authority board. The search committee shall include consumer board members, a county manager, and one or more county commissioners. The Secretary shall have the option to appoint one member to the search committee.~~

...

(17) Have the authority to borrow money with the approval of the Local Government Commission.

...

(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. The county finance officer shall provide the quarterly report to the board of county commissioners at the next regularly scheduled meeting of the board. The clerk of the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period of time. This information shall be ~~presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners.~~delivered to the county and, at the request of the board of county commissioners, may be presented in person by the area director or the director's designee.

...."

SECTION 9.(b) G.S. 122C-115.2 is amended by adding a new subsection to read:

"(e) The Secretary may waive any requirements of this section that are inconsistent with or incompatible with contracts entered into between the Department and the area authority for the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver."

SECTION 10. Part 2 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-126.1. Confidentiality of competitive health care information.**

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of the area authority. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of an area authority shall be a public record, unless otherwise exempted by law, or the contract contains

competitive health care information, the determination of which shall be as provided in subsection (b) of this section.

(b) If an area authority is requested to disclose any contract that the area authority believes in good faith contains or constitutes competitive health care information, the area authority may either redact the portions of the contract believed to constitute competitive health care information prior to disclosure or, if the entire contract constitutes competitive health care information, refuse disclosure of the contract. The person requesting disclosure of the contract may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decision by the court shall be whether the contract, or portions of the contract withheld, constitutes competitive health care information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure. Before rendering a decision, the court shall review the contract in camera and hear arguments from the parties. If the court finds that the contract constitutes or contains competitive health care information, the court may either deny disclosure or may make such other appropriate orders as are permitted under Rule 26(c) of the Rules of Civil Procedure.

(c) Nothing in this section shall be deemed to prevent the Attorney General, the State Auditor, or an elected public body, in closed session, which has responsibility for the area authority, from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information."

SECTION 11.(a) G.S. 126-5(a) reads as rewritten:

"**§ 126-5. Employees subject to Chapter; exemptions.**

(a) The provisions of this Chapter shall apply to:

(1) All State employees not herein exempt, and

(2) All employees of the following local entities:

a. Area mental health, developmental disabilities, and substance abuse ~~authorities.~~authorities except as otherwise provided in Chapter 122C of the General Statutes.

b. Local social services departments.

c. County health departments and district health departments.

d. Local emergency management agencies that receive federal grant-in-aid funds.

An employee of a consolidated county human services agency created pursuant to G.S. 153A-77(b) is not considered an employee of an entity listed in this subdivision.

(3) County employees not included under subdivision (2) of this subsection as the several boards of county commissioners may from time to time determine."

SECTION 11.(b) G.S. 122C-154 reads as rewritten:

"**§ 122C-154. Personnel.**

Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. Employees appointed by the county program director are employees of the county. In a multicounty program, employment of county program staff shall be as agreed upon in the interlocal agreement adopted pursuant to G.S. 122C-115.1. Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the employee. The

area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 11.(c) G.S. 122C-121(a1) reads as rewritten:

"(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. ~~An area board may request an adjustment to the salary ranges under G.S. 126-9(b). The request shall include specific information supporting the need for the adjustment, including comparative salary and patient caseload data for other LMEs, and shall also include the specific amount the area board proposes to pay the director. The area board shall not request a salary adjustment that is more than ten percent (10%) above the normal allowable salary range as determined by the State Personnel Commission.~~"Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the director. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 12.(a) G.S. 153A-76 reads as rewritten:

"**§ 153A-76. Board of commissioners to organize county government.**

The board of commissioners may create, change, abolish, and consolidate offices, positions, departments, boards, commissions, and agencies of the county government, may impose ex officio the duties of more than one office on a single officer, may change the composition and manner of selection of boards, commissions, and agencies, and may generally organize and reorganize the county government in order to promote orderly and efficient administration of county affairs, subject to the following limitations:

(1) The board may not abolish an office, position, department, board, commission, or agency established or required by law.

(2) The board may not combine offices or confer certain duties on the same officer when this action is specifically forbidden by law.

(3) The board may not discontinue or assign elsewhere a function or duty assigned by law to a particular office, position, department, board, commission, or agency.

(4) The board may not change the composition or manner of selection of a local board of education, ~~the board of health, the board of social services,~~the board of elections, or the board of alcoholic beverage control.

(5) The board may not consolidate an area mental health, developmental disabilities, and substance abuse board into a consolidated human services board. The board may not abolish an area mental health, developmental disabilities, and substance abuse board, except as provided in Chapter 122C of the General Statutes."

SECTION 12.(b) G.S. 153A-77 reads as rewritten:

"**§ 153A-77. Authority of boards of commissioners in certain counties over commissions, boards, agencies, etc.**

(a) In the exercise of its jurisdiction over commissions, boards and agencies, the board of county commissioners may assume direct control of any activities theretofore conducted by or through any commission, board or agency by the adoption of a resolution assuming and conferring upon the board of county commissioners all powers, responsibilities and duties of any such commission, board or agency. This ~~subsection~~section shall apply to the board of health, the social services board, area mental health, developmental disabilities, and substance abuse area board ~~and~~or any other commission, board or agency appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners of said county except as provided in G.S. 153A-76. A board of county

commissioners exercising the power and authority under this subsection may, notwithstanding G.S. 130A-25, enforce public health rules adopted by the board through the imposition of civil penalties. If a public health rule adopted by a board of county commissioners imposes a civil penalty, the provisions of G.S. 130A-25 making its violation a misdemeanor shall not be applicable to that public health rule unless the rule states that a violation of the rule is a misdemeanor. The board of county commissioners may exercise the power and authority herein conferred only after a public hearing held by said board pursuant to 30 days' notice of said public hearing given in a newspaper having general circulation in said county.

The board of county commissioners may also appoint advisory boards, committees, councils and agencies composed of qualified and interested county residents to study, interpret and develop community support and cooperation in activities conducted by or under the authority of the board of county commissioners of said county.

(b) In the exercise of its jurisdiction over commissions, boards, and agencies, the board of county commissioners of a county having a county manager pursuant to G.S. 153A-81 may:

(1) Consolidate ~~the provision~~certain provisions of human services in the county under the direct control of a human services director appointed and supervised by the county manager in accordance with subsection (e) of this section;

(2) Create a consolidated human services board having the powers conferred by subsection (c) of this section;

(3) Create a consolidated county human services agency having the authority to carry out the functions of any combination of commissions, boards, or agencies appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners, including the local health department, the county department of social services, ~~and~~or the area mental health, developmental disabilities, and substance abuse services authority; and

(4) Assign other county human services functions to be performed by the consolidated human services agency under the direction of the human services director, with policy-making authority granted to the consolidated human services board as determined by the board of county commissioners.

(c) A consolidated human services board appointed by the board of county commissioners shall serve as the policy-making, rule-making, and administrative board of the consolidated human services agency. The consolidated human services board shall be composed of no more than 25 members. The composition of the board shall reasonably reflect the population makeup of the county and shall include:

(1) Eight persons who are consumers of human services, public advocates, or family members of clients of the consolidated human services agency, including: one person with mental illness, one person with a developmental disability, one person in recovery from substance abuse, one family member of a person with mental illness, one family member of a person with a developmental disability, one family member of a person with a substance abuse problem, and two consumers of other human services.

(1a) Notwithstanding subdivision (1) of this subsection, a consolidated human service board not exercising powers and duties of an area mental health, developmental disabilities, and substance abuse services board shall include four persons who are consumers of human services.

(2) Eight persons who are professionals, each with qualifications in one of these categories: one psychologist, one pharmacist, one engineer, one dentist, one optometrist, one veterinarian, one social worker, and one registered nurse.

(3) Two physicians licensed to practice medicine in this State, one of whom shall be a psychiatrist.
(4) One member of the board of county commissioners.
(5) Other persons, including members of the general public representing various occupations.

The board of county commissioners may elect to appoint a member of the consolidated human services board to fill concurrently more than one category of membership if the member has the qualifications or attributes of more than one category of membership.

All members of the consolidated human services board shall be residents of the county. The members of the board shall serve four-year terms. No member may serve more than two consecutive four-year terms. The county commissioner member shall serve only as long as the member is a county commissioner.

The initial board shall be appointed by the board of county commissioners upon the recommendation of a nominating committee comprised of members of the preconsolidation board of health, social services board, and area mental health, developmental disabilities, and substance abuse services board. In order to establish a uniform staggered term structure for the board, a member may be appointed for less than a four-year term. After the subsequent establishment of the board, its board shall be appointed by the board of county commissioners from nominees presented by the human services board. Vacancies shall be filled for any unexpired portion of a term.

A chairperson shall be elected annually by the members of the consolidated human services board. A majority of the members shall constitute a quorum. A member may be removed from office by the county board of commissioners for (i) commission of a felony or other crime involving moral turpitude; (ii) violation of a State law governing conflict of interest; (iii) violation of a written policy adopted by the county board of commissioners; (iv) habitual failure to attend meetings; (v) conduct that tends to bring the office into disrepute; or (vi) failure to maintain qualifications for appointment required under this subsection. A board member may be removed only after the member has been given written notice of the basis for removal and has had the opportunity to respond.

A member may receive a per diem in an amount established by the county board of commissioners. Reimbursement for subsistence and travel shall be in accordance with a policy set by the county board of commissioners. The board shall meet at least quarterly. The chairperson or three of the members may call a special meeting.

(d) The consolidated human services board shall have authority to:
(1) Set fees for departmental services based upon recommendations of the human services director. Fees set under this subdivision are subject to the same restrictions on amount and scope that would apply if the fees were set by a county board of health, a county board of social services, or a mental health, developmental disabilities, and substance abuse area authority.
(2) Assure compliance with laws related to State and federal programs.
(3) Recommend creation of local human services programs.
(4) Adopt local health regulations and participate in enforcement appeals of local regulations.
(5) Perform regulatory health functions required by State law.
(6) Act as coordinator or agent of the State to the extent required by State or federal law.
(7) Plan and recommend a consolidated human services budget.
(8) Conduct audits and reviews of human services programs, including quality assurance activities, as required by State and federal law or as may otherwise be necessary periodically.
(9) Advise local officials through the county manager.

(10) Perform public relations and advocacy functions.
(11) Protect the public health to the extent required by law.
(12) Perform comprehensive mental health services ~~planning.~~planning if the county is exercising the powers and duties of an area mental health, developmental disabilities, and substance abuse services board under the consolidated human services board.
(13) Develop dispute resolution procedures for human services contractors and clients and public advocates, subject to applicable State and federal dispute resolution procedures for human services programs, when applicable.

Except as otherwise provided, the consolidated human services board shall have the powers and duties conferred by law upon a board of health, a social services board, and an area mental health, developmental disabilities, and substance abuse services board.

Local employees who serve as staff of a consolidated county human services agency are subject to county personnel policies and ordinances only and are not subject to the provisions of the State Personnel ~~Act.~~Act, unless the county board of commissioners elects to subject the local employees to the provisions of that Act. All consolidated county human services agencies shall comply with all applicable federal laws, rules, and regulations requiring the establishment of merit personnel systems.

(e) The human services director of a consolidated county human services agency shall be appointed and dismissed by the county manager with the advice and consent of the consolidated human services board. The human services director shall report directly to the county manager. The human services director shall:

(1) Appoint staff of the consolidated human services agency with the county manager's approval.
(2) Administer State human services programs.
(3) Administer human services programs of the local board of county commissioners.
(4) Act as secretary and staff to the consolidated human services board under the direction of the county manager.
(5) Plan the budget of the consolidated human services agency.
(6) Advise the board of county commissioners through the county manager.
(7) Perform regulatory functions of investigation and enforcement of State and local health regulations, as required by State law.
(8) Act as an agent of and liaison to the State, to the extent required by law.

Except as otherwise provided by law, the human services director or the director's designee shall have the same powers and duties as a social services director, a local health director, ~~and~~or a director of an area mental health, developmental disabilities, and substance abuse services authority.

~~(f) This section applies to counties with a population in excess of 425,000.~~"

SECTION 13.(a) G.S. 122C-122 is repealed.

SECTION 13.(b) G.S. 35A-1202(4) reads as rewritten:

"**§ 35A-1202. Definitions.**

When used in the Subchapter, unless a contrary intent is indicated or the context requires otherwise:

...

(4) "Disinterested public agency" ~~means:~~means
~~a.~~ ~~The~~the director or assistant directors of a ~~local human services agency, or~~county department of social services.
~~b.~~ ~~An adult officer, agent, or employee of a State human services agency. The~~Except as provided in G.S. 35A-1213(f), the fact that a disinterested public agent ~~is employed by a State or local human~~

~~services agency that~~ provides financial assistance, services, or treatment to a ward does not disqualify that person from being appointed as guardian.

...."

SECTION 13.(c) G.S. 35A-1213 reads as rewritten:

"**§ 35A-1213. Qualifications of guardians.**

(a) The clerk may appoint as guardian an adult individual, a corporation, or a disinterested public agent. The applicant may submit to the clerk the name or names of potential guardians, and the clerk may consider the recommendations of the next of kin or other persons.

(b) A nonresident of the State of North Carolina, to be appointed as general guardian, guardian of the person, or guardian of the estate of a North Carolina resident, must indicate in writing his willingness to submit to the jurisdiction of the North Carolina courts in matters relating to the guardianship and must appoint a resident agent to accept service of process for the guardian in all actions or proceedings with respect to the guardianship. Such appointment must be approved by and filed with the clerk, and any agent so appointed must notify the clerk of any change in the agent's address or legal residence. The clerk shall require a nonresident guardian of the estate or a nonresident general guardian to post a bond or other security for the faithful performance of the guardian's duties. The clerk may require a nonresident guardian of the person to post a bond or other security for the faithful performance of the guardian's duties.

(c) A corporation may be appointed as guardian only if it is authorized by its charter to serve as a guardian or in similar fiduciary capacities. A corporation shall meet the requirements outlined in Chapters 55 and 55D of the General Statutes. A corporation will provide a written copy of its charter to the clerk of superior court. A corporation contracting with a public agency to serve as guardian is required to attend guardianship training and provide verification of attendance to the contracting agency.

(d) A disinterested public agent who is appointed by the clerk to serve as guardian is authorized and required to do so; provided, if at the time of the appointment or any time subsequent thereto the disinterested public agent believes that his role or the role of his agency in relation to the ward is such that his service as guardian would constitute a conflict of interest, or if he knows of any other reason that his service as guardian may not be in the ward's best interest, he shall bring such matter to the attention of the clerk and seek the appointment of a different guardian. A disinterested public agent who is appointed as guardian shall serve in that capacity by virtue of his office or employment, which shall be identified in the clerk's order and in the letters of appointment. When the disinterested public agent's office or employment terminates, his successor in office or employment, or his immediate supervisor if there is no successor, shall succeed him as guardian without further proceedings unless the clerk orders otherwise.

(e) Notwithstanding any other provision of this section, an employee of a treatment facility, as defined in G.S. 35A-1101(16), may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works; provided, this subsection shall not apply to or affect the validity of any appointment of a guardian that occurred before October 1, 1987.

(f) An individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve as a guardian for a ward for whom the individual is providing such services."

SECTION 13.(d) G.S. 35A-1292(a) reads as rewritten:

"**§ 35A-1292. Resignation.**

(a) Any guardian who wishes to resign ~~may apply in writing to the clerk,~~shall file a motion with the clerk, setting forth the circumstances of the case. If a general guardian or guardian of the estate, at the time of making the application, also exhibits his final account for

settlement, and if the clerk is satisfied that the guardian has fully accounted, the clerk may accept the resignation of the guardian and discharge him and appoint a successor ~~guardian, but the~~guardian. The guardian so discharged and his sureties are still liable in relation to all matters connected with the guardianship before the ~~discharge.~~discharge and shall continue to ensure that the ward's needs are met until the clerk officially appoints a successor. The guardian shall attend the hearing to modify the guardianship, if physically able."

SECTION 13.(e) In order to achieve continuity of care and services, any successor guardian shall make diligent efforts to continue existing contracts entered into under the authority of G.S. 122C-122 where consistent with the best interest of the ward as required by Chapter 35A of the General Statutes.

SECTION 14. This act is effective when it becomes law.

SENATE BILL 875: LME Governance

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	May 28, 2012
Introduced by:	Sen. Pate	**Prepared by:**	Shawn Parker Committee Counsel
Analysis of:	First Edition		

SUMMARY: Senate Bill 875 amends the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 and other statutes to address identified barriers to the implementation of Statewide expansion of the 1915(b)/(c) Medicaid Waiver as recommended by the Joint Legislative Oversight Committee on Health and Human Services.

[As introduced, this bill was identical to H1075, as introduced by Reps. Dollar, Burr, which is currently in House Health and Human Services.]

CURRENT LAW: 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. Further, State and local governments are directed to develop and maintain a unified system of services centered in area authorities or county programs.[i]

Session Law 2011-264 (HB 916) directed the Department of Health and Human Services to restructure the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders by expanding operation of 1915(b)/(c) Medicaid Waivers statewide. The 1915(b) authority limits freedom of choice, and 1915(c) authority targets eligibility for the program and provides home and community-based services. States must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver.

BILL ANALYSIS:

Sections 1 and 2 provide **that** all area authorities are considered local political subdivisions of the State and that a county's responsibility for the provision of mh/dd/sa services includes adhering to rules, policies, and guidelines developed pursuant to a statewide expansion of a 1915(b)/(c) Medicaid Waiver.

Section 3 directs the Boards of County Commissioners within an area authority's catchment to appoint an area board that consists of no fewer than 11 and no more than 21 voting members, of which the following categories must be represented:

- *At least one county commissioner*
- *The chair of the Consumer and Family Advisory Committee (CFAC)*
- *A family member who is also a member of CFAC*
- *A consumer who is also a member of CFAC*
- *A person with healthcare expertise and experience in mh/dd/sas*
- *A person with social service expertise and experience in mh/dd/sas*
- *A person with financial experience consistent with scale and nature of MCO*
- *A person with insurance experience consistent with scale and nature of MCO*
- *An attorney with health care experience*
- *A Member of public not employed/affiliated with DHHS- appointed by Secretary*
- *The President of LME/MCO Provider Council or Designee (as non-voting- limited to open session)*

Members shall serve up to three consecutive three-year terms. The bill adds a provision to account for excessive absences. All area boards are to be in compliance by July 1, 2013. The Secretary is directed to appoint members consistent with the statute in the event a board of county commissioners fails to appoint each required category of membership.

Section 4 directs annual training for board members to include at a minimum training in fiscal management, budget development, and fiscal accountability. The bill directs the Department in cooperation with the School of Government and LMEs to develop a standard curriculum for this training.

Section 5 authorizes a third term for members of a local CFAC to avoid conflicting with membership requirements of an area board.

Section 6 allows an LME to add counties to its catchment area without unanimous approval of every county within the current LME catchment area.

Section 7 provides a 2-year moratorium on single-county withdrawal from an LME. Further, the Secretary is directed to adopt rules for county disengagement that account for undisrupted services, catchment population requirements, capitation rates, and distribution of real property.

Section 8 authorizes an LME to hold title to real property. *Currently this requires approval from the board of commissioners from each county that comprises the area authority.*

Section 9 removes county commissioner approval for appointing an area director and explicitly gives an LME the authority to borrow money subject to the approval of the Local Government Commission. The section changes the manner in which quarterly fiscal reports are presented and allows the Secretary to waive any inconsistent or incompatible requirements of an LME's business plan based on active contracts to operate a 1915(b)/(c) waiver.

Section 10 provides that competitive health care information is not a public record under Chapter 132 and allows an LME acting in good faith to redact information believed to contain such information or not release the record. If the record is not released, the provision describes a process for judicial intervention.

Section 11 allows a board to approve salaries for directors and employees in excess of ranges established by the State Personnel Commission when supported by documentation of comparable salaries in comparable operations within the region approved by the Secretary.

Section 12 removes the minimum population threshold of 425, 000 to allow any county's board of county commissioners to assume direct control of certain human service entities appointed by or acting under the authority of the board of county commissioners. The section clarifies a consolidation can be a combination of such entities. However, future consolidation of mh/dd/sas boards is prohibited. The section requires all consolidated human service agencies to comply with federal law requiring the establishment of a merit personnel system, and allows the board of commissioners to elect to subject employees who serve as staff to the consolidated human service agency to the provisions of the State Personnel Act.

Section 13 repeals the provision of law authorizing qualified area directors, officers, or employees of an area authority to serve as a guardian for adults adjudicated incompetent under Chapter 35A. The section redefines *disinterested public agent* to mean the director or assistant director of a county department of social services (was local human services agency). Further, the section adds training requirements for corporations contracting with the disinterested public agent and prohibits providers from serving as guardians to individuals to whom it also provides mh/dd/sa services pursuant to a contract with the LME.

EFFECTIVE DATE: This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee

May 30, 2012
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ben Hamm	NCSNA
Jonnine Stevens	NCNA
Paula Carfisherman	Volunteer Advocate - Sister w/ MR/DD
Ann Rodriguez	NC Council of Community Programs
Peg O'Connell	NC Pub Health Assoc
Jennifer Maham	ASNC
Milissa Markiewicz	NCIPH - UNC
Pam Shipman	PBH
Beth Melchor	DHHS
Evelyn Hawthorne	ETTOR
Jessa Goodman	DHHS/DMHDDSAS
Barbara Ryan	DHHS/DMHDDSAS

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ken Melvin	Benchmarks
Jack Walker	Eastern Seal UCP
Suzanne Merrill	DHHS/DAAS
Penni's Streets	DHHS/DAAS
Kelly Crosbie	DHHS/DMA
Tracy Hayes	N.C. DOJ on behalf of DHHS
Denise Foreman	Wake County
Kay Parsay	NASW-NC
Laurel Sisler	NASW-NC
Ashley Perkinson	Perkinson Law Firm
Meredith Lawler	The Policy Group

VISITOR REGISTRATION SHEET

Mental Health & Youth Services — 5-30-12

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Brice Bryant	Caring Touch
Torri Bryant	SRMH-caring Touch
Sarah Wolfe	MWC
Yvonne Copeland	NC Council of Comm Programs
BRIAN INGRAHAM	SMOKY MTN CENTER
Christina Carter	SMOKY MTN CENTER
Mary and Katie SHORT	Parent/Consumer
Jim Edgerton	Alliance Behavioral Health Care
George Corvin MD	Alliance Behavioral Healthcare
Louise Fisher	Volunteer Advocate for Mentally Ill

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee   Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mebane Bash	NCCPPR
Susanna Hailey	K&L Gates
Anne Matthews	UNC Public Health
[illegible]	NCACC
[illegible]	[illegible]
[illegible]	[illegible]
Kelly Nicholson	UNC Health Care
Colleen Kochanek	NCCEP
Corey Davis	UNC Public Health
Steve Jordan	DMHDDSAS
[illegible]	[illegible]
[illegible]	[illegible]

Name	Firm / Agency
JOEL MUNARO	GPM ; 1888C
ROSE HOBEN	NC Herald News
Jon Lee	Jordan Publications
Jan Ramquist	NCIMS

SENATE MENTAL HEALTH & YOUTH SERVICES COMMITTEE
Wednesday, June 6, 2012 at 11:00 to 1:00
Room 544, Legislative Office Building

MINUTES

The Senate Mental Health & Youth Services Committee met at 11:00 on June 6, 2012, in Room 414 of the Legislative Office Building with thirteen members of the committee present. Senator Fletcher Hartsell, Chair, presided.

Senator Hartsell introduced pages Alyssa Smith, Ruth Jackson, Catherine Blalock and Lavell Williams and thanked them for their service. He also recognized the Sergeant-at-Arms and thanked them.

Senator Hartsell noted that the agenda had been modified and that in lieu of SB 825 the committee would be hearing House 1075, the companion to SB 825.

HB 423 – Enact First Evaluation Program. Senator Hartsell noted there was a Proposed Committee Substitute and Senator Jackson moved that it be adopted. All voted and the motion carried. The Proposed Committee Substitute changed the title to: Adult Care Home Pilot/Buncombe County. Senator Apodaca explained the bill after which Senator Nesbitt gave comments. Senator Hartsell and Mr. Shawn Parker, Staff Attorney, gave additional explanation. Senator Carney moved for a favorable report of the Proposed Committee Substitute, unfavorable to the original bill. All voted and the motion carried.

HB 1075 – LME/MCO Governance. Senator Hartsell noted again that HB 1075 was in lieu of SB 825 and also noted the copy of a letter written by Attorney Michael W. Taylor that was in regard to contract issues. (Attachment I) Senator Tucker moved to adopt the Proposed Committee Substitute for purposes of discussion. All voted and the motion carried. Senator Hartsell explained the letter and asked the Committee and the Department of Health and Human Services to review the letter and then asked the Department to respond within a week. Senator Hartsell gave an overall explanation of the bill and recognized Representative Dollar for in-depth explanation. Representative Dollar answered questions from Senator Purcell and Senator Nesbitt made comments. Senator Tucker presented and explained an amendment. Senator Carney moved to adopt the amendment. All voted and the motion carried. Senator Hartsell asked Mr. Parker, Staff Attorney, and Dr. Pat Porter, Senate and House Mental Health Advisor, to explain the sections of the bill and answer questions. He also noted that each section would be discussed in order. At the finish of the explanation and discussion of section nine , and in view of the approaching recess, Representative Dollar and Senator Hartsell made closing statements. Senator Hartsell called for a recess and stated that the Committee would reconvene at fifteen minutes after Session at which time the Committee would hear the remainder of HB 1075 and complete the calendar. The Committee was then recessed.

AFTERNOON SESSION – June 6, 2012 – Reconvening of recessed meeting.

Senator Hartsell opened the afternoon meeting with eight members attending and thanked pages Alyssa Smith, Ruth Jackson, Catherine Blalock and Lavell Williams for their assistance. He

noted that HB 423 was heard at the morning session. Senator Tucker, after having voted with the majority in the morning session, moved to reconsider the vote by which the Proposed Committee Substitute was approved. All voted and the motion carried. Senator Hartsell offered an amendment and explained the amendment. Senator Allran was asked to chair. Senator Carney's question was answered by Mr. Donnie Charleston from Fiscal Research. Mr. Parker from Research gave additional explanation. Senator Nesbitt moved to adopt the amendment. All voted and the motion carried. Senator Hartsell resumed the Chair. Senator Jackson moved to approve the Proposed Committee Substitute as amended, rolled into a new Proposed Committee Substitute, unfavorable to the original bill. All voted and the motion carried.

HB 1055 – Eliminate LME Provider Endorsement.-AB Representative Dollar explained the bill and Mr. Parker gave additional explanation. Senator Jackson moved for a favorable report. All voted and the motion carried.

HB 1056 – Partnership for Children Participant Records. Senator Nesbitt offered a brief explanation. Senator Davis moved for a favorable report. All voted and the motion carried.

HB 1081 – Provisional Licensure Changes Medicaid.-AB Representative Dollar explained the bill. Senator Tucker moved for a favorable report. All voted and the motion carried.

HB 1075 – LME/MCO Governance. The Committee resumed discussion on SB 1075 starting at section ten. Each additional section through section fifteen was discussed with explanations and answers provided by Mr. Parker, Senator Hartsell, Representative Dollar and Ms. Pam Shipman, Deputy Area Director/Chief Operations Officer of Piedmont Behavioral Health. Senator Tucker offered and explained an amendment to section eleven. Representative Dollar accepted the amendment and Senator Davis moved for adoption. All voted and the motion carried. As the Committee felt that they needed more time for discussion of the bill, the decision was made to meet again the following morning. Senator Hartsell noted that the Committee would reconvene at 9:30 the following morning, June 7, 2012, in room 414 of the Legislative Office Building.

There being no further business, the committee was adjourned.

Fletcher L. Hartsell, Jr., Presiding

Gerry Johnson, Committee Assistant

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	June 6, 2012	11:00 to 1:00	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 423*	Enact First Evaluation Program.	Representative Hurley Representative Moffitt Senator Apodaca
SB 875	LME Governance.	Senator Pate

***HB 423 is a PCS – New Title: Adult Care Home Pilot/Buncombe County**

1. Discussion on the implementation of SL 2011-264 Statewide Expansion of 1915 (b)/(c) Waiver
2. Discussion on LME/MCO Hospital Contracts

Senator Fletcher L. Hartsell, Jr., Chair

Senate Mental Health & Youth Services Committee
Wednesday, June 6, 2012, 11:00 to 1:00
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 423*	Enact First Evaluation Program.	Representative Hurley Representative Moffitt Senator Apodaca
SB 875	LME Governance.	Senator Pate

*HB 423 is a PCS – New Title: Adult Care Home Pilot/Buncombe County

Presentations

Other Business

1. Discussion on the implementation of SL 2011-264 Statewide Expansion of 1915 (b)/(c) Waiver
2. Discussion on LME/MCO Hospital Contracts

Adjournment

Principal Clerk
Reading Clerk

Corrected: Please notice Time Change

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	June 6, 2012	12:00 to 2:00	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 423	Enact First Evaluation Program.	Representative Hurley
SB 875	LME Governance.	Senator Pate

Please notice Time Change

Senator Fletcher L. Hartsell, Jr., Chair

Principal Clerk ____
Reading Clerk ____

Corrected: CORRECTION #2 - Please note room and time change

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	June 6, 2012	12:00 to 2:00	414 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 423*	Enact First Evaluation Program.	Representative Hurley Representative Moffitt Senator Apodaca
SB 875	LME Governance.	Senator Pate

*HB 423 is a PCS – New Title: Adult Care Home Pilot/Buncombe County

1. Discussion on the implementation of SL 2011-264 Statewide Expansion of 1915 (b)/(c) Waiver
2. Discussion on LME/MCO Hospital Contracts

CORRECTION #2 - Please note room change

Senator Fletcher L. Hartsell, Jr., Chair

Principal Clerk ____
Reading Clerk ____

Corrected: CORRECTION #3 - Bills added HB 1055 and 1075 and Title change for H423

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	June 6, 2012	12:00 to 2:00	414 LOB

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BILL NO.	SHORT TITLE	SPONSOR
HB 423	Enact First Evaluation Program*	Representative Hurley
SB 875	LME Governance.	Senator Pate
HB 1075	LME/MCO Governance.	Representative Dollar Representative Burr
HB 1056	Partnership for Children Participant Records.	Representative Dollar Representative Burr

*Ch. Protect.Serv.Ch.Care Sub/Rent Exempt.

1. Discussion on the implementation of SL 2011-264 Statewide Expansion of 1915 (b)/(c) Waiver
2. Discussion on LME/MCO Hospital Contracts

CORRECTION #3 - Bills added HB 1055 and 1075 and Title change for H423

Senator Fletcher L. Hartsell, Jr., Chair

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H 3

HOUSE BILL 423
Committee Substitute Favorable 4/20/11
Committee Substitute #2 Favorable 5/10/11

Short Title: Enact First Evaluation Program. (Public)

Sponsors:

Referred to:

March 23, 2011

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ALLOW CERTAIN CERTIFIED PROVIDERS TO CONDUCT INITIAL (FIRST-LEVEL) EXAMINATIONS FOR INVOLUNTARY COMMITMENT OF INDIVIDUALS WITH MENTAL ILLNESS, IN A MANNER CONSISTENT WITH THE FIRST EVALUATION PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. Part 7 of Article 5 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-263.1 Secretary's authority to waive requirement of first examination by physician or eligible psychologist; training of certified providers performing first examinations.**

(a) The Secretary of Health and Human Services may, upon request of an LME, waive the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a master's level psychiatric nurse, or a master's level certified clinical addictions specialist in accordance with subdivision (8) of this subsection to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). In making this type of request, the LME shall specifically describe all of the following:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding all of the following:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver.

(4) A waiver granted by the Secretary under this section shall be in effect for a period of up to three years and may be rescinded at any time within this period if the Secretary finds the LME has failed to meet the requirements of this section.

(5) In no event shall the substitution of a licensed clinical social worker, master's level psychiatric nurse, or master's level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level psychiatric nurse, or the master's level certified clinical addictions specialist.

(6) The Department shall require that individuals performing initial examinations under the waiver have successfully completed the Department's standardized training program and examination. The Department shall maintain a list of these individuals on its Web site.

(7) As part of its waiver request, the LME shall document the availability of a physician to provide backup support.

(8) A master's level certified clinical addiction specialist shall only be authorized to conduct the initial examination of individuals meeting the criteria of G.S. 122C-281(a).

(b) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall expand its standardized certification training program to include refresher training for all certified providers performing initial examinations pursuant to subsection (a) of this section."

SECTION 2. Beginning January 1, 2012, each 24-hour residential facility that (i) falls under the category of non-hospital medical detoxification, facility-based crisis service, or inpatient hospital treatment, (ii) is not a State facility under the jurisdiction of the Secretary of Health and Human Services, and (iii) is designated by the Secretary of Health and Human Services as a facility for the custody and treatment of individuals under a petition of involuntary commitment pursuant to G.S. 122C-252 and 10A NCAC 26C .0101 shall submit a written report on involuntary commitments each January 1 and each July 1 to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall include all of the following:

(1) The number and primary presenting conditions of individuals receiving treatment from the facility under a petition of involuntary commitment.

(2) The number of individuals for whom an involuntary commitment proceeding was initiated at the facility, who were referred to a different facility or program.

(3) The reason for referring the individuals described in subdivision (2) of this section to a different facility or program, including the need for more intensive medical supervision.

SECTION 3. This act becomes effective October 1, 2011.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 423
Committee Substitute Favorable 4/20/11
Committee Substitute #2 Favorable 5/10/11
PROPOSED SENATE COMMITTEE SUBSTITUTE H423-CSTL-27 [v.4]

6/5/2012 5:57:15 PM

Short Title: Ch.Protect.Serv./Ch.Care Sub./Rent Exempt. (Public)

Sponsors:

Referred to:

March 23, 2011

A BILL TO BE ENTITLED

AN ACT TO (1) MAINTAIN COUNTY LEVEL EXPENDITURES IN LOCAL FUNDS FOR CHILD PROTECTIVE SERVICES' WORKERS; (2) USE 2011 DATA SOURCE FOR CHILD CARE SUBSIDY ALLOCATION FORMULA; AND, (3) EXEMPT CONTRACTS FOR THE RENTAL OF OFFICE SPACE THAT DO NOT CONSTITUTE A FINANCIAL RELATIONSHIP UNDER THE FEDERAL STARK ACT FROM THE CONFLICT OF INTEREST PROVISION OF THE HOSPITAL AUTHORITY ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Counties shall maintain their level of expenditures in local funds for Child Protective Services' workers. Of the block grant funds appropriated for Child Protective Services' workers, the total expenditures from State and local funds for the 2012-2013 fiscal year shall not be less than the total expended from State and local funds for the 2011-2012 fiscal year.

SECTION 2. Section 10.2(a) of S.L. 2011-145 is amended by adding the following new subdivisions to read:

"**SECTION 10.2.(a)** The Department of Health and Human Services shall allocate child care subsidy voucher funds to pay the costs of necessary child care for minor children of needy families. The mandatory thirty percent (30%) Smart Start subsidy allocation under G.S. 143B-168.15(g) shall constitute the base amount for each county's child care subsidy allocation. The Department of Health and Human Services shall use the following method when allocating federal and State child care funds, not including the aggregate mandatory thirty percent (30%) Smart Start subsidy allocation:

(1) Funds shall be allocated to a county based upon the projected cost of serving children under age 11 in families with all parents working who earn less than seventy-five percent (75%) of the State median income.

(2) No county's allocation shall be less than ninety percent (90%) of its State fiscal year 2001-2002 initial child care subsidy allocation.

(3) For fiscal year 2012-2013, the Division of Child Development and Early Education shall base the formula identified in subdivision (1) of this subsection on the same data source used for the 2011-2012 fiscal year.

(4) The Department of Health and Human Services shall allocate to counties all State funds appropriated for child care subsidy and shall not withhold funds during the 2012-2013 fiscal year."

SECTION 3. G.S. 131E-21 reads as rewritten:

"**§ 131E-21. Conflict of interest.**

(a) No commissioner or employee of the hospital authority or that person's spouse shall do either of the following:

(1) Acquire any interest, direct or indirect, in any hospital facility or in any property included or planned to be included in a hospital facility.

(2) Have any interest, direct or indirect, in any contract or proposed contract for materials or services to be furnished or used in connection with any hospital facility, except an employment contract for an employee. The foregoing restriction shall not apply to any contract, undertaking, or other transaction with a bank or banking institution, savings and loan association or public utility in the regular course of its business; Provided that any such contract, undertaking, or other transaction shall be authorized by the commissioners by specific resolution on which no commissioner having an interest, direct or indirect, shall vote.

(b) The fact that a person or that person's spouse owns ten percent (10%) or less stock of a corporation or has a ten percent (10%) or less ownership in any other business entity or is an employee of that corporation or other business entity does not make the person have an "interest, direct or indirect" as this phrase is used in subsection (a) of this section; provided that, in order for the exception to apply, the contract, undertaking or other transaction shall be authorized by the commissioners by specific resolution on which no commissioner or employee having an interest, direct or indirect, shall vote.

(c) If a commissioner or employee of an authority or that person's spouse owns or controls an interest, direct or indirect, in any property included or planned to be included in any hospital facility, the commissioner or employee shall immediately disclose the same in writing to the authority and the disclosure shall be entered upon the minutes of the authority. Failure to disclose shall constitute misconduct in office and shall be grounds for a commissioner's removal from office under G.S. 131E-22.

(d) Subsection (a) of this section shall not apply to any commissioner of a hospital authority if (i) the undertaking or contract or series of undertakings or contracts between the hospital authority and one of its officials is approved by specific resolution of the governing body adopted in an open and public meeting and recorded in its minutes and the amount does not exceed twelve thousand five hundred dollars ($12,500) for medically related services and twenty-five thousand dollars ($25,000) for other goods or services within a 12-month period; and (ii) the official entering into the contract or undertaking with the hospital authority does not in an official capacity participate in any way or vote.

(e) Subsection (a) of this section shall not apply to any employment relationship between a hospital authority and the spouse of a commissioner of the hospital authority.

(e1) Subsection (a) of this section shall not apply to any contract for the rental of office space made by a lessee to a lessor if the lease agreement meets the following requirements:

(1) The agreement is set out in writing, is signed by the parties, and specifies the premises it covers.

(2) The term of the agreement is at least one year. If the agreement is terminated during the term with or without cause, the parties may not enter into a new agreement during the first year of the original term of the agreement.

(3) The space leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease. The space shall not be shared with or used by the lessor or any person or entity related to the lessor, except

that the lessee may make payments for the use of space consisting of common areas if the payments do not exceed the lessee's pro rata share of expenses for the space based upon the ratio of the space used exclusively by the lessee to the total amount of space other than common areas occupied by all persons using the common areas.

(4) The rental charges over the term of the agreement are set in advance and are consistent with fair market value.

(5) The rental charges over the term of the agreement are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(6) The agreement would be commercially reasonable even if no referrals were made between the lessee and the lessor.

(7) A holdover month-to-month rental for up to 6 months immediately following an agreement of at least 1 year that met the conditions of subdivision (1) of this subsection shall be valid, provided the holdover rental is on the same terms and conditions as the immediately preceding agreement.

(f) A contract entered into in violation of this section is void. A contract that is void under this section may continue in effect until an alternative can be arranged when: (i) immediate termination would result in harm to the public health or welfare, and (ii) the continuation is approved as provided in this subsection. A hospital authority that is a party to the contract may request approval to continue contracts under this subsection from the chairman of the Local Government Commission. Approval of continuation of contracts under this subsection shall be given for the minimum period necessary to protect the public health or welfare.".

SECTION 4. This act is effective when it becomes law.

HOUSE BILL 423:
Ch.Protect.Serv.Ch.Care Sub./Rent Exempt.

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 6, 2012
Introduced by:	Rep. Hurley	**Prepared by:**	Shawn Parker Committee Counsel
Analysis of:	PCS to Third Edition H423-CSTL-27		Patsy Pierce Legislative Analyst

SUMMARY: ***The Senate Proposed Committee Substitute (PCS) completely rewrites House Bill 423 to include two Budget provisions that are currently in the House Budget (HB 950). One of the Budget provisions directs counties to maintain level of expenditures in local funds for Child Protective Services' workers. The other Budget provision directs the Department of Health and Human Services to use current data to develop the 2012-2013 child care subsidy fund distribution formula and to allocate all funds.***

The PCS also amends Chapter 108C "Medicaid and Health Choice Provider Requirements" by providing a definition for the phrase "failed to substantially comply and amends the conflict of interest provision of the Hospital Authorities Act by exempting certain contracts for the rental of office space that meet specific statutory requirements.

BILL ANALYSIS:

Section 1. This Budget provision directs counties to maintain their level of expenditures in local funds for Child Protective Services' workers.

Section 2. This Budget provision amends Section 10.2(a) of S.L. 2011-145 by directing the Division of Child Development and Early Education of the Department of Health and Human Services (Department) to base the formula for child care subsidy fund distribution in 2012-2013 on the same data source used for the current fiscal year. The Department is also directed to allocate all child care subsidy funds to counties, and not withhold funds, during the 2012-2013 fiscal year.

Section 3. This provision provides a definition of the phrase "failed to substantially comply" as based on a significantly significant and valid sample where 20% or more of the claims did not comply with State or federal law and met the federal definitnon of abuse as provided in 42 CFR 455.2. This would create a threshold amount for the term substantial, prior to DHHS being able to extrapolate certain data under its authority provided by the Chapter.

Section 4. This provision authorizes a commissioner or an employee of a hospital authority, or the spouse of a commissioner, or an employee to contract for the rental of office space with the hospital authority if the lease agreement meets requirements which are consistent with the office rental exemption provision of federal Stark law.

EFFECTIVE DATE: This act is effective when it becomes law.

CURRENT LAW and BACKGROUND:

Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn), also known as the physician self-referral law and commonly referred to as the "Stark Law" prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship. One of the provisions of the Stark Act, 42 C.F.R. 411.357 **(see below)** provides that a contract for the rental of property owned by an employee of a health care provider is not considered a financial relationship so long as certain provisions are followed, mainly that any rental payments are tied to fair market value. There are provisions under 131E-21 related to exempt contracts for goods and services for a certain dollar amount as well a disclosure requirements for commissioners who own property included or planned to be included in any hospital facility. This act would expressly certain exempt lease agreements.

42 C.F.R. § 411.357 Exceptions to the referral prohibition related to compensation arrangements.

For purposes of §411.353, the following compensation arrangements do not constitute a financial relationship:

(a) *Rental of office space.* Payments for the use of office space made by a lessee to a lessor if there is a rental or lease agreement that meets the following requirements:

(1) The agreement is set out in writing, is signed by the parties, and specifies the premises it covers.

(2) The term of the agreement is at least 1 year. To meet this requirement, if the agreement is terminated during the term with or without cause, the parties may not enter into a new agreement during the first year of the original term of the agreement.

(3) The space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee (and is not shared with or used by the lessor or any person or entity related to the lessor), except that the lessee may make payments for the use of space consisting of common areas if the payments do not exceed the lessee's pro rata share of expenses for the space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using the common areas.

(4) The rental charges over the term of the agreement are set in advance and are consistent with fair market value.

(5) The rental charges over the term of the agreement are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(6) The agreement would be commercially reasonable even if no referrals were made between the lessee and the lessor.

(7) A holdover month-to-month rental for up to 6 months immediately following an agreement of at least 1 year that met the conditions of this paragraph (a) will satisfy this paragraph (a), provided the holdover rental is on the same terms and conditions as the immediately preceding agreement.

Retrieved from http://law.justia.com/cfr/title42/42-2.0.1.2.11.10.35.8.html on 6/5/2012

HOUSE BILL 1075*
Committee Substitute Favorable 6/5/12

Short Title: LME/MCO Governance. (Public)

Sponsors:

Referred to:

May 24, 2012

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN GOVERNANCE OF LOCAL MANAGEMENT ENTITIES WITH RESPECT TO THE IMPLEMENTATION OF STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-115(a) reads as rewritten:

"**§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.**

(a) A county shall provide mental health, developmental disabilities, and substance abuse services in accordance with rules, policies, and guidelines adopted pursuant to statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver through an area authority or through a county program established pursuant to G.S. 122C-115.1. Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control."

SECTION 2.(a) G.S. 122C-116 reads as rewritten:

"**§ 122C-116. Status of area authority; status of consolidated human services agency.**

(a) An area authority is a local political subdivision of the ~~State except that a single county area authority is considered a department of the county in which it is located for the purposes of Chapter 159 of the General Statutes.~~State.

(b) A consolidated human services agency is a department of the county."

SECTION 2.(b) G.S. 122C-115.1(i) reads as rewritten:

"(i) Except as otherwise specifically provided, this Chapter applies to counties that provide mental health, developmental disabilities, and substance abuse services through a county program. As used in the applicable sections of this Article, the terms "area authority", "area program", and "area facility" shall be construed to include "county program". ~~The following sections of this Article do not apply to county programs:~~

~~(1) G.S. 122C-115.3, 122C-116, 122C-117, and 122C-118.1.~~

~~(2) G.S. 122C-119 and G.S. 122C-119.1.~~

~~(3) G.S. 122C-120 and G.S. 122C-121.~~

~~(4) G.S. 122C-127.~~

~~(5) G.S. 122C-147.~~
~~(6) G.S. 122C-152 and G.S. 122C-153.~~
~~(7) G.S. 122C-156.~~
~~(8) G.S. 122C-158.~~"

SECTION 3.(a) G.S. 122C-118.1 reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) ~~An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties may have up to 30 members. In a single-county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include two individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.~~ An area board shall have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or the boards of county commissioners within the area, shall appoint members consistent with the requirements provided in subsection (b) of this section. The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category. A member of the board may be removed with or without cause by the initial appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chairman of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) ~~Except as otherwise~~Within the maximum membership provided in ~~this subsection, not more than fifty percent (50%) of~~subsection (a) of this section, the ~~members~~membership of the area board shall reside within the catchment area and ~~represent the following:~~ be composed as follows:

(1) ~~A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.~~At least one member who is a current county commissioner.

(2) ~~A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.~~The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.

(3) At least one family member ~~or individual from a citizens' organization composed primarily of consumers or their family members,~~of the local

CFAC, as recommended by the local CFAC, representing the interests of ~~individuals:~~the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~In~~Individuals in recovery from ~~addiction; or~~addiction, or

c. ~~With~~ Individuals with intellectual or other developmental disabilities.

(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~With~~Individuals with intellectual or other developmental ~~disabilities; or~~disabilities, or

c. ~~In~~ Individuals in recovery from addiction.

(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.

(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.

(8) An individual with insurance expertise consistent with the scale and nature of the managed care organization.

(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(10) An attorney with health care expertise.

(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.

(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

~~An~~Except as provided in subdivision (12) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on an area authority board. Of the members described in subdivisions (2) through (4) of this subsection, the boards of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than two categories of membership if the member has the qualifications or attributes of the two categories of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the member's service as a county commissioner. Any member of an area board who is a county manager serves on the board at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the duration of the member's employment as a county manager. The terms of ~~the other~~members on the area board shall be for three years, except that upon the initial formation of an area board in compliance with subsection (a) of this section, one-third shall be appointed for one year, one-third for two years,

and all remaining members for three years. ~~Members, other than county commissioners and county managers,~~ Members shall not be appointed for more than ~~two~~three consecutive terms. ~~Board members serving as of July 1, 2006, may remain on the board for one additional term. This subsection applies to all area authority board members regardless of the procedure used to appoint members under subsection (a) of this section.~~

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes."

SECTION 3.(b) All area boards shall meet the requirements of G.S. 122C-118.1, as amended by subsection (a) of this section, no later than July 1, 2013.

SECTION 4.(a) G.S. 122C-119.1 reads as rewritten:

"**§ 122C-119.1. Area Authority board members' training.**

All members of the governing body for an area authority shall receive initial orientation on board members' responsibilities and annual training provided by the Department ~~in~~which shall include fiscal management, budget development, and fiscal accountability. A member's refusal to be trained shall be grounds for removal from the board."

SECTION 4.(b) The North Carolina Department of Health and Human Services, in cooperation with the School of Government and the local management entities, shall develop a standardized core curriculum for the training described in subsection (a) of this section.

SECTION 5. G.S. 122C-170(b) reads as rewritten:

"Part 4A. Consumer and Family Advisory Committees.

"**§ 122C-170. Local Consumer and Family Advisory Committees.**

...

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than ~~two~~three consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, developmental disabilities, and substance abuse services.

(2) Family members of consumers of mental health, developmental disabilities, and substance abuse services.

...."

SECTION 6. Area authorities may add one or more additional counties to their existing catchment area by agreement of a majority of the existing member counties.

SECTION 7.(a) Beginning July 1, 2012, and for a period of two years thereafter, the Department of Health and Human Services shall not approve any county's request to withdraw from a multicounty area authority operating under the 1915(b)/(c) Medicaid Waiver. Not later than January 1, 2014, the Secretary shall adopt rules to establish a process for county disengagement that shall at a minimum ensure the following:

(1) Provisions of service are not disrupted by the disengagement.

(2) The disengaging county is either in compliance or plans to merge with an area authority that is in compliance with population requirements provided in G.S. 122C-155(a).

(3) The timing of the disengagement is accounted for and does not conflict with setting capitation rates.

(4) Adequate notice is provided to the affected counties, the Department of Health and Human Services, and the General Assembly.

(5) Provisions for distribution of any real property no longer within the catchment area of the area authority.

SECTION 7.(b) G.S. 122C-112.1 is amended by adding a new subdivision to read:

"(38) Adopt rules establishing a procedure for single-county disengagement from an area authority operating under a 1915(b)/(c) Medicaid Waiver."

SECTION 8. G.S. 122C-147(c) reads as rewritten:

"**§ 122C-147. Financing and title of area authority property.**

...

(c) All real property purchased for use by the area authority shall be provided by local or federal funds unless otherwise allowed under subsection (b) of this section or by specific capital funds appropriated by the General Assembly. The title to this real property and the authority to acquire it is held by the ~~county where the property is located. The authority to hold title to real property and the authority to acquire it, including the area authority's authority to finance its acquisition by an installment contract under G.S. 160A-20, may be held by the area authority or by the contracting governmental entity with the approval of the board or boards of commissioners of all the counties that comprise the area authority. The approval of a board of county commissioners shall be by resolution of the board and may have any necessary or proper conditions, including provisions for distribution of the proceeds in the event of disposition of the property by the area authority.~~ area authority. Real property may not be acquired by means of an installment contract under G.S. 160A-20 unless the Local Government Commission has approved the acquisition. No deficiency judgment may be rendered against any unit of local government in any action for breach of a contractual obligation authorized by this subsection, and the taxing power of a unit of local government is not and may not be pledged directly or indirectly to secure any moneys due under a contract authorized by this subsection.

...."

SECTION 9.(a) G.S. 122C-117 reads as rewritten:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

...

(7) Appoint an area director in accordance with G.S. 122C-121(d). ~~The appointment is subject to the approval of the board of county commissioners except that one or more boards of county commissioners may waive its authority to approve the appointment. The appointment shall be based on a selection by a search committee of the area authority board. The search committee shall include consumer board members, a county manager, and one or more county commissioners. The Secretary shall have the option to appoint one member to the search committee.~~

...

(17) Have the authority to borrow money with the approval of the Local Government Commission.

...

(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. The county finance officer shall provide the quarterly report to the board of county commissioners at the next regularly scheduled meeting of the board. The clerk of the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period of time. This information shall be ~~presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners.~~delivered to the county and, at the request of the board of county commissioners, may be presented in person by the area director or the director's designee.

...."

SECTION 9.(b) G.S. 122C-115.2 is amended by adding a new subsection to read:

"(e) The Secretary may waive any requirements of this section that are inconsistent with or incompatible with contracts entered into between the Department and the area authority for the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver."

SECTION 10. Part 2 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-126.1. Confidentiality of competitive health care information.**

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of the area authority. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of an area authority shall be a public record, unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section.

(b) If an area authority is requested to disclose any contract that the area authority believes in good faith contains or constitutes competitive health care information, the area authority may either redact the portions of the contract believed to constitute competitive health care information prior to disclosure or, if the entire contract constitutes competitive health care information, refuse disclosure of the contract. The person requesting disclosure of the contract may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decision by the court shall be whether the contract, or portions of the contract withheld, constitutes competitive health care information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure. Before rendering a decision, the court shall review the contract in camera and hear arguments from the parties. If the court finds that the contract constitutes or contains competitive health care information, the court may either deny disclosure or may make such other appropriate orders as are permitted under Rule 26(c) of the Rules of Civil Procedure.

(c) Nothing in this section shall be deemed to prevent the Attorney General, the State Auditor, or an elected public body, in closed session, which has responsibility for the area authority, from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information."

SECTION 11.(a) G.S. 126-5(a) reads as rewritten:

"**§ 126-5. Employees subject to Chapter; exemptions.**

(a) The provisions of this Chapter shall apply to:

(1) All State employees not herein exempt, and

(2) All employees of the following local entities:

a. Area mental health, developmental disabilities, and substance abuse ~~authorities.~~authorities, except as otherwise provided in Chapter 122C of the General Statutes.

b. Local social services departments.

c. County health departments and district health departments.

d. Local emergency management agencies that receive federal grant-in-aid funds.

An employee of a consolidated county human services agency created pursuant to G.S. 153A-77(b) is not considered an employee of an entity listed in this subdivision.

(3) County employees not included under subdivision (2) of this subsection as the several boards of county commissioners may from time to time determine."

SECTION 11.(b) G.S. 122C-154 reads as rewritten:

"**§ 122C-154. Personnel.**

Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. Employees appointed by the county program director are employees of the county. In a multicounty program, employment of county program staff shall be as agreed upon in the interlocal agreement adopted pursuant to G.S. 122C-115.1. Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the employee. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 11.(c) G.S. 122C-121(a1) reads as rewritten:

"(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. ~~An area board may request an adjustment to the salary ranges under G.S. 126-9(b). The request shall include specific information supporting the need for the adjustment, including comparative salary and patient caseload data for other LMEs, and shall also include the specific amount the area board proposes to pay the director. The area board shall not request a salary adjustment that is more than ten percent (10%) above the normal allowable salary range as determined by the State Personnel Commission.~~Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the director. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 12.(a) G.S. 153A-76 reads as rewritten:

"**§ 153A-76. Board of commissioners to organize county government.**

The board of commissioners may create, change, abolish, and consolidate offices, positions, departments, boards, commissions, and agencies of the county government, may impose ex officio the duties of more than one office on a single officer, may change the composition and manner of selection of boards, commissions, and agencies, and may generally organize and reorganize the county government in order to promote orderly and efficient administration of county affairs, subject to the following limitations:

(1) The board may not abolish an office, position, department, board, commission, or agency established or required by law.

(2) The board may not combine offices or confer certain duties on the same officer when this action is specifically forbidden by law.

(3) The board may not discontinue or assign elsewhere a function or duty assigned by law to a particular office, position, department, board, commission, or agency.

(4) The board may not change the composition or manner of selection of a local board of education, ~~the board of health, the board of social services,~~the board of elections, or the board of alcoholic beverage control.

(5) A board may not consolidate an area mental health, developmental disabilities, and substance abuse services board into a consolidated human

services board. The board may not abolish an area mental health, developmental disabilities, and substance abuse board, except as provided in Chapter 122C of the General Statutes. This subdivision shall not apply to any board that has exercised the powers and duties of an area mental health, developmental disabilities, and substance abuse services board as of January 1, 2012."

SECTION 12.(b) G.S. 153A-77 reads as rewritten:

"**§ 153A-77. Authority of boards of commissioners in certain counties over commissions, boards, agencies, etc.**

(a) In the exercise of its jurisdiction over commissions, boards and agencies, the board of county commissioners may assume direct control of any activities theretofore conducted by or through any commission, board or agency by the adoption of a resolution assuming and conferring upon the board of county commissioners all powers, responsibilities and duties of any such commission, board or agency. This ~~subsection~~section shall apply to the board of health, the social services board, area mental health, developmental disabilities, and substance abuse area board ~~and~~or any other commission, board or agency appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners of said county except as provided in G.S. 153A-76. A board of county commissioners exercising the power and authority under this subsection may, notwithstanding G.S. 130A-25, enforce public health rules adopted by the board through the imposition of civil penalties. If a public health rule adopted by a board of county commissioners imposes a civil penalty, the provisions of G.S. 130A-25 making its violation a misdemeanor shall not be applicable to that public health rule unless the rule states that a violation of the rule is a misdemeanor. The board of county commissioners may exercise the power and authority herein conferred only after a public hearing held by said board pursuant to 30 days' notice of said public hearing given in a newspaper having general circulation in said county.

The board of county commissioners may also appoint advisory boards, committees, councils and agencies composed of qualified and interested county residents to study, interpret and develop community support and cooperation in activities conducted by or under the authority of the board of county commissioners of said county.

(b) In the exercise of its jurisdiction over commissions, boards, and agencies, the board of county commissioners of a county having a county manager pursuant to G.S. 153A-81 may:

(1) Consolidate ~~the provision~~certain provisions of human services in the county under the direct control of a human services director appointed and supervised by the county manager in accordance with subsection (e) of this section;

(2) Create a consolidated human services board having the powers conferred by subsection (c) of this section;

(3) Create a consolidated county human services agency having the authority to carry out the functions of any combination of commissions, boards, or agencies appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners, including the local health department, the county department of social services, ~~and~~or the area mental health, developmental disabilities, and substance abuse services authority; and

(4) Assign other county human services functions to be performed by the consolidated human services agency under the direction of the human services director, with policy-making authority granted to the consolidated human services board as determined by the board of county commissioners.

(c) A consolidated human services board appointed by the board of county commissioners shall serve as the policy-making, rule-making, and administrative board of the

consolidated human services agency. The consolidated human services board shall be composed of no more than 25 members. The composition of the board shall reasonably reflect the population makeup of the county and shall include:

(1) Eight persons who are consumers of human services, public advocates, or family members of clients of the consolidated human services agency, including: one person with mental illness, one person with a developmental disability, one person in recovery from substance abuse, one family member of a person with mental illness, one family member of a person with a developmental disability, one family member of a person with a substance abuse problem, and two consumers of other human services.

(1a) Notwithstanding subdivision (1) of this subsection, a consolidated human services board not exercising powers and duties of an area mental health, developmental disabilities, and substance abuse services board shall include four persons who are consumers of human services.

(2) Eight persons who are professionals, each with qualifications in one of these categories: one psychologist, one pharmacist, one engineer, one dentist, one optometrist, one veterinarian, one social worker, and one registered nurse.

(3) Two physicians licensed to practice medicine in this State, one of whom shall be a psychiatrist.

(4) One member of the board of county commissioners.

(5) Other persons, including members of the general public representing various occupations.

The board of county commissioners may elect to appoint a member of the consolidated human services board to fill concurrently more than one category of membership if the member has the qualifications or attributes of more than one category of membership.

All members of the consolidated human services board shall be residents of the county. The members of the board shall serve four-year terms. No member may serve more than two consecutive four-year terms. The county commissioner member shall serve only as long as the member is a county commissioner.

The initial board shall be appointed by the board of county commissioners upon the recommendation of a nominating committee comprised of members of the preconsolidation board of health, social services board, and area mental health, developmental disabilities, and substance abuse services board. In order to establish a uniform staggered term structure for the board, a member may be appointed for less than a four-year term. After the subsequent establishment of the board, its board shall be appointed by the board of county commissioners from nominees presented by the human services board. Vacancies shall be filled for any unexpired portion of a term.

A chairperson shall be elected annually by the members of the consolidated human services board. A majority of the members shall constitute a quorum. A member may be removed from office by the county board of commissioners for (i) commission of a felony or other crime involving moral turpitude; (ii) violation of a State law governing conflict of interest; (iii) violation of a written policy adopted by the county board of commissioners; (iv) habitual failure to attend meetings; (v) conduct that tends to bring the office into disrepute; or (vi) failure to maintain qualifications for appointment required under this subsection. A board member may be removed only after the member has been given written notice of the basis for removal and has had the opportunity to respond.

A member may receive a per diem in an amount established by the county board of commissioners. Reimbursement for subsistence and travel shall be in accordance with a policy set by the county board of commissioners. The board shall meet at least quarterly. The chairperson or three of the members may call a special meeting.

(d) The consolidated human services board shall have authority to:

(1) Set fees for departmental services based upon recommendations of the human services director. Fees set under this subdivision are subject to the same restrictions on amount and scope that would apply if the fees were set by a county board of health, a county board of social services, or a mental health, developmental disabilities, and substance abuse area authority.
(2) Assure compliance with laws related to State and federal programs.
(3) Recommend creation of local human services programs.
(4) Adopt local health regulations and participate in enforcement appeals of local regulations.
(5) Perform regulatory health functions required by State law.
(6) Act as coordinator or agent of the State to the extent required by State or federal law.
(7) Plan and recommend a consolidated human services budget.
(8) Conduct audits and reviews of human services programs, including quality assurance activities, as required by State and federal law or as may otherwise be necessary periodically.
(9) Advise local officials through the county manager.
(10) Perform public relations and advocacy functions.
(11) Protect the public health to the extent required by law.
(12) Perform comprehensive mental health services ~~planning.~~planning if the county is exercising the powers and duties of an area mental health, developmental disabilities, and substance abuse services board under the consolidated human services board.
(13) Develop dispute resolution procedures for human services contractors and clients and public advocates, subject to applicable State and federal dispute resolution procedures for human services programs, when applicable.

Except as otherwise provided, the consolidated human services board shall have the powers and duties conferred by law upon a board of health, a social services board, and an area mental health, developmental disabilities, and substance abuse services board.

Local employees who serve as staff of a consolidated county human services agency are subject to county personnel policies and ordinances only and are not subject to the provisions of the State Personnel ~~Act.~~Act, unless the county board of commissioners elects to subject the local employees to the provisions of that Act. All consolidated county human services agencies shall comply with all applicable federal laws, rules, and regulations requiring the establishment of merit personnel systems.

(e) The human services director of a consolidated county human services agency shall be appointed and dismissed by the county manager with the advice and consent of the consolidated human services board. The human services director shall report directly to the county manager. The human services director shall:

(1) Appoint staff of the consolidated human services agency with the county manager's approval.
(2) Administer State human services programs.
(3) Administer human services programs of the local board of county commissioners.
(4) Act as secretary and staff to the consolidated human services board under the direction of the county manager.
(5) Plan the budget of the consolidated human services agency.
(6) Advise the board of county commissioners through the county manager.
(7) Perform regulatory functions of investigation and enforcement of State and local health regulations, as required by State law.
(8) Act as an agent of and liaison to the State, to the extent required by law.

Except as otherwise provided by law, the human services director or the director's designee shall have the same powers and duties as a social services director, a local health director, ~~and~~or a director of an area mental health, developmental disabilities, and substance abuse services authority.

(f) This section applies to counties with a population in excess of 425,000."

SECTION 13.(a) G.S. 122C-122 is repealed.

SECTION 13.(b) G.S. 35A-1202(4) reads as rewritten:

"**§ 35A-1202. Definitions.**

When used in the Subchapter, unless a contrary intent is indicated or the context requires otherwise:

...

(4) "Disinterested public agent" ~~means:~~means

~~a.~~ ~~The~~the director or assistant directors of a ~~local human services agency, or~~county department of social services.

~~b.~~ ~~An adult officer, agent, or employee of a State human services agency. The~~Except as provided in G.S. 35A-1213(f), the fact that a disinterested public agent ~~is employed by a State or local human services agency that~~ provides financial assistance, services, or treatment to a ward does not disqualify that person from being appointed as guardian.

...."

SECTION 13.(c) G.S. 35A-1213 reads as rewritten:

"**§ 35A-1213. Qualifications of guardians.**

(a) The clerk may appoint as guardian an adult individual, a corporation, or a disinterested public agent. The applicant may submit to the clerk the name or names of potential guardians, and the clerk may consider the recommendations of the next of kin or other persons.

(b) A nonresident of the State of North Carolina, to be appointed as general guardian, guardian of the person, or guardian of the estate of a North Carolina resident, must indicate in writing his willingness to submit to the jurisdiction of the North Carolina courts in matters relating to the guardianship and must appoint a resident agent to accept service of process for the guardian in all actions or proceedings with respect to the guardianship. Such appointment must be approved by and filed with the clerk, and any agent so appointed must notify the clerk of any change in the agent's address or legal residence. The clerk shall require a nonresident guardian of the estate or a nonresident general guardian to post a bond or other security for the faithful performance of the guardian's duties. The clerk may require a nonresident guardian of the person to post a bond or other security for the faithful performance of the guardian's duties.

(c) A corporation may be appointed as guardian only if it is authorized by its charter to serve as a guardian or in similar fiduciary capacities. A corporation shall meet the requirements outlined in Chapters 55 and 55D of the General Statutes. A corporation will provide a written copy of its charter to the clerk of superior court. A corporation contracting with a public agency to serve as guardian is required to attend guardianship training and provide verification of attendance to the contracting agency.

(d) A disinterested public agent who is appointed by the clerk to serve as guardian is authorized and required to do so; provided, if at the time of the appointment or any time subsequent thereto the disinterested public agent believes that his role or the role of his agency in relation to the ward is such that his service as guardian would constitute a conflict of interest, or if he knows of any other reason that his service as guardian may not be in the ward's best interest, he shall bring such matter to the attention of the clerk and seek the appointment of a different guardian. A disinterested public agent who is appointed as guardian shall serve in that capacity by virtue of his office or employment, which shall be identified in the clerk's order and

in the letters of appointment. When the disinterested public agent's office or employment terminates, his successor in office or employment, or his immediate supervisor if there is no successor, shall succeed him as guardian without further proceedings unless the clerk orders otherwise.

(e) Notwithstanding any other provision of this section, an employee of a treatment facility, as defined in G.S. 35A-1101(16), may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works; provided, this subsection shall not apply to or affect the validity of any appointment of a guardian that occurred before October 1, 1987.

(f) An individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve as a guardian for a ward for whom the individual is providing such services."

SECTION 13.(d) G.S. 35A-1292(a) reads as rewritten:

"**§ 35A-1292. Resignation.**

(a) Any guardian who wishes to resign ~~may apply in writing to the clerk,~~shall file a motion with the clerk setting forth the circumstances of the case. If a general guardian or guardian of the estate, at the time of making the application, also exhibits his final account for settlement, and if the clerk is satisfied that the guardian has fully accounted, the clerk may accept the resignation of the guardian and discharge him and appoint a successor ~~guardian, but the~~guardian. The guardian so discharged and his sureties are still liable in relation to all matters connected with the guardianship before the ~~discharge.~~discharge and shall continue to ensure that the ward's needs are met until the clerk officially appoints a successor. The guardian shall attend the hearing to modify the guardianship, if physically able."

SECTION 13.(e) In order to achieve continuity of care and services, any successor guardian shall make diligent efforts to continue existing contracts entered into under the authority of G.S. 122C-122 where consistent with the best interest of the ward as required by Chapter 35A of the General Statutes.

SECTION 14.(a) Section 1(a)(3) of S.L. 2011-264 reads as rewritten:

"(3) Designate ~~a single entity~~an area authority for mental health, developmental disabilities, and substance abuse services to assume responsibility for all aspects of Waiver management. The following operational models are ~~acceptable options for Local Management Entity (LME) applicants:~~acceptable:

a. Merger model: A single larger LME is formed from the merger of two or more LMEs.

b. Interlocal agreement among LMEs: A single LME is identified as the leader for all Waiver operations, financial management, and accountability for performance measures."

SECTION 14.(b) Section 1(c) of S.L. 2011-264 reads as rewritten:

"**SECTION 1.(c)** The Department shall require LMEs that have not been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013, to merge with or be aligned through an interlocal agreement with an LME that has been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver. If any LME fails to comply with this requirement, or fails to meet performance requirements of an approved contract with the Department to operate a 1915(b)/(c) Medicaid Waiver, the Department shall assign responsibility for management of the 1915(b)/(c) Medicaid Waiver on behalf of the noncompliant LME to an LME that is successfully operating the Waiver and successfully meeting performance requirements of the contract with the Department. Those LMEs approved to operate the 1915(b)/(c) Medicaid Waiver under an interlocal agreement must have a single LME entity designated as responsible for all aspects of Waiver operations and solely responsible for meeting contract requirements."

SECTION 15. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 1075*
Committee Substitute Favorable 6/5/12
PROPOSED SENATE COMMITTEE SUBSTITUTE H1075-CSSQ-83 [v.1]

6/6/2012 10:34:26 AM

Short Title: LME/MCO Governance. (Public)

Sponsors:

Referred to:

May 24, 2012

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN GOVERNANCE OF LOCAL MANAGEMENT ENTITIES WITH RESPECT TO THE IMPLEMENTATION OF STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-115(a) reads as rewritten:

"**§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.**

(a) A county shall provide mental health, developmental disabilities, and substance abuse services in accordance with rules, policies, and guidelines adopted pursuant to statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver through an area ~~authority or~~ authority, through a county program established pursuant to ~~G.S. 122C-115.1.~~G.S. 122C-115.1, or through a behavioral health authority established pursuant to Part 2B of this Chapter. Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control."

SECTION 2.(a) G.S. 122C-116 reads as rewritten:

"**§ 122C-116. Status of area authority; status of consolidated human services agency.**

(a) An area authority is a local political subdivision of the ~~State except that a single county area authority is considered a department of the county in which it is located for the purposes of Chapter 159 of the General Statutes.~~State.

(b) A consolidated human services agency is a department of the county."

SECTION 2.(b) G.S. 122C-115.1(i) reads as rewritten:

"(i) Except as otherwise specifically provided, this Chapter applies to counties that provide mental health, developmental disabilities, and substance abuse services through a county program. As used in the applicable sections of this Article, the terms "area authority", "area program", and "area facility" shall be construed to include "county program". ~~The following sections of this Article do not apply to county programs:~~

~~(1) G.S. 122C-115.3, 122C-116, 122C-117, and 122C-118.1.~~
~~(2) G.S. 122C-119 and G.S. 122C-119.1.~~
~~(3) G.S. 122C-120 and G.S. 122C-121.~~
~~(4) G.S. 122C-127.~~
~~(5) G.S. 122C-147.~~
~~(6) G.S. 122C-152 and G.S. 122C-153.~~
~~(7) G.S. 122C-156.~~
~~(8) G.S. 122C-158.~~"

SECTION 3.(a) G.S. 122C-118.1 reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) ~~An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties may have up to 30 members. In a single-county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include two individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.~~ An area board shall have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or the boards of county commissioners within the area, shall appoint members consistent with the requirements provided in subsection (b) of this section. The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category. A member of the board may be removed with or without cause by the initial appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chairman of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) ~~Except as otherwise~~Within the maximum membership provided in ~~this subsection, not more than fifty percent (50%) of~~subsection (a) of this section, the ~~members~~membership of the area board shall reside within the catchment area and ~~represent the following:~~ be composed as follows:

(1) ~~A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.~~At least one member who is a current county commissioner.

(2) ~~A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.~~The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.

(3) At least one family member ~~or individual from a citizens' organization composed primarily of consumers or their family members,~~of the local CFAC, as recommended by the local CFAC, representing the interests of ~~individuals:~~the following:

a. ~~With~~Individuals with mental ~~illness:~~illness, or

b. ~~In~~Individuals in recovery from ~~addiction; or~~addiction, or

c. ~~With~~ Individuals with intellectual or other developmental disabilities.

(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~With~~Individuals with intellectual or other developmental ~~disabilities; or~~disabilities, or

c. ~~In~~ Individuals in recovery from addiction.

(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.

(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.

(8) An individual with insurance expertise consistent with the scale and nature of the managed care organization.

(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(10) An attorney with health care expertise.

(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.

(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

~~An~~Except as provided in subdivision (12) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on an area authority board. Of the members described in subdivisions (2) through (4) of this subsection, the boards of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than two categories of membership if the member has the qualifications or attributes of the two categories of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed

the earlier of three years or the member's service as a county commissioner. Any member of an area board who is a county manager serves on the board at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the duration of the member's employment as a county manager. The terms of ~~the other~~members on the area board shall be for three years, except that upon the initial formation of an area board in compliance with subsection (a) of this section, one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. ~~Members, other than county commissioners and county managers,~~ Members shall not be appointed for more than ~~two~~three consecutive terms. ~~Board members serving as of July 1, 2006, may remain on the board for one additional term. This subsection applies to all area authority board members regardless of the procedure used to appoint members under subsection (a) of this section.~~

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes."

SECTION 3.(b) All area boards shall meet the requirements of G.S. 122C-118.1, as amended by subsection (a) of this section, no later than July 1, 2013.

SECTION 4.(a) G.S. 122C-119.1 reads as rewritten:

"**§ 122C-119.1. Area Authority board members' training.**

All members of the governing body for an area authority shall receive initial orientation on board members' responsibilities and annual training provided by the Department ~~in~~which shall include fiscal management, budget development, and fiscal accountability. A member's refusal to be trained shall be grounds for removal from the board."

SECTION 4.(b) The North Carolina Department of Health and Human Services, in cooperation with the School of Government and the local management entities, shall develop a standardized core curriculum for the training described in subsection (a) of this section.

SECTION 5. G.S. 122C-170(b) reads as rewritten:

"Part 4A. Consumer and Family Advisory Committees.

"**§ 122C-170. Local Consumer and Family Advisory Committees.**

...

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than ~~two~~three consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, developmental disabilities, and substance abuse services.

(2) Family members of consumers of mental health, developmental disabilities, and substance abuse services.

...."

SECTION 6. Area authorities may add one or more additional counties to their existing catchment area by agreement of a majority of the existing member counties.

SECTION 7.(a) Beginning July 1, 2012, and for a period of two years thereafter, the Department of Health and Human Services shall not approve any county's request to withdraw from a multicounty area authority operating under the 1915(b)/(c) Medicaid Waiver. Not later than January 1, 2014, the Secretary shall adopt rules to establish a process for county disengagement that shall at a minimum ensure the following:

(1) Provisions of service are not disrupted by the disengagement.

(2) The disengaging county is either in compliance or plans to merge with an area authority that is in compliance with population requirements provided in G.S. 122C-155(a).

(3) The timing of the disengagement is accounted for and does not conflict with setting capitation rates.

(4) Adequate notice is provided to the affected counties, the Department of Health and Human Services, and the General Assembly.

(5) Provisions for distribution of any real property no longer within the catchment area of the area authority.

SECTION 7.(b) G.S. 122C-112.1 is amended by adding a new subdivision to read:

"(38) Adopt rules establishing a procedure for single-county disengagement from an area authority operating under a 1915(b)/(c) Medicaid Waiver."

SECTION 8. G.S. 122C-147(c) reads as rewritten:

"§ 122C-147. Financing and title of area authority property.

...

(c) All real property purchased for use by the area authority shall be provided by local or federal funds unless otherwise allowed under subsection (b) of this section or by specific capital funds appropriated by the General Assembly. The title to this real property and the authority to acquire it is held by the ~~county where the property is located. The authority to hold title to real property and the authority to acquire it, including the area authority's authority to finance its acquisition by an installment contract under G.S. 160A-20, may be held by the area authority or by the contracting governmental entity with the approval of the board or boards of commissioners of all the counties that comprise the area authority. The approval of a board of county commissioners shall be by resolution of the board and may have any necessary or proper conditions, including provisions for distribution of the proceeds in the event of disposition of the property by the area authority.~~ area authority. Real property may not be acquired by means of an installment contract under G.S. 160A-20 unless the Local Government Commission has approved the acquisition. No deficiency judgment may be rendered against any unit of local government in any action for breach of a contractual obligation authorized by this subsection, and the taxing power of a unit of local government is not and may not be pledged directly or indirectly to secure any moneys due under a contract authorized by this subsection.

...."

SECTION 9.(a) G.S. 122C-117 reads as rewritten:

"§ 122C-117. Powers and duties of the area authority.

(a) The area authority shall do all of the following:

...

(7) Appoint an area director in accordance with G.S. 122C-121(d). ~~The appointment is subject to the approval of the board of county commissioners except that one or more boards of county commissioners may waive its authority to approve the appointment. The appointment shall be based on a selection by a search committee of the area authority board. The search committee shall include consumer board members, a county manager, and one or more county commissioners. The Secretary shall have the option to appoint one member to the search committee.~~

...

(17) Have the authority to borrow money with the approval of the Local Government Commission.

...

(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. The county finance officer shall provide the quarterly report to the board of county commissioners at the next regularly scheduled meeting of the board. The clerk of the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period

of time. This information shall be ~~presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners.~~delivered to the county and, at the request of the board of county commissioners, may be presented in person by the area director or the director's designee.

...."

SECTION 9.(b) G.S. 122C-115.2 is amended by adding a new subsection to read:

"(e) The Secretary may waive any requirements of this section that are inconsistent with or incompatible with contracts entered into between the Department and the area authority for the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver."

SECTION 10. Part 2 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-126.1. Confidentiality of competitive health care information.**

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of the area authority. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of an area authority shall be a public record, unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section.

(b) If an area authority is requested to disclose any contract that the area authority believes in good faith contains or constitutes competitive health care information, the area authority may either redact the portions of the contract believed to constitute competitive health care information prior to disclosure or, if the entire contract constitutes competitive health care information, refuse disclosure of the contract. The person requesting disclosure of the contract may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decision by the court shall be whether the contract, or portions of the contract withheld, constitutes competitive health care information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure. Before rendering a decision, the court shall review the contract in camera and hear arguments from the parties. If the court finds that the contract constitutes or contains competitive health care information, the court may either deny disclosure or may make such other appropriate orders as are permitted under Rule 26(c) of the Rules of Civil Procedure.

(c) Nothing in this section shall be deemed to prevent the Attorney General, the State Auditor, or an elected public body, in closed session, which has responsibility for the area authority, from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information."

SECTION 11.(a) G.S. 126-5(a) reads as rewritten:

"**§ 126-5. Employees subject to Chapter; exemptions.**

(a) The provisions of this Chapter shall apply to:

(1) All State employees not herein exempt, and

(2) All employees of the following local entities:

a. Area mental health, developmental disabilities, and substance abuse ~~authorities.~~authorities, except as otherwise provided in Chapter 122C of the General Statutes.
b. Local social services departments.
c. County health departments and district health departments.
d. Local emergency management agencies that receive federal grant-in-aid funds.

An employee of a consolidated county human services agency created pursuant to G.S. 153A-77(b) is not considered an employee of an entity listed in this subdivision.

(3) County employees not included under subdivision (2) of this subsection as the several boards of county commissioners may from time to time determine."

SECTION 11.(b) G.S. 122C-154 reads as rewritten:

"**§ 122C-154. Personnel.**

Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. Employees appointed by the county program director are employees of the county. In a multicounty program, employment of county program staff shall be as agreed upon in the interlocal agreement adopted pursuant to G.S. 122C-115.1. Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the employee. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 11.(c) G.S. 122C-121(a1) reads as rewritten:

"(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. ~~An area board may request an adjustment to the salary ranges under G.S. 126-9(b). The request shall include specific information supporting the need for the adjustment, including comparative salary and patient caseload data for other LMEs, and shall also include the specific amount the area board proposes to pay the director. The area board shall not request a salary adjustment that is more than ten percent (10%) above the normal allowable salary range as determined by the State Personnel Commission.~~Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the director. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 12.(a) G.S. 122C-122 is repealed.

SECTION 12.(b) G.S. 35A-1202(4) reads as rewritten:

"**§ 35A-1202. Definitions.**

When used in the Subchapter, unless a contrary intent is indicated or the context requires otherwise:

...

(4) "Disinterested public agent" ~~means:~~means

~~a.~~ ~~The~~the director or assistant directors of a ~~local human services agency, or~~county department of social services.

~~b. An adult officer, agent, or employee of a State human services agency. The~~Except as provided in G.S. 35A-1213(f), the fact that a disinterested public agent ~~is employed by a State or local human services agency that~~ provides financial assistance, services, or treatment to a ward does not disqualify that person from being appointed as guardian.

...."

SECTION 12.(c) G.S. 35A-1213 reads as rewritten:

"**§ 35A-1213. Qualifications of guardians.**

(a) The clerk may appoint as guardian an adult individual, a corporation, or a disinterested public agent. The applicant may submit to the clerk the name or names of potential guardians, and the clerk may consider the recommendations of the next of kin or other persons.

(b) A nonresident of the State of North Carolina, to be appointed as general guardian, guardian of the person, or guardian of the estate of a North Carolina resident, must indicate in writing his willingness to submit to the jurisdiction of the North Carolina courts in matters relating to the guardianship and must appoint a resident agent to accept service of process for the guardian in all actions or proceedings with respect to the guardianship. Such appointment must be approved by and filed with the clerk, and any agent so appointed must notify the clerk of any change in the agent's address or legal residence. The clerk shall require a nonresident guardian of the estate or a nonresident general guardian to post a bond or other security for the faithful performance of the guardian's duties. The clerk may require a nonresident guardian of the person to post a bond or other security for the faithful performance of the guardian's duties.

(c) A corporation may be appointed as guardian only if it is authorized by its charter to serve as a guardian or in similar fiduciary capacities. A corporation shall meet the requirements outlined in Chapters 55 and 55D of the General Statutes. A corporation will provide a written copy of its charter to the clerk of superior court. A corporation contracting with a public agency to serve as guardian is required to attend guardianship training and provide verification of attendance to the contracting agency.

(d) A disinterested public agent who is appointed by the clerk to serve as guardian is authorized and required to do so; provided, if at the time of the appointment or any time subsequent thereto the disinterested public agent believes that his role or the role of his agency in relation to the ward is such that his service as guardian would constitute a conflict of interest, or if he knows of any other reason that his service as guardian may not be in the ward's best interest, he shall bring such matter to the attention of the clerk and seek the appointment of a different guardian. A disinterested public agent who is appointed as guardian shall serve in that capacity by virtue of his office or employment, which shall be identified in the clerk's order and in the letters of appointment. When the disinterested public agent's office or employment terminates, his successor in office or employment, or his immediate supervisor if there is no successor, shall succeed him as guardian without further proceedings unless the clerk orders otherwise.

(e) Notwithstanding any other provision of this section, an employee of a treatment facility, as defined in G.S. 35A-1101(16), may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works; provided, this subsection shall not apply to or affect the validity of any appointment of a guardian that occurred before October 1, 1987.

(f) An individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve as a guardian for a ward for whom the individual is providing such services."

SECTION 12.(d) G.S. 35A-1292(a) reads as rewritten:

"**§ 35A-1292. Resignation.**

(a) Any guardian who wishes to resign ~~may apply in writing to the clerk,~~shall file a motion with the clerk setting forth the circumstances of the case. If a general guardian or guardian of the estate, at the time of making the application, also exhibits his final account for settlement, and if the clerk is satisfied that the guardian has fully accounted, the clerk may accept the resignation of the guardian and discharge him and appoint a successor ~~guardian, but the~~guardian. The guardian so discharged and his sureties are still liable in relation to all matters connected with the guardianship before the ~~discharge.~~discharge and shall continue to ensure that the ward's needs are met until the clerk officially appoints a successor. The guardian shall attend the hearing to modify the guardianship, if physically able."

SECTION 12.(e) In order to achieve continuity of care and services, any successor guardian shall make diligent efforts to continue existing contracts entered into under the authority of G.S. 122C-122 where consistent with the best interest of the ward as required by Chapter 35A of the General Statutes.

SECTION 13.(a) Section 1(a)(3) of S.L. 2011-264 reads as rewritten:

"(3) Designate ~~a single entity~~an area authority for mental health, developmental disabilities, and substance abuse services to assume responsibility for all aspects of Waiver management. The following operational models are ~~acceptable options for Local Management Entity (LME) applicants:~~acceptable:

a. Merger model: A single larger LME is formed from the merger of two or more LMEs.

b. Interlocal agreement among LMEs: A single LME is identified as the leader for all Waiver operations, financial management, and accountability for performance measures."

SECTION 13.(b) Section 1(c) of S.L. 2011-264 reads as rewritten:

"**SECTION 1.(c)** The Department shall require LMEs that have not been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013, to merge with or be aligned through an interlocal agreement with an LME that has been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver. If any LME fails to comply with this requirement, or fails to meet performance requirements of an approved contract with the Department to operate a 1915(b)/(c) Medicaid Waiver, the Department shall assign responsibility for management of the 1915(b)/(c) Medicaid Waiver on behalf of the noncompliant LME to an LME that is successfully operating the Waiver and successfully meeting performance requirements of the contract with the Department. Those LMEs approved to operate the 1915(b)/(c) Medicaid Waiver under an interlocal agreement must have a single LME entity designated as responsible for all aspects of Waiver operations and solely responsible for meeting contract requirements."

SECTION 14.(a) Article 4 of Chapter 122C of the General Statutes is amended by adding a new Part to read:

"Part 2B. Behavioral Health Authority.

"**§ 122C-29. Behavioral Health Authority Creation; Approval and Oversight.**

A behavioral health authority may be created under the provisions of this Part whenever the governing board of the local management entity, which has been operating as a managed care organization under a 1915(b)/(c) Medicaid Waiver for at least three years, finds and adopts a resolution finding that it is in the interest of the public health and welfare to create a behavioral health authority in order to manage resources that may be available for mental health, intellectual and other developmental disabilities, and substance abuse services. An LME's organization as a behavioral health authority is subject to the approval of the Secretary which shall be based on the LME's demonstration of successful operation as a managed care

organization. The LME shall be subject to periodic review and may be revoked by the Secretary upon a finding that the LME is no longer successfully operating as an managed care organization as defined in 42 C.F.R 438.2.

"**§ 122C-29.1. Functions of a behavioral health authority.**

A behavioral health authority shall perform all the functions necessary to carry out the purposes of this Part, including, but not limited to, the following:

(1) Establish accountability for the development and management of a local system that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for individuals in need of mental health, intellectual and developmental disabilities, and substance abuse services.

(2) Operate the 1915(b)/(c) Medicaid Waiver, a proven system for the management of mental health, intellectual and developmental disabilities, and substance abuse services.

(3) Manage resources that are or become available for mental health, intellectual and developmental disabilities, and substance abuse services.

(4) Use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid program while ensuring medically necessary care and deploy a system for the allocation of resources based on the reliable assessment of intensity of need. These strategies shall efficiently direct individuals to appropriate services and shall ensure that they receive no more and no less than the amount of services determined to be medically necessary and at the appropriate funding level.

(5) Maintain a local presence in order to respond to the unique needs and priorities of localities.

(6) Ensure communication with consumers, families, providers, and stakeholders regarding disability-specific and general Waiver operations by implementing a process for feedback and exchange of information and ideas.

(7) Establish and maintain systems for ongoing communication and coordination regarding the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems such as local departments of social services, Community Care of North Carolina, hospitals, school systems, the Division of Juvenile Justice of the Department of Public Safety, and other community agencies.

(8) Maintain disability specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

(9) Conduct administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information technology systems, financial reporting, and staffing.

(10) Maintain full accountability of for all aspects of Waiver operations and for meeting all contract requirements specified by the Department of Health and Human Services.

(11) Authorize the utilization of State psychiatric hospitals and other State facilities.

(12) Authorize eligibility determination requests for the 1915(b)/(c) Medicaid Waiver.

"§ 122C-29.2. Directors of a behavioral health authority.

(a) Upon approval by the Secretary to organize under this part, the Area Board of the LME shall become the Board of Directors of the behavioral health authority. Directors shall serve out the term for which they were appointed to the Area Board. Thereafter, when a Director resigns, is removed from office, completes a term of office, or when there is an increase in the number of Directors, the election of Directors to the Board shall be in accordance with bylaws set forth for such purpose and may be amended as necessary or convenient to carry out the functions, powers, duties and responsibilities of the Behavioral Health Authority.

(b) At a minimum, the bylaws of the Behavioral Health Authority shall set the number, composition, term, and method of appointment of the Board of Directors. Membership of the Board of Directors shall take into account representation of the counties or geographic areas in which the behavioral health authority operates the 1915(b)/(c) Medicaid Waiver and manages resources for mental health, intellectual and developmental disabilities, and substance abuse services and should be comprised of a mix of individuals with the necessary expertise to govern Managed Care Organizations. When possible, the Directors should include a physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina, and who is board certified in psychiatry; a clinical professional from the fields of mental health, developmental disabilities, or substance abuse; an individual with financial expertise, including previous fiscal oversight experience with large organizations; and at least one family member or individual from a citizens' organization representing the interests of individuals with mental illness, intellectual and developmental disabilities, or substance abuse. An individual that contracts with a behavioral health authority for the delivery of behavioral healthcare services shall not serve on the Board of Directors during the period for which the contract for services is in effect.

(c) The Board of Directors shall be responsible for ensuring the behavioral health authority maintains a local presence and is responsive to the unique needs and priorities of localities.

"§ 122C-29.3. Powers of the behavioral health authority.

(a) A behavioral health authority shall have all powers necessary or convenient to carry out the purposes of this Part, including the following powers, which are in addition to those powers granted elsewhere in this Part:

(1) To engage in comprehensive planning, implementing, and monitoring of community based mental health, intellectual and developmental disabilities, and substance abuse services, including for individuals committed to the custody of the Department of Social Services and the Division of Juvenile Justice of the Department of Public Safety.

(2) To comply with federal requirements for Medicaid, Medicare, block grants, and other federally funded health care programs.

(3) To perform public relations and community advocacy functions.

(4) To maintain a 24-hour a day, seven day a week crisis response service. Crisis response shall include telephone and face-to-face capabilities. Crisis phone response shall include triage and referral to appropriate face-to-face crisis providers. Crisis services do not require prior authorization, but shall be delivered in compliance with appropriate policies and procedures. Crisis services shall be designed for prevention, intervention, and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety.

(5) To accept donations or money, personal property, or real estate for the benefit of the behavioral health authority and to take title to the same from any person, firm, corporation or society.

(6) To purchase, lease, obtain options upon, or otherwise acquire any real or personal property or any interest therein from any person, firm, corporation, city, county, government or society.

(7) To sell, exchange, transfer, assign, or pledge any real or personal property or any interest therein to any person, firm, corporation, city, county, government or society.

(8) To own, hold, clear and improve property.

(9) To appoint a Chief Executive Officer and to fix his or her compensation.

(10) To delegate to its agents or employees any powers or duties as it may deem appropriate.

(11) To employ its own counsel and legal staff.

(12) To adopt, amend and repeal bylaws for the conduct of its business.

(13) To enter into contracts for necessary supplies, equipment, or services for the operation of its business.

(14) To appoint committees or subcommittees as it shall deem advisable, to fix their duties and responsibilities, and to do all things necessary in connection with the management, supervision, control and operation of the behavioral health authority's business.

(15) To enter into any contracts or other arrangements with any municipality, other public agency of this or any other State or of the United States, or with any individual, private organization, corporation, or nonprofit association for the provision of behavioral health or other services.

(16) To act as an agent for the federal, State or local government in connection with the management of behavioral health services.

(17) To insure the property or the operations of the behavioral health authority against risks as the behavioral health authority may deem advisable.

(18) To invest any funds held in reserves or sinking funds, or any funds not required for immediate disbursement, in property or securities in which trustees, guardians, executors, administrators, and others acting in a fiduciary capacity may legally invest funds under their control.

(19) To sue and be sued.

(20) To have a seal and to alter it at pleasure.

(21) To have perpetual succession.

(22) To make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the behavioral health authority, including providing services to governmental or private entities, including Employee Assistance Programs.

(23) To provide teaching and instruction programs and schools for psychiatrists, psychologists, psychiatric nurses, technicians and students, interns, and other behavioral healthcare professionals.

(24) To agree to limitations upon the exercise of any powers conferred upon the behavioral health authority by this Part in connection with any loan by a government.

(b) A behavioral health authority may exercise any or all of the powers conferred upon it by this Part, either generally or directly, or through designated agents, including any corporation or corporations which are or shall be formed under the laws of this State.

(c) No provisions with respect to the acquisition, operation or disposition of property by other public bodies shall be applicable to a behavioral health authority unless otherwise specified by the General Assembly.

"**§ 122C-29.4. Compensation; Personnel Policies; Employee Benefits Plans.**

(a) For the purpose of personnel administration, a behavioral health authority is exempted from Chapter 126 of the General Statutes.

(b) A behavioral health authority shall determine the pay, expense allowances, and other compensation of its officers and employees, and may establish position classification and pay plans and incentive compensation plans.

(c) A behavioral health authority shall:

(1) Adopt personnel policies and procedures regarding, without limitation, vacations, personal leave, service award programs, other personnel policies and procedures, and any other measures that enhance the ability of a behavioral health authority to hire and retain employees.

(2) Determine the work hours, workdays, and holidays applicable to its employees.

(3) Establish and pay all or part of the cost of benefit plans for its employees and former employees, including without limitation, life, health and disability plans, pension, deferred compensation and other retirement plans, and other fringe benefit plans.

(4) Pay severance payments and provide other employee severance benefits to its employees and former employees pursuant to a severance plan established in connection with a reduction in the size of the workforce plan, or with respect to an individual employee, pursuant to an employment agreement entered into prior to the date the employee receives notice of termination of employment.

(5) Provide for biennial assessments of the behavioral health authority's personnel plans by an independent entity that specializes in human resources development and management. Such assessments shall be submitted to the Secretary and shall ensure that position classifications and compensation are appropriately matched to industry standards and local job market requirements.

(d) A behavioral health authority shall be subject to the same requirements and responsibilities regarding the disclosure and privacy of personnel records in accordance with G.S. 122C-158.

"**§ 122C-29.5. Limited Liability.**

(a) A person serving as a director, trustee, or officer of a behavioral health authority shall be immune individually from civil liability for monetary damages, except to the extent covered by insurance, for any act or failure to act arising out of this service, except where the person:

(1) Was not acting within the scope of his official duties;

(2) Was not acting in good faith;

(3) Committed gross negligence or willful or wanton misconduct that resulted in the damage or injury; or

(4) Derived an improper personal financial benefit from the transaction.

(b) The immunity in subsection (a) is personal to the directors, trustees, and officers, and does not immunize a behavioral health authority for liability for the acts or omissions of the directors, trustees, or officers.

(c) In addition to the immunity granted in subsection (a), a behavioral health authority may waive its governmental immunity from liability for damages caused by the negligence or

tort of any agent, employee, or Director of the behavioral health authority when acting within the scope of his authority or within the course of his duties or employment. Governmental immunity is waived by the act of obtaining this insurance, but it is waived only to the extent that the behavioral health authority is indemnified by insurance for the negligence or tort.

(d) A behavioral health authority may incur liability pursuant to this section only with respect to a claim arising after the behavioral health authority has procured liability insurance pursuant to this section and during the time when the insurance is in force.

(e) No part of the pleadings that relate to or allege facts as to a defendant's insurance against liability may be read or mentioned in the presence of the trial jury in any action brought pursuant to this section. These issues shall be heard and determined by the judge, and the jury shall be absent during any motions, arguments, testimony, or announcement of findings of fact or conclusions of law with respect to insurance.

(f) Upon request by any agent, employee, or Director or former agent, employee, or Director, a behavioral health authority may provide for the defense of any civil or criminal action or proceeding brought against the agent, employee, or Director, either in his official or in his individual capacity, or both, on account of any act done or omission made, or any act allegedly done or omission allegedly made, in the scope and course of his duty as an agent, employee, or Director. The defense may be provided by employing counsel or by purchasing insurance that requires the insurer to provide the defense. Nothing in this section requires a behavioral health authority to provide for the defense of any action or proceeding of any nature.

"**§ 122C-29.6. Applicability of the Local Government Budget and Fiscal Control Act.**

(a) The Local Government Budget and Fiscal Control Act applies to behavioral health authorities, except that the provisions of Parts 1, 2, and 3 of Article 3 of the Act do not apply to behavioral health authorities, which shall instead be subject to the provisions of this section.

(b) A behavioral health authority shall appoint or designate a finance officer, who shall have the following powers and duties:

(1) Prepare the annual budget for presentation to the governing board of the behavioral health authority and shall administer the budget as approved by the board;

(2) Keep the accounts of the behavioral health authority in accordance with generally accepted principles of accounting;

(3) Prepare and file a statement of the financial condition of the behavioral health authority as revealed by its accounts upon the request of the behavioral health authority's governing board or the governing board of any county, city, or other unit of local government that has issued on behalf of the behavioral health authority and has outstanding its general obligation or revenue bonds or makes current appropriations to the behavioral health authority;

(4) Receive and deposit all moneys accruing to the behavioral health authority, or supervise the receipt and deposit of money by other duly authorized officers or employees of the behavioral health authority;

(5) Supervise the investment of idle funds of the behavioral health authority; and

(6) Maintain all records concerning the bonded debt of the behavioral health authority, if any, determine the amount of money that will be required for debt service during each fiscal year, and maintain all sinking funds, but shall not be responsible for records concerning the bonded debt of any county, city, or other unit of local government incurred on behalf of the behavioral health authority.

(c) The Local Government Commission has authority to issue rules and regulations governing procedures for the receipt, deposit, investment, transfer, and disbursement of money and other assets by behavioral health authorities, may inquire into and investigate the internal control procedures of a behavioral health authority, and may require any modifications in internal control procedures which, in the opinion of the Commission, are necessary or desirable to prevent embezzlements, mishandling of funds, or continued operating deficits.

(d) The accounting system of a behavioral health authority shall be so designed that the true financial condition of the behavioral health authority can be determined therefrom at any time. As soon as possible after the close of each fiscal year, the accounts shall be audited by a certified public accountant or by an accountant certified by the Local Government Commission as qualified to audit local government accounts. The auditor shall be selected by and shall report directly to the behavioral health authority's governing board. The audit contract or agreement shall be in writing, shall include all its terms and conditions, and shall be submitted to the secretary of the Local Government Commission for his approval as to form, terms and conditions. The terms and conditions of the audit shall include the scope of the audit, and the requirement that upon completion of the examination the auditor shall prepare a written report embodying financial statements and his opinion and comments relating thereto. The finance officer shall file a copy of the audit with the secretary of the Local Government Commission and with the finance officer of any county, city, or other unit of local government that has issued on behalf of the behavioral health authority and has outstanding its general obligation or revenue bonds or makes current appropriations to the behavioral health authority (other than appropriations for the cost of behavioral healthcare or programs).

(e) A behavioral health authority may deposit or invest at interest all or part of its cash balance pursuant to G.S. 159-30 and may deposit any funds held in reserves or sinking funds, or any funds not required for immediate disbursement, with the State Treasurer for investment pursuant to G.S. 147-69.2.

(f) A behavioral health authority is subject to G.S. 159-31 with regard to selection of an official depository and security of deposits.

(g) A behavioral health authority is subject to G.S. 159-32 with regard to daily deposits.

(h) A behavioral health authority may accept electronic payments pursuant to G.S. 159-32.1.

(i) A behavioral health authority is subject to G.S. 159-33 with regard to semiannual reports to the Local Government Commission on the status of deposits and investments.

(j) A behavioral health authority having outstanding general obligation or revenue bonds is subject to G.S. 159-35, 159-36, 159-37, and 159-38.

"**§ 122C-29.7. Revenue Bonds and Purchase Money Security Interests**

(a) A behavioral health authority shall have the power to issue revenue bonds under the Local Government Revenue Bond Act, Chapter 159 of the General Statutes, Article 5, or the bond and revenue anticipation provisions of Chapter 159 of the General Statutes, Article 9, for the purpose of acquiring, constructing, reconstructing, improving, enlarging, bettering, equipping, extending, or operating behavioral health facilities.

(b) A behavioral health authority shall have the power to borrow for the purposes above enumerated upon its notes or other evidences of indebtedness, subject to the approval of the Local Government Commission. Such approval shall be required regardless of the amount of any such borrowing.

(c) A behavioral health authority shall have the power and authority to purchase real or personal property under installment contracts, purchase money mortgages or deeds of trust, or other instruments, which create in the property purchased a security interest to secure payment of the purchase price and interest thereon. No deficiency judgment may be rendered against a behavioral health authority for breach of an obligation authorized by this section.

(d) A behavioral health authority may contract pursuant to this section in an amount less than five million dollars ($5,000,000) in any single transaction without the approval of the Local Government Commission; provided, however, that the approval of the Local Government Commission shall be required for any single contract pursuant to this section if the aggregate dollar amount of all such contracts outstanding after any such single transaction would exceed ten percent (10%) of the total operating revenues, as hereinafter defined, of the behavioral health authority for its most recently completed fiscal year as set forth in the audited financial statements of such behavioral health authority for such fiscal year.

(e) Approval of the Local Government Commission under this section shall be obtained in accordance with such rules and regulations as the Local Government Commission may prescribe and shall be evidenced by the Secretary of the Commission's certificate on the contract or note or other evidence of indebtedness. In determining whether to approve any such contract or borrowing, the Local Government Commission shall consider whether the behavioral health authority can demonstrate the financial responsibility and capability of the behavioral health authority to fulfill its obligations with respect to such contract or borrowing. Any contract or borrowing subject to this subsection requiring the approval of the Local Government Commission that does not bear the Secretary of the Commission's certificate thereon shall be void, and it shall be unlawful for any officer, employee or agent of a behavioral health authority to make any payments of money thereunder. An order of the Local Government Commission approving any such contract or borrowing shall not be regarded as an approval of the legality of the contract or borrowing in any respect.

(f) For purposes of this section, the "total operating revenues" of a behavioral health authority for a fiscal year means revenue, less provisions for contractual adjustments, plus other operating revenues, all as determined in accordance with generally accepted accounting principles.

"**§ 122C-29.8. Local Consumer and Family Advisory Committees**

A behavioral health authority shall establish Local Consumer and Family Advisory Committees in accordance with G.S. 122C-170.

"**§ 122C-29.9. Client Rights and Human Rights Committees**

A behavioral health authority shall adopt the State's policy on policy on client rights as contained in G.S. 122C-51 and establish client rights and human rights committees responsible for protecting the rights of clients in accordance with G.S. 122C-64.

"**§ 122C-29.10. Involuntary Commitments**

A behavioral health authority shall have the same duties and responsibilities for involuntary commitments as area authorities created pursuant to G.S. 122C-115(c).

"**§ 122C-29.11. Grievance System.**

(a) A behavioral health authority shall establish Medicaid grievance procedures as required by the federal Medicaid managed care rules and as approved by the Secretary. Such grievance procedures shall provide a process by which consumers and providers may challenge the Medicaid denial of coverage of, or payment for, mental health, intellectual and developmental disabilities, or substance abuse services.

(b) Medicaid State fair hearings involving the 1915(b)/(c) Medicaid Waiver shall be decided by a hearing officer at the Division of Medical Assistance in accordance with 10A N.C.A.C. 22H, which shall be amended to include rules specifically set forth for the adjudication of State fair hearings involving Medicaid managed care.

(c) A behavioral health authority shall comply with the provisions contained in G.S. 122C-151.4 for consumer and provider appeals related to State funded mental health, intellectual and developmental disabilities, and substance abuse services, except that G.S. 122C-151.4(f) shall not apply to appeals involving a behavioral health authority.

"**§ 122C-29.12. Public Guardians**

A behavioral health authority does not qualify as a disinterested public agent and may not serve as the guardian for an individual adjudicated incompetent under the provisions of Subchapter I of Chapter 35A of the General Statutes. A behavioral health authority may not contract with a third party to serve as a guardian for an individual that is, or would be, eligible to have behavioral healthcare managed by the behavioral health authority.

"**§ 122C-29.13. Confidentiality of Competitive Healthcare Information**

(a) A behavioral health authority is subject to all consumer confidentiality requirements and State public records laws, except that the disclosure of competitive healthcare information shall be pursuant to the provisions of this section.

(b) For purposes of this section, competitive healthcare information means information relating to competitive healthcare activities by or on behalf of a behavioral health authority. Competitive healthcare information shall be confidential and not a public record under Chapter 132 of the General Statutes.

(c) If a behavioral health authority is requested to disclose any material which the behavioral health authority believes in good faith contains or constitutes competitive healthcare information, the behavioral health authority may either redact the portions believed to constitute competitive healthcare information prior to disclosure, or refuse to disclose the material in its entirety. The person requesting disclosure may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decisions by the court shall be whether the material constitutes competitive healthcare information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure.

(d) Nothing in this section shall be deemed to prevent an elected public body, in closed session, which has responsibility for the behavioral health authority, the Attorney General, or the State Auditor from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information.

"**§ 122C-29.14. Part Controlling**

Insofar as the provisions of this Part are inconsistent with the provisions of any other law, the provisions of this Part shall be controlling. Except as provided for in this Part, the provisions of G.S. 122C do not apply to behavioral health authorities created under this Part.

SECTION 14.(b) G.S. 122C-3(21) reads as rewritten:

"(20b) "Local management entity" or "LME" means an area authority, county program, behavioral health authority, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure."

SECTION 15. This act is effective when it becomes law.

HOUSE BILL 1075: LME/MCO Governance

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 6, 2012
Introduced by:	Reps. Dollar, Burr	**Prepared by:**	Shawn Parker Committee Counsel
Analysis of:	PCS to Second Edition H1075-CSSQ-83		

SUMMARY: ***House Bill 1075 amends the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 and other statutes to address identified barriers to the implementation of Statewide expansion of the 1915(b)/(c) Medicaid Waiver as recommended by the Joint Legislative Oversight Committee on Health and Human Services.***

The Senate Proposed Committee Substitute (i) removes the provision relating to consolidation of human service agencies, and (ii) adds a provision to establish behavioral health authorities.

CURRENT LAW:

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. Further, State and local governments are directed to develop and maintain a unified system of services centered in area authorities or county programs.

Session Law 2011-264 (HB 916) directed the Department of Health and Human Services to restructure the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders by expanding operation of 1915(b)/(c) Medicaid Waivers statewide. The 1915(b) authority limits freedom of choice, and 1915(c) authority targets eligibility for the program and provides home and community-based services. States must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver.

Sections 1915(b) and(c) of the Social Security Act authorizes the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid statutory requirements. The waivers allow states to cover a broad array of home and community-based services for certain populations as an alternative to institutional care. Section 1915(b) waivers are commonly known as "freedom of choice" or managed care waivers. Section 1915(c) waivers allow the provision of home and community-based services in lieu of institutional care. Section 1915(b)/(c) waivers combine all Medicaid-funded mental health/developmental disability/substance abuse (MH/DD/SAS) services to allow a single capitated managed care system as a vehicle for service delivery to Medicaid recipients at the community level.

BILL ANALYSIS:

Sections 1 and 2 provide that all area authorities are considered local political subdivisions of the State and that a county's responsibility for the provision of mh/dd/sa services includes adhering to rules, policies, and guidelines developed pursuant to a statewide expansion of a 1915(b)/(c) Medicaid Waiver.

Section 3 directs the Boards of County Commissioners within an area authority's catchment to appoint an area board that consists of no fewer than 11 and no more than 21 voting members, of which the following categories must be represented:

- *At least one county commissioner*
- *The chair of the Consumer and Family Advisory Committee (CFAC)*
- *A family member who is also a member of CFAC*

- *A consumer who is also a member of CFAC*
- *A person with healthcare expertise and experience in mh/dd/sas*
- *A person with social service expertise and experience in mh/dd/sas*
- *A person with financial experience consistent with scale and nature of MCO*
- *A person with insurance experience consistent with scale and nature of MCO*
- *An attorney with health care experience*
- *A Member of public not employed/affiliated with DHHS- appointed by Secretary*
- *The President of LME/MCO Provider Council or Designee (as non-voting- limited to open session)*

Members shall serve up to three consecutive three-year terms. The bill adds a provision to account for excessive absences. All area boards are to be in compliance by July 1, 2013. The Secretary is directed to appoint members consistent with the statute in the event a board of county commissioners fails to appoint each required category of membership.

Section 4 directs annual training for board members which includes, at a minimum, training in fiscal management, budget development, and fiscal accountability. The bill directs the Department in cooperation with the School of Government and LMEs to develop a standard curriculum for this training.

Section 5 authorizes a third term for members of a local CFAC to avoid conflicting with membership requirements of an area board.

Section 6 allows an LME to add counties to its catchment area without unanimous approval of every county within the current LME catchment area.

Section 7 provides a 2-year moratorium on single-county withdrawal from an LME. Further, the Secretary is directed to adopt rules for county disengagement that account for undisrupted services, catchment population requirements, capitation rates, and distribution of real property.

Section 8 authorizes an LME to hold title to real property. *Currently this requires approval from the board of commissioners from each county that comprises the area authority.*

Section 9 removes county commissioner approval for appointing an area director and explicitly gives an LME the authority to borrow money subject to the approval of the Local Government Commission. The section changes the manner in which quarterly fiscal reports are presented and allows the Secretary to waive any inconsistent or incompatible requirements of an LME's business plan based on active contracts to operate a 1915(b)/(c) waiver.

Section 10 provides that competitive health care information is not a public record under Chapter 132 and allows an LME acting in good faith to redact information believed to contain such information or not release the record. If the record is not released, the provision describes a process for judicial intervention.

Section 11 allows a board to approve salaries for directors and employees in excess of ranges established by the State Personnel Commission when supported by documentation of comparable salaries in comparable operations within the region approved by the Secretary.

Section 12 repeals the provision of law authorizing qualified area directors, officers, or employees of an area authority to serve as a guardian for adults adjudicated incompetent under Chapter 35A. The section redefines *disinterested public agent* to mean the director or assistant director of a county department of social services (was local human services agency). Further, the section adds training requirements for corporations contracting with the disinterested public agent and prohibits providers from serving as guardians to individuals to whom it also provides mh/dd/sa services pursuant to a contract with the LME.

Section 13 clarifies that only an LME may manage a 1915(b)/(c) Medicaid Waiver.

Section 14 authorizes the creation of behavioral health authorities as an operational model for contracting for and managing a local behavioral health program under a 1915(b)/(c) Medicaid waiver. A local management entity which has operated as a managed care organization for three years and whose governing board makes a finding and adopts a resolution that it would be in the best interest of the public health and welfare to do so may establish a behavioral health authority to manage all mh/dd/sas resources that may be available. The authority is subject to the Secretary's approval and may be revoked. A newly created Part 2A of Article for of Chapter 122C would provide all powers, duties, functions, and exemptions for a behavioral health authority.

H1075-SMSQ-76(CSSQ-83) v1

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April 2, 2012

The Honorable Fletcher Hartsell
NC Senate
300 N. Salisbury Street, Room 300-C
Raleigh, NC 27603-5925

Dear Senator Hartsell:

I am responding to your request for an update on the status of contract negotiations between hospitals, LMEs and DMA. I have been given permission to respond to you by the Area Director/CEO of my client, Western Highlands Network, which went live on the 1915(b)(c) managed care Medicaid Waiver as of January 3, 2012.

As background, LMEs are required to have written contracts with service providers under federal regulations found in 42 C.F.R. §438.206 and §438.214 and under state law found in N.C.G.S. 122C-142(a) along with regulations found in 10A NCAC. N.C.G.S. 122C-142(a) mandates that the Secretary of NC Department of Health and Human Services must approve all LME provider contracts.

It is essential to understand how important these provider contracts really are. These contracts serve a key role in defining the relationship between the LMEs and the members of its provider network and in spelling out in detail the mutual obligations of the parties. At this juncture, with the expansion of the 1915(b)(c) managed care Medicaid Waiver from one LME (PBH) as of 2011 to LMEs all across North Carolina in 2012 and 2013, the importance of good service provider contract templates as guidelines for operating a very complex managed care system cannot be exaggerated.

In the HB916, the 2011 law which mandated the statewide expansion of the 1915(b)(c) managed care Medicaid Waiver, the General Assembly required that this expansion be done "in fidelity with PBH". There was a very good reason for this provision in HB916. It was PBH that had the experience of running the 1915(b)(c) waiver. Over the years PBH developed a set of contract templates for service provider agencies, licensed independent practitioners ("LIPs"), and hospitals. These contract templates included a short contract with fairly lengthy General Conditions. The PBH contract templates, many portions of which I drafted during the more than 25 years that I represented PBH, were developed based on the requirements of federal and state laws and regulations with wording crafted to reflect the actual day-to-day experiences of PBH in

managing providers operating under the 1915(b)(c) managed care Medicaid Waiver since it went live on April 1, 2005.

In 2011, DMA sent out many PBH documents, including the PBH provider contract templates, to LMEs, including Western Highlands Network, that were preparing to go on the 1915(b)(c) Waiver. Western Highlands Network ("WHN"), in preparation for the 1915(b)(c) Waiver, began a process of enrolling its network providers that included sending them the service provider contracts based on the PBH templates.
As we reached December 2011 with our go-live date of January 3, 2012, rapidly approaching, only two providers, Mission and Pardee hospitals, were refusing to sign the contracts that WHN had sent them. Mission's lawyer, Curtis Venable, sent WHN a proposed contract that had many provisions that were very objectionable to WHN to anyone who understood how the 1915(b)(c) Waiver works. After a certain amount of back and forth discussions between these two hospitals and DMA, Mission and Pardee agreed to sign the WHN contract based on the PBH template for a 90-day term, and DMA said that it would work with the hospitals and the LMEs to amend some of the provider contract language to make it more amenable to the hospitals. That 90-day term of the Mission and Pardee contracts expires early this month.

As I understand what happened next, in January 2012 a committee was set up to work on drafting amendments for the hospital contract template. The committee included representatives of DMA and the NC Hospital Association, including Mission's lawyer Curtis Venable. The North Carolina Council of Community Programs ("the Council") was invited to send representatives, and three area directors, Betty Taylor of CenterPoint, Leza Wainwright of East Carolina Behavioral Health, and Arthur Carder of WHN, were asked by the Council to participate. Betty Taylor and Leza Wainwright did participate in the committee. Arthur Carder, however, chose not to participate and to let fellow area directors "carry the ball" for LME interests. He took this approach because he did not want these negotiations to be about a conflict between near neighbors WHN and Mission arising from contract disagreements back in December 2011. Mr. Carder expected that the negotiations would address only the provider contract template for hospitals and only a few provisions within that template. Mr. Carder also had a reasonable expectation that he and his legal counsel along with representatives of other LMEs would be given ample opportunity to review and respond to any proposed hospital contract template changes before anything was set in stone by DMA mandate.

PBH did not participate in the drafting of the new contract templates.

Instead, it was only in late February that we learned at WHN that development of a new provider contract template was reaching conclusion with the assistance of Assistant Attorney General Tracy J. Hayes (tjhayes@ncdoj.gov). I asked that I be able to review this new contract template, and Ms. Hayes sent it to me on February 28, 2012. She told me, "The hospital addendum is pretty much final."

I was very surprised and disappointed by what I saw when I reviewed the new contract template as the author of a lot of the current PBH contract template and understanding the importance of its various provisions for managing the system of care. The new template

represents a radical change, very much in the providers' favor and purports to be a template for all types of providers, not just hospitals.

The new template consists of a main contract with provisions applicable to all providers with a separate Appendix G that is different for each provider type (agencies, LIPs, hospitals). The format of General Conditions is done away with, and its contents are re-written in major ways and scattered throughout the new template in ways that make it very difficult to compare and contrast new with old. My very capable legal secretary who is familiar with the PBH contract template told me it looked like someone had thrown the current PBH template into a blender.

Upon receiving the new draft contract template on February 28, 2012, we immediately set to work to try to determine what changes had been made. We saw many problems.

One of the major themes that we saw in the new contract template was a replication of numerous objectionable provisions that had been proposed by Mission's attorney, Curtis Venable, back in December 2011.

On Monday afternoon, March 5, 2012, I received an email from Assistant Attorney General Tracy Hayes saying that she had to send out the final contract the next day and asking whether I had any comments. I quickly composed and sent her an email (Attachment A) in which I laid out at least 19 areas of concern with the draft template, and Ms. Hayes was kind enough to meet with me for an hour and a half the next day, Tuesday, March 6, 2012, and listen to my concerns, although it was made clear to me that the committee was very near concluding its work and approving the contract templates.

When I questioned the way in which I perceived the new contract template to be heavily tilted in favor of the hospitals, I was informed by Ms. Hayes that the hospitals had informed DMA that they would not participate in the new 1915(b)/(c) Medicaid Waiver without the contract changes that they were demanding being made and DMA believed that the system could not operate without the cooperation of the hospitals.

I followed up my meeting with Ms. Hayes with a couple of emails expressing other concerns and Arthur Carder began sending his concerns to his Area Director colleagues who were on the committee.

A few changes were made, but many of our major concerns remain unaddressed. As the end of the 90-day term of the Mission and Pardee contracts was rapidly approaching, I became very concerned that a very problematic template was about to be approved so on March 16, 2012, I sent an email to Ms. Hayes urgently asking that all stakeholders be invited to a conference to negotiate a workable contract template, and I received a response from her as you can see in Attachment B.

I was very disappointed when the new service provider contract template was promulgated by DMA (albeit still bearing a "Draft" stamp) on March 21, 2012. There are very significant problems and some out right illegalities with the new contract templates.

Major Problems with New Draft Service Provider Contract Template

It now appears that an attempt to meet the objections of Mission hospital have now morphed into a complete re-write of the contract templates for all providers without meaningful participation either by LME/MCOs (PIHPs) who have actual experience in operating the 1915(b)/(c) Medicaid Waiver or by anyone who has a knowledge of NC local government law, many requirements of which apply to LMEs that are designated as local political subdivisions of the State of North Carolina by N.C.G.S. 122C-116(a), organized by participating counties under N.C.G.S. 122C-115.

Further, a working group of contract managers from the LMEs was working in parallel to produce suggestions for some changes in the original PBH contract template, and these are being ignored. These new contract templates are not in fidelity with PBH.

To illustrate how the laws affecting LMEs and their operation seem to have been missed, the new contract template even cites **the wrong provision of the LME law** under which a multi-county area program such as WHN is organized (N.C.G.S. 122C-115.1 vs. the correct N.C.G.S. 122C-115).

A major concern is that instead of laying out the various detailed requirements for compliance by the Contractor with the managed care system, such as utilization management, provider monitoring, documentation of services, record keeping, authorizations for treatment, audits, investigations of enrollee grievances, submission of claims and reimbursements, the new contract templates only collect together some federal and state laws and regulations under a term defined as **"Controlling Authority"** and then simply say that in all these important areas the Contractor will comply with "Controlling Authority" without the specificity of the present PBH contract templates. This opens the door to endless bickering as to exactly what the service provider contractors are expected to do because there are many interpretations that can be placed upon regulations, many of which simply say that the LME/MCO (PIHP) is required to have contract provisions in place covering these areas.

It should be noted that the new contract template's definition of "Controlling Authority" **does not even mention the North Carolina Administrative Code** or **WHN's Waiver contract with DMA.**

It will be extremely difficult for LME contract administrators to work with this "Controlling Authority" concept in contract drafting. And please note that this was the approach that was pushed forward by Mission hospital back in December 2011.

There are several items in the new draft contract template that I view as outright illegalities or at least very problematical:

- The term of the contract is stated to be for up to three (3) years, but the so-called "Evergreen" language, making the contract subject to annual budgetary appropriations in accordance with the requirements of Article 3 of Subchapter III of Chapter 159 of the

General Statutes, **the Local Government Budget and Fiscal Control Act.** (applicable to LMEs under N.C.G.S. 122C-144.1(a)) has been removed.

- Throughout, the new template makes the LMEs agree to be subject to the new **N.C.G.S. Chapter 108C**, which is not entirely clear to us on jurisdictional grounds.

- The general requirement that contract service providers submit **incident reports** to the LMEs for provider monitoring purposes under 10A NCAC 27G Section .0600 has been removed.

- The very specific **service documentation requirements** set out at length in the DMA-WHN Waiver contract, Section 8.1, citing various DHHS manuals, has been removed. These requirements are key in determining whether services for which reimbursements have been paid have actually been provided and whether **paybacks** are due.

- Contrary to the necessities of managing a system of care, LME/PIHP staff will no longer have an automatic contract-mandated right to **have access to clients at a providers' facility**, but will have to depend on a determination by the Contractor's deciding that such access is "clinically appropriate". Without a right to inspect the Contractor's premises and actually see the clients on these premises, meaningful managed care and monitoring is severely restricted.

- In the new contract template, the LME/PIHPs agree that all business records of the Contractor will be kept out of the public domain. Depending on the business records in questions, this could result in a clear **violation of the NC Public Records Law**, N.C.G.S. Chapter 132, which has a very narrow definition of "trade secrets" exempt from the Act's coverage under N.C.G.S. 132-1.2:

  § 132-1.2. Confidential information.
  Nothing in this Chapter shall be construed to require or authorize a public agency or its subdivision to disclose any information that:
  (1) Meets all of the following conditions:
  a. Constitutes a "trade secret" as defined in G.S. 66-152(3).
  b. Is the property of a private "person" as defined in G.S. 66-152(2).
  c. Is disclosed or furnished to the public agency in connection with the owner's performance of a public contract or in connection with a bid, application, proposal, industrial development project, or in compliance with laws, regulations, rules, or ordinances of the United States, the State, or political subdivisions of the State.
  d. Is designated or indicated as "confidential" or as a "trade secret" at the time of its initial disclosure to the public agency.

- The "Prompt Pay" requirements under which the LME/PIHP has 18 days from receipt of claim to approve, deny or request additional information about a claim is impaired by requiring the LME/PIHP to provide a "Claims Status" report within 5-7 days of receipt of claim.

- Waiver of Sovereign Immunity – In the hospital-specific Appendix G of the new draft template, the LME/PIHP would waive sovereign immunity as follows:

  1. <u>WAIVER OF SOVEREIGN IMMUNITY</u>:
  LME/PIHP, only in the manner and to the extent permitted by North Carolina law, including but not limited to N.C.G.S. 122C-152 and N.C.G.S. 122C-210.1, waives the defense of sovereign immunity as to both suit and liability as to all claims and counterclaims between the parties arising from this agreement. This provision shall continue following termination of this Contract for any reason.

  As a longtime local government attorney who has represented LMEs for 29 years, who has served as a County Attorney and who has also represented several other local governments, I find this Waiver of Sovereign Immunity provision particularly disturbing. I cannot imagine why anyone with any concern for the wellbeing of LMEs or their employees would have agreed that such a provision was acceptable. I believe that it is lawful for an LME to waive sovereign immunity only in the manner permitted by N.C.G.S. 122C-152 by the purchase of insurance.

  Thank you for asking me and for your attention to this issue.

Sincerely,

Michael W. Taylor

Enclosures:
Attachments A and B

Attachment A to Letter to Senator Hartsell, April 2, 2012

From: TyrSla@aol.com [mailto:TyrSla@aol.com]
Sent: Monday, March 05, 2012 3:17 PM
To: Hayes, Tracy
Cc: Stauffer, Iain; kelly.crosbie@dhhs.nc.gov; herr1821@westernhighlands.org; donaldr@westernhighlands.org; tyrsla@aol.com
Subject: LME/MCO service provider contract templates

Dear Tracy:

Thank you very much for giving me the opportunity to review your draft service provider contract templates. My intent with the present email is to give you a brief summary of some of the concerns about the service provider contract templates you sent me that have been raised in a review of these documents at Western Highlands by Don Herring, Donald Reuss and myself. I also attach the comparison document that we have developed, setting out side by side (as much as possible) the clauses of the same subjects in your draft templates and in the currently existing contract template, along with the proposed changes that are being sought, as I understand it, by the LME Working Group with and through the NC Council.

I had intended for this to be a much more polished submission to you, but when I saw your email earlier this afternoon I realized that I need to convey our concerns to you as quickly as possible and that the importance of speed has overtaken that of polished format for the moment.

I would be happy to speak to you by telephone or in person about our concerns. I understood when I spoke with Iain a short while ago that you are working on a federal court brief due tomorrow. Knowing how intensive and attention-demanding that can be, although I would like to speak with you this afternoon, I can be in your office in Raleigh first thing in the morning or speak to you by telephone tomorrow, as you prefer.

I appreciate all the hard work you have done on these templates, having done a good bit of such work myself. As I mentioned, although there have been many additions and changes, I developed the basic format and much of the wording for the basic contract templates you've been working from in my nearly 30 years as an area program/LME attorney and particularly as I represented the first LME to go live with the 1915(b)/(c) Waiver.

Please understand that I try very hard not to have pride of authorship in these contract documents. However, having been on the front lines of Waiver operations for several years now, I see many of the clauses, as well as the way they are organized, in the presently existing DMA-approved contract templates as a lot more than mere surplusage because much of the language was drafted to address specific issues in UM, provider monitoring, record keeping, and overall management of the system of care.

In other words, the presently existing service provider contract templates, while certainly not perfect, have been honed over the years on the basis of hard experience to serve as purposeful instruments of care management. Because the LME's are placed in charge of managing the system of care, it is to be expected that some providers of care who are being managed and who do not understand the legislative mandates and the overarching policy reasons for the 1915(b)(c) waiver are going to resist, to the extent possible, imposition of any managed care authority upon them.

With that said, I would like to turn to mention a few of the issues that concern me. I am attaching the comparison document that we have developed that attempts to lay down side by side the clauses on the same or similar subjects. This has been difficult to do because the new templates have sliced and diced and reorganized the old ones, but we have done our best to compare apples to apples, so to speak.

I have only had time to go through the procurement contract template and Appendix G for hospitals as of yet, so my comments are directed at those documents. Perhaps if we can work through a few of these issues, we can reach a better understanding of where we are and might be going.

1. Controlling Authority - A concept that has been introduced into the new draft procurment contract template is that of "controlling authority", a new term that appears 23 times in the draft hospital contract template. The term is defined in Article I, ¶4, of the General Conditions. While it certainly makes sense to collect up all the legal authority with which Contractor must comply in one place, this draft goes a step further and in several places the language is drafted in such a way that the Contractor's performance obligations are said to be in accordance with "Controlling Authority" rather than specific requirements that appear in the currently existing DMA-approved contract template. While this might at first blush seem to be a harmless change, in fact it could make a wide variety of care management issues impossible or very difficult for the LME to enforce and manage. For example, there is a simple reference to Controlling Authority and an omission of specificity in many paragraphs, including those governing:

-event reporting,

-documentation with medical records,

-provider monitoring,

-cooperation with investigations,

-maintenance of detailed records of administrative costs,

-audits of paid claims,

-paybacks,

-investigations of enrollee grievances,

-utilization monitoring, and

-authorization of services.

By being drafted in this fashion, the way is left open for the hospital providers to challenge each and every contractual requirement, in part because in many cases, in the usual way with federal regs, the "controlling authority" is very general, anticipating that the specificity will be inserted by the PIHP[Don Herring] via the State Medicaid Authority (DMA in NC) .

Please be aware that this "controlling authority" approach was previously proposed last year shortly before Western Highlands went live with the Waiver by legal counsel for one of the hospitals in our area, and was rejected by DMA. It now appears that hospital counsel is trying to enter by another door with this "controlling authority" approach and other contract changes.

Among other concerns are the following:

2. In Article VIII, b. (iii), the draft moves with inclusion of "both parties" language from allowing the LME/PIHP to conduct an audit of the provider upon termination to establishing a right of the hospital to audit the LME/PIHP upon termination. Our audits are done by state and federal authorities, not by our providers.

3. The requirements are removed for providing the LME/PIHP with information necessary for its database searches, such as full names and addresses of employees who are excluded by CMS. The new draft does mention that the hospital shall not bill for excluded staff, but no disclosure to the LME/PIHP is required, thus turning the system into one of self-policing.

4. Records retention requirements mandated by state regs and state law are omitted.

5. As mentioned, there is no specificity in the requirements in the Event Reporting section, despite the very strict requirements for reporting by providers and monitoring by LME/PIHPs of defined levels of events.

6. In Article II, ¶ 8 a., access to the clients by LME /PIHP personnel is allowed only "if clinically appropriate", which is not sufficient to allow proper care coordination. The LME/PIHPs have had a working group looking at the existing service provider contract templates, and we believe that there should be a requirement in that LME/PIHP personnel be permitted to attend treatment team and discharge planning meetings in the hospital treatment unit, including interviewing the enrollee if needed . An inability to do so again improperly limits the role of the LME/PIHP in managing the system of care and places the LME/PIHP out of compliance with the DMA Contract they sign .

7. In PAYMENT OF CLAIMS (Art. IV, Bill. & Reimb., ¶ 8)), NC "prompt pay" statutes need to be cited.

8. A matter of great concern in dealing with the hospitals is the fact that while authorizations for treatment are not required for emergency treatment, treatment authorizations are required for inpatient services. There is an opportunity for blurring this line in the formulation in your draft under PAYMENT OF CLAIMS (Art. IV, Bill. & Reimb., ¶ 8), 5. which states "LME/PIHP will provide payment to CONTRACTOR for emergency and post stabilization services and for professional physician based services not requiring authorization". It must be clear that TARs are required for inpatient hospital services. Once again, an interpretation which would make the position of the LME/PIHPs more difficulty in this regard was pushed late last year by Mission's legal counsel. The idea was to taking CFR language and extending its meaning so that emergency and post-treatment stabilization INCLUDED inpatient units, which is clearly not the intention of the Fed CFR.

9. The follow-up with enrollees seems to get at "provide follow-up" rather than clearly delineating responsibilities. See CARE MANAGEMENT/COORDINATION OF CARE #b.

10. EVENT REPORTING AND ABUSE/NEGLECT/EXPLOITATION - allows again for "best efforts" which is inconsistent with DMA - LME/MCO Contract requirements and NCGA laws/rules.

11. BILLING AUDITS, DOCUMENTATION AND RECORDS RETENTION - again use of "best efforts" to comply with UM processes in direct violation of Fed regs that give specific timelines/content for initial auths, concurrent reviews and care management.

12. ACCESS BY THE LME/PIHP TO ENROLLEES AND ENROLLEE CARE MONITORING - "appropriately credentialed LME/PIHP staff" cannot be required by providers. "Requested in advance"and (24) hours prior notice ages before under e. (last sentence) - Program integrity activities do not have to be arranged in advance with CONTRACTOR" - all activities with enrollees have to do with program integrity as applies to requirements in DMA Contract.

14. Billing and Reimbursement, Article IV, ¶ 3, refers to Appendix F. Where is Appendix F?

15. In Billing and Reimbursement section, omitted is language in the current contract that specifies that rates are set by LME/PIHP and as set in DMA rate setting letter. Also omitted is language in the current contract which says the formula is "Allowable charges X Hospital's RCC (ratio cost to charge) X 80%". Language related to Diagnostic Related Group (DGR) is omitted. INSTEAD, new language in proposed Hospital template says that the allowable charges will be the lesser of Hospital's "usual and customary" charges or rates set by LME/PIHP - but the LME/PIHP's are not setting rates but are relying on DMA for rate setting for hospitals.

16.Waiver of Sovereign Immunity for contractual obligations - SI is waived by purchase of insurance under G.S. 122C-152.

17. Utilization Management process is gutted by taking out all specificity as to the UM process, including any reference Treatement Authorization Requests (TARs), treatment authorizations, etc.

18. The requirement regarding the conflict of interest policy is in the cited 1993 Session Laws and should not be removed.

There are several other concerns which I have with the hospital contract template. I have not yet had time to complete my review of your Appendices G for hospitals and for other providers. I would be very happy to come to Raleigh to meet with you about these templates or to confer with you by telephone. Thanks for all you hard work, and I look forward to speaking with you.

Mike Taylor
Michael W. Taylor, Attorney at Law, PLLC
P. O. Box 65
Albemarle, NC 28002

tel. 704 983-4209
fax 704 983-4684
cell 704 985-5722

Attachment B to Letter to Senator Hartsell, April 2, 2012

----Original Message----
From: Hayes, Tracy <TJHayes@ncdoj.gov>
To: tyrsla <tyrsla@aol.com>
Cc: Donald Reuss <donaldr@westernhighlands.org>; Don E. Herring <herr1821@westernhighlands.org>; kelly.crosbie <kelly.crosbie@dhhs.nc.gov>; tara.larson <tara.larson@dhhs.nc.gov>
Sent: Fri, Mar 16, 2012 10:18 am
Subject: RE: PIHP/Hospital Contract Template

Mike,

Thank you for your email. As I think I mentioned previously, I was not responsible for convening the meetings with NCHA that have been held over the past couple of months. My role was simply to assist DMA in revising the existing provider contract template, which many hospitals and LMEs thought was problematic. Several LME representatives were at those meetings. If Western Highlands thinks that the Department needs to convene another meeting, you would need to request that directly from DMA. Obviously, no one wants the contract to be "unworkable." However, based on input received from other LME representatives and the Council, we think the draft that was circulated does not in any way prevent the LMEs from complying with 122C or the PIHP contract.

Regards,

Tracy Hayes
Special Deputy Attorney General
NC Office of the Attorney General

From: Michael Taylor [tyrsla@aol.com]
Sent: Friday, March 16, 2012 10:05 AM
To: Hayes, Tracy
Cc: Donald Reuss; Don E. Herring; kelly.crosbie@dhhs.nc.gov
Subject: PIHP/Hospital Contract Template

Tracy:

I hope you are well today. Spring tends to bring on a sense of optimism, and I'm trying to make that my attitude as we deal with this somewhat thorny issue.

First, thank you for your diligent work here. Thank you for sharing with me the draft templates on Feb. 28th' for meeting with me on March 5th, and for your assurances that you would raise with DMA the concerns we raised with you. As we await whatever templates may be finalized, I know you can understand our continuing concerns.

As I think I've made you aware, we at Western Highlands in the PIHP world very much want to wind up with contract templates that allow us to manage the system of care (our lawfully assigned task) with hospitals as a key and, let me underscore, happy component of the system of care. We can't do this without strong providers with whom we have great relationships.

In considering the contract templates you were kind enough to share with me on February 28th, I have concluded that some of the proposed changes may reflect a simple lack of understanding on the hospitals' part of the world we LMEs/PIHPs live in and the requirements placed upon us - such as compliance with GS Chapter 122C - of which hospitals may be unaware.

A philosopher once said that, between two parties, we only know whether we have an argument if we first agree to define our terms and do so.

I would suggest that before final contract templates be put in place and set in concrete, a meeting fostering open and friendly dialogue would be held between DMA, the hospitals, and those who are actually out here on the front lines working daily to implement this legislatively-mandated managed care Medicaid Waiver.

It is in no one's interest that coontract provisions that are unworkable for either party should be in place.

Please consider convening such a meeting.

Mike Taylor
Cell 704 985-5722
Sent via BlackBerry by AT&T

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1075*

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H1075-ATL-25 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Date June 6 ,2012

Senator Tucker

moves to amend the bill on page 3, lines 36-37, by inserting between the lines:

"(13) An administrator of a hospital providing mental health, developmental disabilities, and substance abuse emergency services to serve as a nonvoting member and shall only participate in area board activities that are open to the public.";

and on page 3, line 37, by rewriting the line to read:

"Except as provided in subdivisions (12) and (13) of this subsection, an individual that contracts".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

S 1

SENATE BILL 875*

Short Title:	LME Governance.	(Public)
Sponsors:	Senator Pate.	
Referred to:	Mental Health & Youth Services.	

May 24, 2012

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN GOVERNANCE OF LOCAL MANAGEMENT ENTITIES WITH RESPECT TO THE IMPLEMENTATION OF STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-115(a) reads as rewritten:

"**§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.**

(a) A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program established pursuant to ~~G.S. 122C-115.1.~~G.S. 122C-115.1 and in accordance with rules, policies, and guidelines adopted pursuant to statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver. Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control."

SECTION 2. G.S. 122C-116 reads as rewritten:

"**§ 122C-116. Status of area authority; status of consolidated human services agency.**

(a) An area authority is a local political subdivision of the ~~State except that a single county area authority is considered a department of the county in which it is located for the purposes of Chapter 159 of the General Statutes.~~State.

(b) A consolidated human services agency is a department of the county."

SECTION 3.(a) G.S. 122C-118.1 reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) ~~An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties may have up to 30 members. In a single county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by~~

~~adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include two individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.~~ An area board shall have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or the boards of county commissioners within the area, shall appoint members consistent with the requirements provided in subsection (b) of this section. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category. A member of the board may be removed with or without cause by the initial appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chairman of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) ~~Except as otherwise~~Within the maximum membership provided in ~~this subsection, not more than fifty percent (50%) of~~subsection (a) of this section, the ~~members~~membership of the area board shall reside within the catchment area and ~~represent the following:~~ be composed as follows:

(1) ~~A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.~~At least one member who is a current county commissioner.

(2) ~~A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.~~The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.

(3) At least one family member ~~or individual from a citizens' organization composed primarily of consumers or their family members,~~of the local CFAC, as recommended by the local CFAC, representing the interests of ~~individuals:~~the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~In~~Individuals in recovery from ~~addiction; or~~addiction, or

c. ~~With~~ Individuals with intellectual or other developmental disabilities.

(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~With~~Individuals with intellectual or other developmental ~~disabilities; or~~disabilities, or

c. ~~In~~ Individuals in recovery from addiction.

(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.
(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.
(8) An individual with insurance expertise consistent with the scale and nature of the managed care organization.
(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.
(10) An attorney with health care expertise.
(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.
(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member and shall only participate in Board activities that are open to the public.

~~An~~Except as provided in subdivision (12) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. Of the members described in subdivisions (2) through (4) of this subsection, the board of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than two categories of membership if the member has the qualifications or attributes of the two categories of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the member's service as a county commissioner. Any member of an area board who is a county manager serves on the board at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the duration of the member's employment as a county manager. The terms of ~~the other~~members on the area board shall be for three years, except that upon the initial formation of an area board in compliance with subsection (a) of this section, one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. ~~Members, other than county commissioners and county managers,~~ Members shall not be appointed for more than ~~two~~three consecutive terms. ~~Board members serving as of July 1, 2006, may remain on the board for one additional term. This subsection applies to all area authority board members regardless of the procedure used to appoint members under subsection (a) of this section.~~

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes."

SECTION 3.(b) All area boards shall meet the requirements of G.S. 122C-118.1, as amended by Section 3 of this act, no later than July 1, 2013.

SECTION 4.(a) G.S. 122C-119.1 reads as rewritten:

"§ 122C-119.1. Area Authority board members' training.

All members of the governing body for an area authority shall receive initial orientation on board members' responsibilities and annual training provided by the Department ~~in~~and shall include fiscal management, budget development, and fiscal accountability. A member's refusal to be trained shall be grounds for removal from the board."

SECTION 4.(b) The North Carolina Department of Health and Human Services, in cooperation with the School of Government and the local management entities, shall develop a standardized core curriculum for the training described in Section 4(a) of this act.

SECTION 5. G.S. 122C-170(b) reads as rewritten:

"Part 4A. Consumer and Family Advisory Committees.

"§ 122C-170. Local Consumer and Family Advisory Committees.

...

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than ~~two~~three consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, developmental disabilities, and substance abuse services.

(2) Family members of consumers of mental health, developmental disabilities, and substance abuse services.

...."

SECTION 6. Area authorities may add one or more additional counties to their existing catchment area by agreement of a majority of the existing member counties.

SECTION 7.(a) Beginning July 1, 2012, and for a period of two years thereafter, the Department of Health and Human Services shall not approve any county's request to withdraw from a multicounty area authority operating under the 1915 (b)/(c) Medicaid Waiver. Not later than January 1, 2014, the Secretary shall adopt rules to establish a process for county disengagement that shall at a minimum ensure the following:

(1) Provisions of service are not disrupted by the disengagement.

(2) The disengaging county is either in compliance or plans to merge with an area authority that is in compliance with population requirements provided in G.S. 122C-155(a).

(3) The timing of the disengagement is accounted for and does not conflict with setting capitation rates.

(4) Adequate notice is provided to the affected counties, the Department of Health and Human Services, and the General Assembly.

(5) Provisions for distribution of any real property no longer within the catchment area of the area authority.

SECTION 7.(b) G.S. 122C-112.1 is amended by adding a new subdivision to read:

"(38) Adopt rules establishing a procedure for single-county disengagement from an area authority operating under a 1915 (b)/(c) Medicaid Waiver."

SECTION 8. G.S. 122C-147(c) reads as rewritten:

"§ 122C-147. Financing and title of area authority property.

...

(c) All real property purchased for use by the area authority shall be provided by local or federal funds unless otherwise allowed under subsection (b) of this section or by specific capital funds appropriated by the General Assembly. The title to this real property and the authority to acquire it is held by the ~~county where the property is located. The authority to hold title to real property and the authority to acquire it, including the area authority's authority to finance its acquisition by an installment contract under G.S. 160A-20, may be held by the area authority or by the contracting governmental entity with the approval of the board or boards of commissioners of all the counties that comprise the area authority. The approval of a board of county commissioners shall be by resolution of the board and may have any necessary or proper conditions, including provisions for distribution of the proceeds in the event of disposition of the property by the area authority.~~ area authority. Real property may not be acquired by means of an installment contract under G.S. 160A-20 unless the Local Government

Commission has approved the acquisition. No deficiency judgment may be rendered against any unit of local government in any action for breach of a contractual obligation authorized by this subsection, and the taxing power of a unit of local government is not and may not be pledged directly or indirectly to secure any moneys due under a contract authorized by this subsection.

...."

SECTION 9.(a) G.S. 122C-117 reads as rewritten:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

...

(7) Appoint an area director in accordance with G.S. 122C-121(d). ~~The appointment is subject to the approval of the board of county commissioners except that one or more boards of county commissioners may waive its authority to approve the appointment. The appointment shall be based on a selection by a search committee of the area authority board. The search committee shall include consumer board members, a county manager, and one or more county commissioners. The Secretary shall have the option to appoint one member to the search committee.~~

...

(17) Have the authority to borrow money with the approval of the Local Government Commission.

...

(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. The county finance officer shall provide the quarterly report to the board of county commissioners at the next regularly scheduled meeting of the board. The clerk of the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period of time. This information shall be ~~presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners.~~delivered to the county and, at the request of the board of county commissioners, may be presented in person by the area director or the director's designee.

...."

SECTION 9.(b) G.S. 122C-115.2 is amended by adding a new subsection to read:

"(e) The Secretary may waive any requirements of this section that are inconsistent with or incompatible with contracts entered into between the Department and the area authority for the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver."

SECTION 10. Part 2 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-126.1. Confidentiality of competitive health care information.**

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of the area authority. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of an area authority shall be a public record, unless otherwise exempted by law, or the contract contains

competitive health care information, the determination of which shall be as provided in subsection (b) of this section.

(b) If an area authority is requested to disclose any contract that the area authority believes in good faith contains or constitutes competitive health care information, the area authority may either redact the portions of the contract believed to constitute competitive health care information prior to disclosure or, if the entire contract constitutes competitive health care information, refuse disclosure of the contract. The person requesting disclosure of the contract may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decision by the court shall be whether the contract, or portions of the contract withheld, constitutes competitive health care information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure. Before rendering a decision, the court shall review the contract in camera and hear arguments from the parties. If the court finds that the contract constitutes or contains competitive health care information, the court may either deny disclosure or may make such other appropriate orders as are permitted under Rule 26(c) of the Rules of Civil Procedure.

(c) Nothing in this section shall be deemed to prevent the Attorney General, the State Auditor, or an elected public body, in closed session, which has responsibility for the area authority, from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information."

SECTION 11.(a) G.S. 126-5(a) reads as rewritten:

"§ 126-5. Employees subject to Chapter; exemptions.

(a) The provisions of this Chapter shall apply to:

(1) All State employees not herein exempt, and

(2) All employees of the following local entities:

a. Area mental health, developmental disabilities, and substance abuse ~~authorities.~~authorities except as otherwise provided in Chapter 122C of the General Statutes.

b. Local social services departments.

c. County health departments and district health departments.

d. Local emergency management agencies that receive federal grant-in-aid funds.

An employee of a consolidated county human services agency created pursuant to G.S. 153A-77(b) is not considered an employee of an entity listed in this subdivision.

(3) County employees not included under subdivision (2) of this subsection as the several boards of county commissioners may from time to time determine."

SECTION 11.(b) G.S. 122C-154 reads as rewritten:

"§ 122C-154. Personnel.

Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. Employees appointed by the county program director are employees of the county. In a multicounty program, employment of county program staff shall be as agreed upon in the interlocal agreement adopted pursuant to G.S. 122C-115.1. Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the employee. The

area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 11.(c) G.S. 122C-121(a1) reads as rewritten:

"(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. ~~An area board may request an adjustment to the salary ranges under G.S. 126-9(b). The request shall include specific information supporting the need for the adjustment, including comparative salary and patient caseload data for other LMEs, and shall also include the specific amount the area board proposes to pay the director. The area board shall not request a salary adjustment that is more than ten percent (10%) above the normal allowable salary range as determined by the State Personnel Commission.~~"Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the director. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 12.(a) G.S. 153A-76 reads as rewritten:

"**§ 153A-76. Board of commissioners to organize county government.**

The board of commissioners may create, change, abolish, and consolidate offices, positions, departments, boards, commissions, and agencies of the county government, may impose ex officio the duties of more than one office on a single officer, may change the composition and manner of selection of boards, commissions, and agencies, and may generally organize and reorganize the county government in order to promote orderly and efficient administration of county affairs, subject to the following limitations:

(1) The board may not abolish an office, position, department, board, commission, or agency established or required by law.

(2) The board may not combine offices or confer certain duties on the same officer when this action is specifically forbidden by law.

(3) The board may not discontinue or assign elsewhere a function or duty assigned by law to a particular office, position, department, board, commission, or agency.

(4) The board may not change the composition or manner of selection of a local board of education, ~~the board of health, the board of social services,~~the board of elections, or the board of alcoholic beverage control.

(5) The board may not consolidate an area mental health, developmental disabilities, and substance abuse board into a consolidated human services board. The board may not abolish an area mental health, developmental disabilities, and substance abuse board, except as provided in Chapter 122C of the General Statutes."

SECTION 12.(b) G.S. 153A-77 reads as rewritten:

"**§ 153A-77. Authority of boards of commissioners in certain counties over commissions, boards, agencies, etc.**

(a) In the exercise of its jurisdiction over commissions, boards and agencies, the board of county commissioners may assume direct control of any activities theretofore conducted by or through any commission, board or agency by the adoption of a resolution assuming and conferring upon the board of county commissioners all powers, responsibilities and duties of any such commission, board or agency. This ~~subsection~~section shall apply to the board of health, the social services board, area mental health, developmental disabilities, and substance abuse area board ~~and~~or any other commission, board or agency appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners of said county except as provided in G.S. 153A-76. A board of county

commissioners exercising the power and authority under this subsection may, notwithstanding G.S. 130A-25, enforce public health rules adopted by the board through the imposition of civil penalties. If a public health rule adopted by a board of county commissioners imposes a civil penalty, the provisions of G.S. 130A-25 making its violation a misdemeanor shall not be applicable to that public health rule unless the rule states that a violation of the rule is a misdemeanor. The board of county commissioners may exercise the power and authority herein conferred only after a public hearing held by said board pursuant to 30 days' notice of said public hearing given in a newspaper having general circulation in said county.

The board of county commissioners may also appoint advisory boards, committees, councils and agencies composed of qualified and interested county residents to study, interpret and develop community support and cooperation in activities conducted by or under the authority of the board of county commissioners of said county.

(b) In the exercise of its jurisdiction over commissions, boards, and agencies, the board of county commissioners of a county having a county manager pursuant to G.S. 153A-81 may:

(1) Consolidate ~~the provision~~certain provisions of human services in the county under the direct control of a human services director appointed and supervised by the county manager in accordance with subsection (e) of this section;

(2) Create a consolidated human services board having the powers conferred by subsection (c) of this section;

(3) Create a consolidated county human services agency having the authority to carry out the functions of any combination of commissions, boards, or agencies appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners, including the local health department, the county department of social services, ~~and~~or the area mental health, developmental disabilities, and substance abuse services authority; and

(4) Assign other county human services functions to be performed by the consolidated human services agency under the direction of the human services director, with policy-making authority granted to the consolidated human services board as determined by the board of county commissioners.

(c) A consolidated human services board appointed by the board of county commissioners shall serve as the policy-making, rule-making, and administrative board of the consolidated human services agency. The consolidated human services board shall be composed of no more than 25 members. The composition of the board shall reasonably reflect the population makeup of the county and shall include:

(1) Eight persons who are consumers of human services, public advocates, or family members of clients of the consolidated human services agency, including: one person with mental illness, one person with a developmental disability, one person in recovery from substance abuse, one family member of a person with mental illness, one family member of a person with a developmental disability, one family member of a person with a substance abuse problem, and two consumers of other human services.

(1a) Notwithstanding subdivision (1) of this subsection, a consolidated human service board not exercising powers and duties of an area mental health, developmental disabilities, and substance abuse services board shall include four persons who are consumers of human services.

(2) Eight persons who are professionals, each with qualifications in one of these categories: one psychologist, one pharmacist, one engineer, one dentist, one optometrist, one veterinarian, one social worker, and one registered nurse.

(3) Two physicians licensed to practice medicine in this State, one of whom shall be a psychiatrist.
(4) One member of the board of county commissioners.
(5) Other persons, including members of the general public representing various occupations.

The board of county commissioners may elect to appoint a member of the consolidated human services board to fill concurrently more than one category of membership if the member has the qualifications or attributes of more than one category of membership.

All members of the consolidated human services board shall be residents of the county. The members of the board shall serve four-year terms. No member may serve more than two consecutive four-year terms. The county commissioner member shall serve only as long as the member is a county commissioner.

The initial board shall be appointed by the board of county commissioners upon the recommendation of a nominating committee comprised of members of the preconsolidation board of health, social services board, and area mental health, developmental disabilities, and substance abuse services board. In order to establish a uniform staggered term structure for the board, a member may be appointed for less than a four-year term. After the subsequent establishment of the board, its board shall be appointed by the board of county commissioners from nominees presented by the human services board. Vacancies shall be filled for any unexpired portion of a term.

A chairperson shall be elected annually by the members of the consolidated human services board. A majority of the members shall constitute a quorum. A member may be removed from office by the county board of commissioners for (i) commission of a felony or other crime involving moral turpitude; (ii) violation of a State law governing conflict of interest; (iii) violation of a written policy adopted by the county board of commissioners; (iv) habitual failure to attend meetings; (v) conduct that tends to bring the office into disrepute; or (vi) failure to maintain qualifications for appointment required under this subsection. A board member may be removed only after the member has been given written notice of the basis for removal and has had the opportunity to respond.

A member may receive a per diem in an amount established by the county board of commissioners. Reimbursement for subsistence and travel shall be in accordance with a policy set by the county board of commissioners. The board shall meet at least quarterly. The chairperson or three of the members may call a special meeting.

(d) The consolidated human services board shall have authority to:
(1) Set fees for departmental services based upon recommendations of the human services director. Fees set under this subdivision are subject to the same restrictions on amount and scope that would apply if the fees were set by a county board of health, a county board of social services, or a mental health, developmental disabilities, and substance abuse area authority.
(2) Assure compliance with laws related to State and federal programs.
(3) Recommend creation of local human services programs.
(4) Adopt local health regulations and participate in enforcement appeals of local regulations.
(5) Perform regulatory health functions required by State law.
(6) Act as coordinator or agent of the State to the extent required by State or federal law.
(7) Plan and recommend a consolidated human services budget.
(8) Conduct audits and reviews of human services programs, including quality assurance activities, as required by State and federal law or as may otherwise be necessary periodically.
(9) Advise local officials through the county manager.

(10) Perform public relations and advocacy functions.
(11) Protect the public health to the extent required by law.
(12) Perform comprehensive mental health services ~~planning.~~planning if the county is exercising the powers and duties of an area mental health, developmental disabilities, and substance abuse services board under the consolidated human services board.
(13) Develop dispute resolution procedures for human services contractors and clients and public advocates, subject to applicable State and federal dispute resolution procedures for human services programs, when applicable.

Except as otherwise provided, the consolidated human services board shall have the powers and duties conferred by law upon a board of health, a social services board, and an area mental health, developmental disabilities, and substance abuse services board.

Local employees who serve as staff of a consolidated county human services agency are subject to county personnel policies and ordinances only and are not subject to the provisions of the State Personnel ~~Act.~~Act, unless the county board of commissioners elects to subject the local employees to the provisions of that Act. All consolidated county human services agencies shall comply with all applicable federal laws, rules, and regulations requiring the establishment of merit personnel systems.

(e) The human services director of a consolidated county human services agency shall be appointed and dismissed by the county manager with the advice and consent of the consolidated human services board. The human services director shall report directly to the county manager. The human services director shall:

(1) Appoint staff of the consolidated human services agency with the county manager's approval.
(2) Administer State human services programs.
(3) Administer human services programs of the local board of county commissioners.
(4) Act as secretary and staff to the consolidated human services board under the direction of the county manager.
(5) Plan the budget of the consolidated human services agency.
(6) Advise the board of county commissioners through the county manager.
(7) Perform regulatory functions of investigation and enforcement of State and local health regulations, as required by State law.
(8) Act as an agent of and liaison to the State, to the extent required by law.

Except as otherwise provided by law, the human services director or the director's designee shall have the same powers and duties as a social services director, a local health director, ~~and~~or a director of an area mental health, developmental disabilities, and substance abuse services authority.

~~(f) This section applies to counties with a population in excess of 425,000.~~"

SECTION 13.(a) G.S. 122C-122 is repealed.

SECTION 13.(b) G.S. 35A-1202(4) reads as rewritten:

"**§ 35A-1202. Definitions.**

When used in the Subchapter, unless a contrary intent is indicated or the context requires otherwise:

...

(4) "Disinterested public agent" ~~means:~~means
~~a.~~ ~~The~~the director or assistant directors of a ~~local human services agency, or~~county department of social services.
~~b. An adult officer, agent, or employee of a State human services agency. The~~Except as provided in G.S. 35A-1213(f), the fact that a disinterested public agent ~~is employed by a State or local human~~

~~services agency that~~ provides financial assistance, services, or treatment to a ward does not disqualify that person from being appointed as guardian.

...."

SECTION 13.(c) G.S. 35A-1213 reads as rewritten:

"**§ 35A-1213. Qualifications of guardians.**

(a) The clerk may appoint as guardian an adult individual, a corporation, or a disinterested public agent. The applicant may submit to the clerk the name or names of potential guardians, and the clerk may consider the recommendations of the next of kin or other persons.

(b) A nonresident of the State of North Carolina, to be appointed as general guardian, guardian of the person, or guardian of the estate of a North Carolina resident, must indicate in writing his willingness to submit to the jurisdiction of the North Carolina courts in matters relating to the guardianship and must appoint a resident agent to accept service of process for the guardian in all actions or proceedings with respect to the guardianship. Such appointment must be approved by and filed with the clerk, and any agent so appointed must notify the clerk of any change in the agent's address or legal residence. The clerk shall require a nonresident guardian of the estate or a nonresident general guardian to post a bond or other security for the faithful performance of the guardian's duties. The clerk may require a nonresident guardian of the person to post a bond or other security for the faithful performance of the guardian's duties.

(c) A corporation may be appointed as guardian only if it is authorized by its charter to serve as a guardian or in similar fiduciary capacities. A corporation shall meet the requirements outlined in Chapters 55 and 55D of the General Statutes. A corporation will provide a written copy of its charter to the clerk of superior court. A corporation contracting with a public agency to serve as guardian is required to attend guardianship training and provide verification of attendance to the contracting agency.

(d) A disinterested public agent who is appointed by the clerk to serve as guardian is authorized and required to do so; provided, if at the time of the appointment or any time subsequent thereto the disinterested public agent believes that his role or the role of his agency in relation to the ward is such that his service as guardian would constitute a conflict of interest, or if he knows of any other reason that his service as guardian may not be in the ward's best interest, he shall bring such matter to the attention of the clerk and seek the appointment of a different guardian. A disinterested public agent who is appointed as guardian shall serve in that capacity by virtue of his office or employment, which shall be identified in the clerk's order and in the letters of appointment. When the disinterested public agent's office or employment terminates, his successor in office or employment, or his immediate supervisor if there is no successor, shall succeed him as guardian without further proceedings unless the clerk orders otherwise.

(e) Notwithstanding any other provision of this section, an employee of a treatment facility, as defined in G.S. 35A-1101(16), may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works; provided, this subsection shall not apply to or affect the validity of any appointment of a guardian that occurred before October 1, 1987.

(f) An individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve as a guardian for a ward for whom the individual is providing such services."

SECTION 13.(d) G.S. 35A-1292(a) reads as rewritten:

"**§ 35A-1292. Resignation.**

(a) Any guardian who wishes to resign ~~may apply in writing to the clerk,~~shall file a motion with the clerk, setting forth the circumstances of the case. If a general guardian or guardian of the estate, at the time of making the application, also exhibits his final account for

settlement, and if the clerk is satisfied that the guardian has fully accounted, the clerk may accept the resignation of the guardian and discharge him and appoint a successor ~~guardian, but the~~guardian. The guardian so discharged and his sureties are still liable in relation to all matters connected with the guardianship before the ~~discharge.~~discharge and shall continue to ensure that the ward's needs are met until the clerk officially appoints a successor. The guardian shall attend the hearing to modify the guardianship, if physically able."

SECTION 13.(e) In order to achieve continuity of care and services, any successor guardian shall make diligent efforts to continue existing contracts entered into under the authority of G.S. 122C-122 where consistent with the best interest of the ward as required by Chapter 35A of the General Statutes.

SECTION 14. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 423
Committee Substitute Favorable 4/20/11
Committee Substitute #2 Favorable 5/10/11
PROPOSED SENATE COMMITTEE SUBSTITUTE H423-CSTL-27 [v.9]

6/6/2012 11:16:28 AM

Short Title: Ch.Protect.Serv./Ch.Care Sub./Rent Exempt. (Public)

Sponsors:

Referred to:

March 23, 2011

A BILL TO BE ENTITLED

AN ACT TO (1) MAINTAIN COUNTY LEVEL EXPENDITURES IN LOCAL FUNDS FOR CHILD PROTECTIVE SERVICES' WORKERS; (2) USE 2011 DATA SOURCE FOR CHILD CARE SUBSIDY ALLOCATION FORMULA; (3) CLARIFY THE TERM SUBSTANTIAL COMPLIANCE AS IT RELATES TO MEDICAID AND HEALTH CHOICE PROVIDER REQUIREMENTS AND, (4) EXEMPT CONTRACTS FOR THE RENTAL OF OFFICE SPACE THAT DO NOT CONSTITUTE A FINANCIAL RELATIONSHIP UNDER THE FEDERAL STARK ACT FROM THE CONFLICT OF INTEREST PROVISION OF THE HOSPITAL AUTHORITY ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Counties shall maintain their level of expenditures in local funds for Child Protective Services' workers. Of the block grant funds appropriated for Child Protective Services' workers, the total expenditures from State and local funds for the 2012-2013 fiscal year shall not be less than the total expended from State and local funds for the 2011-2012 fiscal year.

SECTION 2. Section 10.2(a) of S.L. 2011-145 is amended by adding the following new subdivisions to read:

"**SECTION 10.2.(a)** The Department of Health and Human Services shall allocate child care subsidy voucher funds to pay the costs of necessary child care for minor children of needy families. The mandatory thirty percent (30%) Smart Start subsidy allocation under G.S. 143B-168.15(g) shall constitute the base amount for each county's child care subsidy allocation. The Department of Health and Human Services shall use the following method when allocating federal and State child care funds, not including the aggregate mandatory thirty percent (30%) Smart Start subsidy allocation:

(1) Funds shall be allocated to a county based upon the projected cost of serving children under age 11 in families with all parents working who earn less than seventy-five percent (75%) of the State median income.

(2) No county's allocation shall be less than ninety percent (90%) of its State fiscal year 2001-2002 initial child care subsidy allocation.

(3) For fiscal year 2012-2013, the Division of Child Development and Early Education shall base the formula identified in subdivision (1) of this subsection on the same data source used for the 2011-2012 fiscal year.

(4) The Department of Health and Human Services shall allocate to counties all State funds appropriated for child care subsidy and shall not withhold funds during the 2012-2013 fiscal year."

SECTION 3. G.S. 108C-2 is amended by adding a new subdivision to read:

"(4a) Failed to substantially comply with the requirements of State or federal law or regulation- Based on a statistically significant and valid sample of a provider's claims for the audited period, twenty percent or more of the sampled claims did not comply with the requirements of State or federal law or regulation and met the definition of abuse as defined in 42 C.F.R. 455.2."

SECTION 4. G.S. 131E-21 reads as rewritten:

"§ 131E-21. Conflict of interest.

(a) No commissioner or employee of the hospital authority or that person's spouse shall do either of the following:

(1) Acquire any interest, direct or indirect, in any hospital facility or in any property included or planned to be included in a hospital facility.

(2) Have any interest, direct or indirect, in any contract or proposed contract for materials or services to be furnished or used in connection with any hospital facility, except an employment contract for an employee. The foregoing restriction shall not apply to any contract, undertaking, or other transaction with a bank or banking institution, savings and loan association or public utility in the regular course of its business; Provided that any such contract, undertaking, or other transaction shall be authorized by the commissioners by specific resolution on which no commissioner having an interest, direct or indirect, shall vote.

(b) The fact that a person or that person's spouse owns ten percent (10%) or less stock of a corporation or has a ten percent (10%) or less ownership in any other business entity or is an employee of that corporation or other business entity does not make the person have an "interest, direct or indirect" as this phrase is used in subsection (a) of this section; provided that, in order for the exception to apply, the contract, undertaking or other transaction shall be authorized by the commissioners by specific resolution on which no commissioner or employee having an interest, direct or indirect, shall vote.

(c) If a commissioner or employee of an authority or that person's spouse owns or controls an interest, direct or indirect, in any property included or planned to be included in any hospital facility, the commissioner or employee shall immediately disclose the same in writing to the authority and the disclosure shall be entered upon the minutes of the authority. Failure to disclose shall constitute misconduct in office and shall be grounds for a commissioner's removal from office under G.S. 131E-22.

(d) Subsection (a) of this section shall not apply to any commissioner of a hospital authority if (i) the undertaking or contract or series of undertakings or contracts between the hospital authority and one of its officials is approved by specific resolution of the governing body adopted in an open and public meeting and recorded in its minutes and the amount does not exceed twelve thousand five hundred dollars ($12,500) for medically related services and twenty-five thousand dollars ($25,000) for other goods or services within a 12-month period; and (ii) the official entering into the contract or undertaking with the hospital authority does not in an official capacity participate in any way or vote.

(e) Subsection (a) of this section shall not apply to any employment relationship between a hospital authority and the spouse of a commissioner of the hospital authority.

(e1) Subsection (a) of this section shall not apply to any contract for the rental of office space made by a lessee to a lessor if the lease agreement meets the following requirements:

(1) The agreement is set out in writing, is signed by the parties, and specifies the premises it covers.

(2) The term of the agreement is at least one year. If the agreement is terminated during the term with or without cause, the parties may not enter into a new agreement during the first year of the original term of the agreement.

(3) The space leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease. The space shall not be shared with or used by the lessor or any person or entity related to the lessor, except that the lessee may make payments for the use of space consisting of common areas if the payments do not exceed the lessee's pro rata share of expenses for the space based upon the ratio of the space used exclusively by the lessee to the total amount of space other than common areas occupied by all persons using the common areas.

(4) The rental charges over the term of the agreement are set in advance and are consistent with fair market value.

(5) The rental charges over the term of the agreement are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(6) The agreement would be commercially reasonable even if no referrals were made between the lessee and the lessor.

(7) A holdover month-to-month rental for up to 6 months immediately following an agreement of at least 1 year that met the conditions of subdivision (1) of this subsection shall be valid, provided the holdover rental is on the same terms and conditions as the immediately preceding agreement.

(f) A contract entered into in violation of this section is void. A contract that is void under this section may continue in effect until an alternative can be arranged when: (i) immediate termination would result in harm to the public health or welfare, and (ii) the continuation is approved as provided in this subsection. A hospital authority that is a party to the contract may request approval to continue contracts under this subsection from the chairman of the Local Government Commission. Approval of continuation of contracts under this subsection shall be given for the minimum period necessary to protect the public health or welfare."

SECTION 5. Section 3 of this act is effective when it becomes law and applies to all audits except those with overpayments that have become final prior to that date, the remainder of the act is effective when it becomes law.

HOUSE BILL 423:
Ch.Protect.Serv.Ch.Care Sub./Rent Exempt.

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 6, 2012
Introduced by:	Rep. Hurley	**Prepared by:**	Shawn Parker Committee Counsel
Analysis of:	PCS to Third Edition H423-CSTL-27		Patsy Pierce Legislative Analyst

SUMMARY: ***The Senate Proposed Committee Substitute (PCS) completely rewrites House Bill 423 to include two Budget provisions that are currently in the House Budget (HB 950). One of the Budget provisions directs counties to maintain level of expenditures in local funds for Child Protective Services' workers. The other Budget provision directs the Department of Health and Human Services to use current data to develop the 2012-2013 child care subsidy fund distribution formula and to allocate all funds.***

The PCS also amends Chapter 108C "Medicaid and Health Choice Provider Requirements" by providing a definition for the phrase "failed to substantially comply and amends the conflict of interest provision of the Hospital Authorities Act by exempting certain contracts for the rental of office space that meet specific statutory requirements.

BILL ANALYSIS:

Section 1. This Budget provision directs counties to maintain their level of expenditures in local funds for Child Protective Services' workers.

Section 2. This Budget provision amends Section 10.2(a) of S.L. 2011-145 by directing the Division of Child Development and Early Education of the Department of Health and Human Services (Department) to base the formula for child care subsidy fund distribution in 2012-2013 on the same data source used for the current fiscal year. The Department is also directed to allocate all child care subsidy funds to counties, and not withhold funds, during the 2012-2013 fiscal year.

Section 3. This provision provides a definition of the phrase "failed to substantially comply" as based on a significantly significant and valid sample where 20% or more of the claims did not comply with State or federal law and met the federal definitnon of abuse as provided in 42 CFR 455.2. This would create a threshold amount for the term substantial, prior to DHHS being able to extrapolate certain data under its authority provided by the Chapter.

Section 4. This provision authorizes a commissioner or an employee of a hospital authority, or the spouse of a commissioner, or an employee to contract for the rental of office space with the hospital authority if the lease agreement meets requirements which are consistent with the office rental exemption provision of federal Stark law.

EFFECTIVE DATE: This act is effective when it becomes law.

CURRENT LAW and BACKGROUND:

Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn), also known as the physician self-referral law and commonly referred to as the "Stark Law" prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship. One of the provisions of the Stark Act, 42 C.F.R. 411.357 **(see below)** provides that a contract for the rental of property owned by an employee of a health care provider is not considered a financial relationship so long as certain provisions are followed, mainly that any rental payments are tied to fair market value. There are provisions under 131E-21 related to exempt contracts for goods and services for a certain dollar amount as well a disclosure requirements for commissioners who own property included or planned to be included in any hospital facility. This act would expressly certain exempt lease agreements.

42 C.F.R. § 411.357 Exceptions to the referral prohibition related to compensation arrangements.

For purposes of §411.353, the following compensation arrangements do not constitute a financial relationship:

(a) *Rental of office space.* Payments for the use of office space made by a lessee to a lessor if there is a rental or lease agreement that meets the following requirements:

(1) The agreement is set out in writing, is signed by the parties, and specifies the premises it covers.

(2) The term of the agreement is at least 1 year. To meet this requirement, if the agreement is terminated during the term with or without cause, the parties may not enter into a new agreement during the first year of the original term of the agreement.

(3) The space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee (and is not shared with or used by the lessor or any person or entity related to the lessor), except that the lessee may make payments for the use of space consisting of common areas if the payments do not exceed the lessee's pro rata share of expenses for the space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using the common areas.

(4) The rental charges over the term of the agreement are set in advance and are consistent with fair market value.

(5) The rental charges over the term of the agreement are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(6) The agreement would be commercially reasonable even if no referrals were made between the lessee and the lessor.

(7) A holdover month-to-month rental for up to 6 months immediately following an agreement of at least 1 year that met the conditions of this paragraph (a) will satisfy this paragraph (a), provided the holdover rental is on the same terms and conditions as the immediately preceding agreement.

Retrieved from http://law.justia.com/cfr/title42/42-2.0.1.2.11.10.35.8.html on 6/5/2012

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 423

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H423-ATL-26 [v.2]

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Date June 6 ,2012

Senator Hartsell

moves to amend the bill on page 2, lines 1-3, by deleting those lines.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 1055*

Short Title:	Eliminate LME Provider Endorsement.-AB	(Public)
Sponsors:	Representatives Burr and Dollar (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Health and Human Services.	

May 23, 2012

A BILL TO BE ENTITLED

AN ACT RELATING TO PROVIDER ENDORSEMENT FUNCTIONS OF LOCAL MANAGEMENT ENTITIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-114 reads as rewritten:

"**§ 122C-114. Powers and duties of the Commission.**

(a) The Commission shall have authority as provided by this Chapter, Chapters 90 and 148 of the General Statutes, and by G.S. 143B-147.

(b) The Commission shall adopt rules regarding all of the following:

(1) The development of a process for screening, triage, and referral, including a uniform portal process, for implementation by the Secretary as required under G.S. 122C-112.1(14).

(2) LME monitoring ~~and endorsement~~ of providers of mental health, developmental disabilities, and substance abuse services.

(3) LME provision of technical assistance to providers of mental health, developmental disabilities, and substance abuse services.

(4) The requirements of a qualified public or private provider as that term is used in G.S. 122C-141. In adopting rules under this subsection, the Commission shall take into account the need to ensure fair competition among providers."

SECTION 2. 122C-115.4(b)(2) reads as rewritten:

"(2) Provider ~~endorsement,~~ monitoring, technical assistance, capacity development, and quality control. ~~An LME may remove a provider's endorsement if a provider fails to do any of the following:~~

~~a. Meet defined quality criteria.~~

~~b. Adequately document the provision of services.~~

~~c. Provide required staff training.~~

~~d. Provide required data to the LME.~~

~~e. Allow the LME access in accordance with rules established under G.S. 143B-139.1.~~

~~f. Allow the LME access in the event of an emergency or in response to a complaint related to the health or safety of a client.~~

If at anytime the LME has reasonable cause to believe a violation of licensure rules has occurred, the LME shall make a referral to the Division

of Health Service Regulation. If at anytime the LME has reasonable cause to believe the abuse, neglect, or exploitation of a client has occurred, the LME shall make a referral to the local Department of Social Services, Child Protective Services Program, or Adult Protective Services Program."

SECTION 3. G.S. 122C-151.4(a) reads as rewritten:

"(a) Definitions. – The following definitions apply in this section:

(1) "Appeals Panel" means the State MH/DD/SA Appeals Panel established under this section.

(1a) "Client" means an individual who is admitted to or receiving public services from an area facility. "Client" includes the client's personal representative or designee.

(1b) "Contract" means a contract with an area authority or county program to provide services, other than personal services, to clients and other recipients of services.

(2) "Contractor" means a person who has a contract or who had a contract during the current fiscal ~~year, or whose application for endorsement has been denied by an area authority or county program.~~year.

(3) "Former contractor" means a person who had a contract during the previous fiscal year."

SECTION 4. This act is effective when it becomes law.

HOUSE BILL 1055:
Eliminate LME Provider Endorsement.-AB

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 6, 2012
Introduced by:	Reps. Burr, Dollar	**Prepared by:**	Amy Jo Johnson Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 1055 makes changes to the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 (Chapter 122C of the North Carolina General Statutes), to eliminate provider endorsement as one of the functions and duties of a local management entity.***

[As introduced, this bill was identical to S835, as introduced by Sen. Pate, which is currently in Senate Health Care.]

BACKGROUND: House Bill 1055 was recommended by the Joint Legislative Oversight Committee on Health and Human Services.

EFFECTIVE DATE: This act is effective when it becomes law.

H1055-SMTK-68(e1) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

HOUSE BILL 1056*

Short Title:	Partnership for Children Participant Records.	(Public)
Sponsors:	Representatives Burr and Dollar (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Health and Human Services.	

May 23, 2012

A BILL TO BE ENTITLED

AN ACT TO LIMIT ACCESS TO IDENTIFYING INFORMATION OF MINOR PARTICIPANTS IN PROGRAMS FUNDED BY THE NORTH CAROLINA PARTNERSHIP FOR CHILDREN OR OTHER LOCAL PARTNERSHIPS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 132-1.12 is rewritten to read:

"**§ 132-1.12. Limited access to identifying information of minors participating in local government parks and recreation ~~programs.~~programs and programs funded by the North Carolina Partnership for Children, Inc., or a local partnership.**

(a) A public record, as defined by G.S. 132-1, does not include, as to any minor participating in a park or recreation program sponsored by a local government or combination of local governments, a program funded by the North Carolina Partnership for Children, Inc., under G.S. 143B-168.12, or a program funded by a local partnership under G.S. 143B-168.14, any of the following information as to that minor participant: (i) name, (ii) address, (iii) age, (iv) date of birth, (v) telephone number, (vi) the name or address of that minor participant's parent or legal guardian, or (vii) any other identifying information on an application to participate in such program or other records related to that program.

(b) The county, municipality, and zip code of residence of each participating minor covered by subsection (a) of this section is a public record, with the information listed in subsection (a) of this section redacted.

(c) Nothing in this section makes the information listed in subsection (a) of this section confidential information."

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

HOUSE BILL 1056:
Partnership for Children Participant Records

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 6, 2012
Introduced by:	Reps. Burr, Dollar	**Prepared by:**	Shawn Parker Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 1056 creates an exception to the public records law so that identifying information of minors participating in programs funded by the North Carolina Partnership or certain local partnerships will not be publicly available information.***

[As introduced, this bill was identical to S834, as introduced by Sen. Pate, which is currently in Senate Health Care.]

BILL ANALYSIS: Numerous records made in the transaction of public business by any agency or subdivision of North Carolina government are the property of the people and therefore the law allows individuals to obtain copies of public records for free or at minimal cost.

House Bill 1056 creates an exception so that identifying information of minors participating in programs funded by the North Carolina Partnership for Children, Inc. or local partnerships established as part of North Carolina's early childhood initiatives program will not be considered public records. The county, municipality, and zip code of a participant is public with all identifying information redacted. The bill specifically provides that the identifying information is not confidential information. Custodians of the records would have the option of disclosing the information, but are not required to do so.

G.S. 138-1.12 was enacted in 2008 to provide limited access to identifying information of minors participating in local parks and recreation programs. House Bill 1056 extends that provision of law to include minors participating in programs funded as part of the State's early childhood initiative program.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: This bill was a recommendation of the Joint Legislative Oversight Committee on Health and Human Services.

H1056-SMSQ-74(e1) v1

HOUSE BILL 1081*

Short Title:	Provisional Licensure Changes Medicaid.-AB	(Public)
Sponsors:	Representatives Burr and Dollar (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Health and Human Services.	

May 24, 2012

A BILL TO BE ENTITLED

AN ACT RELATING TO CHANGES PERTAINING TO LICENSED CLINICAL SOCIAL WORKERS, CLINICAL ADDICTION SPECIALISTS, AND PSYCHOLOGISTS, AS RECOMMENDED BY THE JOINT OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.5(d) reads as rewritten:

"(d) For permanent licensure as a licensed psychologist, an otherwise qualified psychologist must secure two years of acceptable and appropriate supervised experience germane to his or her training and intended area of practice as a psychologist. The Board shall permit such supervised experience to be acquired on a less than full-time basis, and shall additionally specify in its rules the format, setting, content, time frame, amounts of supervision, qualifications of supervisors, disclosure of supervisory relationships, the organization of the supervised experience, and the nature of the responsibility assumed by the supervisor. Supervision of health services must be received from qualified licensed psychologists holding health services provider certificates, or from other psychologists recognized by the Board in accordance with Board rules.

(1) One of these years of experience shall be postdoctoral, and for this year, the Board may require, as specified in its rules, that the supervised experience be comparable to the knowledge and skills acquired during formal doctoral or postdoctoral education, in accordance with established professional standards.

(2) One of these years may be predoctoral and the Board shall establish rules governing appropriate supervised predoctoral experience.

(3) A psychologist who meets all other requirements of G.S. 90-270.11(a) as a licensed psychologist, except the two years of supervised experience, may be issued a provisional license as a psychologist or a license as a psychological associate, without having received a master's degree or specialist degree in psychology, by the Board for the practice of psychology. ~~If the psychologist terminates the supervised experience before the completion of two years, the Board may place the psychologist on inactive status, during which time supervision will not be required, and the practice of psychology or the offer to practice psychology is prohibited. In the event a licensed psychologist issued a provisional license under this subsection is placed on inactive status or is completing the supervised experience on a part-time basis, the Board~~

~~may renew the provisional license as necessary until such time as the psychologist has completed the equivalent of two years' supervised experience.~~"

SECTION 2. G.S. 90B-3 reads as rewritten:

"**§ 90B-3. Definitions.**

The following definitions apply in this Chapter:

...

(7a) ~~Provisional Licensed Clinical Social Worker.~~Licensed Clinical Social Worker Associate. – A person issued ~~a provisional~~an associate license to provide clinical social work services pursuant to G.S. 90B-7(f).

(8) Social Worker. – A person certified, licensed, or ~~provisionally~~associate licensed by this Chapter or otherwise exempt under G.S. 90B-10."

SECTION 3. G.S. 90B-7(f) reads as rewritten:

"(f) The Board may issue ~~a provisional~~an associate license in clinical social work to a person who has a masters or doctoral degree in a social work program from a college or university having a social work program approved by the Council on Social Work Education and desires to be licensed as a clinical social worker. The ~~provisional~~associate license may not be issued for a period exceeding two years and the person issued the ~~provisional~~associate license must practice under the supervision of a licensed clinical social worker or a Board-approved alternate. Notwithstanding G.S. 90B-6(g), ~~a provisional~~an associate licensee shall pass the qualifying clinical examination prescribed by the Board within two years to be eligible for renewal of the ~~provisional~~associate license. The ~~provisional~~associate licensee shall complete all requirements for ~~full~~ licensure within three renewal cycles, or a total of six years, unless otherwise directed by the Board."

SECTION 4. G.S. 90B-16(a) reads as rewritten:

"**§ 90B-16. Title protection.**

(a) Except as provided in G.S. 90B-10, an individual who (i) is not certified, licensed, or ~~provisionally~~associate licensed by this Chapter as a social worker, (ii) does not hold a bachelor's or master's degree in social work from a college or university having a social work program accredited or admitted to candidacy for accreditation by the Council of Social Work Education, or (iii) has not received a doctorate in social work shall not use the title "Social Worker" or any variation of the title."

SECTION 5. G.S. 90-113.31A reads as rewritten:

"**§ 90-113.31A. Definitions.**

The following definitions shall apply in this Article:

...

(22a) ~~Provisional licensed clinical addictions specialist.~~Licensed Clinical Addictions Specialist Associate. – A registrant who successfully completes 300 hours of Board-approved supervised practical training in pursuit of licensure as a clinical addictions specialist.

...

(26) Substance abuse professional. – A registrant, certified substance abuse counselor, substance abuse counselor intern, certified substance abuse prevention consultant, certified clinical supervisor, ~~provisional licensed clinical addictions specialist,~~licensed clinical addictions specialist associate, licensed clinical addictions specialist, certified substance abuse residential facility director, clinical supervisor intern, or certified criminal justice addictions professional."

SECTION 6. G.S. 90-113.42(d) reads as rewritten:

"(d) Only individuals registered, certified, or licensed under this Article may use the title "Certified Substance Abuse Counselor", "Certified Substance Abuse Prevention Consultant",

"Certified Clinical Supervisor", ~~"Licensed Clinical Addictions Specialist".~~"Licensed Clinical Addictions Specialist Associate", "Certified Substance Abuse Residential Facility Director", "Certified Criminal Justice Addictions Professional", "Substance Abuse Counselor Intern", "Provisional Licensed Clinical Addictions Specialist", "Clinical Supervisor Intern", or "Registrant"."

SECTION 7. G.S. 90-113.43 reads as rewritten:

"**§ 90-113.43. Illegal practice; misdemeanor penalty.**

(a) Except as otherwise authorized in this Article, no person shall:

(1) Offer substance abuse professional services, practice, attempt to practice, or supervise while holding himself or herself out to be a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, licensed clinical addictions specialist, ~~provisional licensed clinical addictions specialist,~~ licensed clinical addictions specialist associate, certified substance abuse residential facility director, certified criminal justice addictions professional, clinical supervisor intern, substance abuse counselor intern, or registrant without first having obtained a notification of registration, certification, or licensure from the Board.

(2) Use in connection with any name any letters, words, numerical codes, or insignia indicating or implying that this person is a registrant, certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, substance abuse counselor intern, certified criminal justice addictions professional, or ~~provisional licensed clinical addictions specialist,~~ licensed clinical addictions specialist associate, unless this person is registered, certified, or licensed pursuant to this Article.

(3) Practice or attempt to practice as a certified substance abuse counselor, certified substance abuse prevention consultant, certified clinical supervisor, licensed clinical addictions specialist, certified criminal justice addictions professional, substance abuse counselor intern, ~~provisional licensed clinical addictions specialist,~~ licensed clinical addictions specialist associate, clinical supervisor intern, certified substance abuse residential facility director or registrant with a revoked, lapsed, or suspended certification or license.

(4) Aid, abet, or assist any person to practice as a certified substance abuse counselor, certified substance abuse prevention consultant, certified criminal justice addictions professional, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, registrant, substance abuse counselor intern, ~~provisional licensed clinical addictions specialist,~~ licensed clinical addictions specialist associate, or clinical supervisor intern in violation of this Article.

(5) Knowingly serve in a position required by State law or rule or federal law or regulation to be filled by a registrant, certified substance abuse counselor, certified substance abuse prevention consultant, certified criminal justice addictions professional, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, substance abuse counselor intern, ~~provisional licensed clinical addictions specialist,~~ licensed clinical addictions specialist associate, or clinical supervisor intern unless that person is registered, certified, or licensed under this Article.

(6) Repealed by S.L. 1997-492, s. 13.

(7) Repealed by Session Laws 2008-130, s. 6, effective July 28, 2008.

(b) A person who engages in any of the illegal practices enumerated by this section is guilty of a Class 1 misdemeanor. Each act of unlawful practice constitutes a distinct and separate offense."

SECTION 8. Section 10.31(d)(1)n. of S.L. 2011-145 reads as rewritten:

"n. Mental health services. – Coverage is limited to children eligible for EPSDT services provided by:

1. Licensed or certified psychologists, licensed clinical social workers, licensed clinical social workers associates, certified clinical nurse specialists in psychiatric mental health advanced practice, nurse practitioners certified as clinical nurse specialists in psychiatric mental health advanced practice, licensed psychological associates, licensed professional counselors, licensed professional counselor associates, licensed marriage and family therapists, licensed marriage and family therapist associates, licensed clinical addictions specialists, licensed clinical addiction specialists associate, and certified clinical supervisors, when Medicaid-eligible children are referred by the Community Care of North Carolina primary care physician, a Medicaid-enrolled psychiatrist, or the area mental health program or local management entity, and
2. Institutional providers of residential services as defined by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and approved by the Centers for Medicare and Medicaid Services (CMS) for children and Psychiatric Residential Treatment Facility services that meet federal and State requirements as defined by the Department."

SECTION 9. This act is effective when it becomes law.

HOUSE BILL 1081:
Provisional Licensure Changes Medicaid.-AB

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 6, 2012
Introduced by:	Reps. Burr, Dollar	**Prepared by:**	Janice Paul
Analysis of:	First Edition		Committee Counsel

SUMMARY: House Bill 1081 would make changes to the titles of certain licensed professionals to provide clarification regarding their licensure status and to meet requirements of the Center for Medicare and Medicaid Services. It would also add certain professionals to the list of providers of mandatory mental health services for children.

[As introduced, this bill was identical to S832, as introduced by Sen. Pate, which is currently in Senate Health Care.]

[As introduced, this bill was identical to S832, as introduced by Sen. Pate, which is currently in Senate Health Care.]

BILL ANALYSIS:

Section 1 of House Bill 1081 provides that the North Carolina Psychology Board may issue a provisional license as a psychologist or a psychological associate to a licensed psychologist who has not had the requisite two years' supervised experience and who has not yet received a master's or specialist degree in psychology. This section also eliminates the Board's ability to place a psychologist on inactive status for failure to complete the supervised experience requirement within two years, or to renew a provisional license until that experience requirement is met.

Sections 2, 3 and 4 change the title, "Provisional Licensed Clinical Social Worker," to "Licensed Clinical Social Worker Associate," and make conforming changes.

Sections 5, 6 and 7 change the title, "Provisional Licensed Clinical Addictions Specialist," to "Licensed Clinical Addictions Specialist Associate," and make conforming changes.

Section 8. Section 10.31(d)(1)n. of the 2011 budget bill, S.L. 2011-145, requires the Department of Health and Human Services to spend funds appropriated for Medicaid services in accordance with a specified schedule of services and payment bases. Section 8 of HB 1081 would add the following to the designation of providers of mandatory mental health services for children: licensed clinical social worker associates, licensed professional counselor associates, licensed marriage and family therapist associates, and licensed clinical addiction specialist associates.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: The Center for Medicare and Medicaid Services (CMS) requires that licensed professionals enroll directly in the Medicaid Program in an effort to better link payments to specific providers and to enhance program integrity efforts. Historically, some professions have had newly-licensed professionals bill through another provider -- for example, "incident to" a physician or through a Local Management Entity (LME) -- instead of enrolling directly.

H1081-SMTJ-72(e1) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 1075*
Committee Substitute Favorable 6/5/12
PROPOSED SENATE COMMITTEE SUBSTITUTE H1075-CSSQ-83 [v.1]

6/6/2012 10:34:26 AM

Short Title: LME/MCO Governance. (Public)

Sponsors:

Referred to:

May 24, 2012

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN GOVERNANCE OF LOCAL MANAGEMENT ENTITIES WITH RESPECT TO THE IMPLEMENTATION OF STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-115(a) reads as rewritten:

"**§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.**

(a) A county shall provide mental health, developmental disabilities, and substance abuse services in accordance with rules, policies, and guidelines adopted pursuant to statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver through an area ~~authority or~~ authority, through a county program established pursuant to ~~G.S. 122C-115.1.~~G.S. 122C-115.1, or through a behavioral health authority established pursuant to Part 2B of this Chapter. Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control."

SECTION 2.(a) G.S. 122C-116 reads as rewritten:

"**§ 122C-116. Status of area authority; status of consolidated human services agency.**

(a) An area authority is a local political subdivision of the ~~State except that a single county area authority is considered a department of the county in which it is located for the purposes of Chapter 159 of the General Statutes.~~State.

(b) A consolidated human services agency is a department of the county."

SECTION 2.(b) G.S. 122C-115.1(i) reads as rewritten:

"(i) Except as otherwise specifically provided, this Chapter applies to counties that provide mental health, developmental disabilities, and substance abuse services through a county program. As used in the applicable sections of this Article, the terms "area authority", "area program", and "area facility" shall be construed to include "county program". ~~The following sections of this Article do not apply to county programs:~~

~~(1) G.S. 122C-115.3, 122C-116, 122C-117, and 122C-118.1.~~
~~(2) G.S. 122C-119 and G.S. 122C-119.1.~~
~~(3) G.S. 122C-120 and G.S. 122C-121.~~
~~(4) G.S. 122C-127.~~
~~(5) G.S. 122C-147.~~
~~(6) G.S. 122C-152 and G.S. 122C-153.~~
~~(7) G.S. 122C-156.~~
~~(8) G.S. 122C-158.~~"

SECTION 3.(a) G.S. 122C-118.1 reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) ~~An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties may have up to 30 members. In a single-county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include two individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.~~ An area board shall have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or the boards of county commissioners within the area, shall appoint members consistent with the requirements provided in subsection (b) of this section. The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category. A member of the board may be removed with or without cause by the initial appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chairman of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) ~~Except as otherwise~~Within the maximum membership provided in ~~this subsection, not more than fifty percent (50%) of~~subsection (a) of this section, the ~~members~~membership of the area board shall reside within the catchment area and ~~represent the following:~~ be composed as follows:

(1) ~~A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.~~At least one member who is a current county commissioner.

(2) ~~A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.~~The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.

(3) At least one family member ~~or individual from a citizens' organization composed primarily of consumers or their family members,~~of the local CFAC, as recommended by the local CFAC, representing the interests of ~~individuals:~~the following:

a. ~~With~~Individuals with mental ~~illness:~~illness, or

b. ~~In~~Individuals in recovery from ~~addiction; or~~addiction, or

c. ~~With~~ Individuals with intellectual or other developmental disabilities.

(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~With~~Individuals with intellectual or other developmental ~~disabilities; or~~disabilities, or

c. ~~In~~ Individuals in recovery from addiction.

(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.

(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.

(8) An individual with insurance expertise consistent with the scale and nature of the managed care organization.

(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(10) An attorney with health care expertise.

(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.

(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

~~An~~Except as provided in subdivision (12) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on an area authority board. Of the members described in subdivisions (2) through (4) of this subsection, the boards of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than two categories of membership if the member has the qualifications or attributes of the two categories of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed

the earlier of three years or the member's service as a county commissioner. Any member of an area board who is a county manager serves on the board at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the duration of the member's employment as a county manager. The terms of ~~the other~~members on the area board shall be for three years, except that upon the initial formation of an area board in compliance with subsection (a) of this section, one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. ~~Members, other than county commissioners and county managers,~~ Members shall not be appointed for more than ~~two~~three consecutive terms. ~~Board members serving as of July 1, 2006, may remain on the board for one additional term. This subsection applies to all area authority board members regardless of the procedure used to appoint members under subsection (a) of this section.~~

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes."

SECTION 3.(b) All area boards shall meet the requirements of G.S. 122C-118.1, as amended by subsection (a) of this section, no later than July 1, 2013.

SECTION 4.(a) G.S. 122C-119.1 reads as rewritten:

"**§ 122C-119.1. Area Authority board members' training.**

All members of the governing body for an area authority shall receive initial orientation on board members' responsibilities and annual training provided by the Department ~~in~~which shall include fiscal management, budget development, and fiscal accountability. A member's refusal to be trained shall be grounds for removal from the board."

SECTION 4.(b) The North Carolina Department of Health and Human Services, in cooperation with the School of Government and the local management entities, shall develop a standardized core curriculum for the training described in subsection (a) of this section.

SECTION 5. G.S. 122C-170(b) reads as rewritten:

"Part 4A. Consumer and Family Advisory Committees.

"**§ 122C-170. Local Consumer and Family Advisory Committees.**

...

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than ~~two~~three consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, developmental disabilities, and substance abuse services.

(2) Family members of consumers of mental health, developmental disabilities, and substance abuse services.

...."

SECTION 6. Area authorities may add one or more additional counties to their existing catchment area by agreement of a majority of the existing member counties.

SECTION 7.(a) Beginning July 1, 2012, and for a period of two years thereafter, the Department of Health and Human Services shall not approve any county's request to withdraw from a multicounty area authority operating under the 1915(b)/(c) Medicaid Waiver. Not later than January 1, 2014, the Secretary shall adopt rules to establish a process for county disengagement that shall at a minimum ensure the following:

(1) Provisions of service are not disrupted by the disengagement.

(2) The disengaging county is either in compliance or plans to merge with an area authority that is in compliance with population requirements provided in G.S. 122C-155(a).

(3) The timing of the disengagement is accounted for and does not conflict with setting capitation rates.

(4) Adequate notice is provided to the affected counties, the Department of Health and Human Services, and the General Assembly.

(5) Provisions for distribution of any real property no longer within the catchment area of the area authority.

SECTION 7.(b) G.S. 122C-112.1 is amended by adding a new subdivision to read:

"(38) Adopt rules establishing a procedure for single-county disengagement from an area authority operating under a 1915(b)/(c) Medicaid Waiver."

SECTION 8. G.S. 122C-147(c) reads as rewritten:

"**§ 122C-147. Financing and title of area authority property.**

...

(c) All real property purchased for use by the area authority shall be provided by local or federal funds unless otherwise allowed under subsection (b) of this section or by specific capital funds appropriated by the General Assembly. The title to this real property and the authority to acquire it is held by the ~~county where the property is located. The authority to hold title to real property and the authority to acquire it, including the area authority's authority to finance its acquisition by an installment contract under G.S. 160A-20, may be held by the area authority or by the contracting governmental entity with the approval of the board or boards of commissioners of all the counties that comprise the area authority. The approval of a board of county commissioners shall be by resolution of the board and may have any necessary or proper conditions, including provisions for distribution of the proceeds in the event of disposition of the property by the area authority.~~ area authority. Real property may not be acquired by means of an installment contract under G.S. 160A-20 unless the Local Government Commission has approved the acquisition. No deficiency judgment may be rendered against any unit of local government in any action for breach of a contractual obligation authorized by this subsection, and the taxing power of a unit of local government is not and may not be pledged directly or indirectly to secure any moneys due under a contract authorized by this subsection.

...."

SECTION 9.(a) G.S. 122C-117 reads as rewritten:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

...

(7) Appoint an area director in accordance with G.S. 122C-121(d). ~~The appointment is subject to the approval of the board of county commissioners except that one or more boards of county commissioners may waive its authority to approve the appointment. The appointment shall be based on a selection by a search committee of the area authority board. The search committee shall include consumer board members, a county manager, and one or more county commissioners. The Secretary shall have the option to appoint one member to the search committee.~~

...

(17) Have the authority to borrow money with the approval of the Local Government Commission.

...

(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. The county finance officer shall provide the quarterly report to the board of county commissioners at the next regularly scheduled meeting of the board. The clerk of the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period

of time. This information shall be ~~presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners.~~delivered to the county and, at the request of the board of county commissioners, may be presented in person by the area director or the director's designee.

...."

SECTION 9.(b) G.S. 122C-115.2 is amended by adding a new subsection to read:

"(e) The Secretary may waive any requirements of this section that are inconsistent with or incompatible with contracts entered into between the Department and the area authority for the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver."

SECTION 10. Part 2 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-126.1. Confidentiality of competitive health care information.**

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of the area authority. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of an area authority shall be a public record, unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section.

(b) If an area authority is requested to disclose any contract that the area authority believes in good faith contains or constitutes competitive health care information, the area authority may either redact the portions of the contract believed to constitute competitive health care information prior to disclosure or, if the entire contract constitutes competitive health care information, refuse disclosure of the contract. The person requesting disclosure of the contract may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decision by the court shall be whether the contract, or portions of the contract withheld, constitutes competitive health care information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure. Before rendering a decision, the court shall review the contract in camera and hear arguments from the parties. If the court finds that the contract constitutes or contains competitive health care information, the court may either deny disclosure or may make such other appropriate orders as are permitted under Rule 26(c) of the Rules of Civil Procedure.

(c) Nothing in this section shall be deemed to prevent the Attorney General, the State Auditor, or an elected public body, in closed session, which has responsibility for the area authority, from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information."

SECTION 11.(a) G.S. 126-5(a) reads as rewritten:

"**§ 126-5. Employees subject to Chapter; exemptions.**

(a) The provisions of this Chapter shall apply to:

(1) All State employees not herein exempt, and

(2) All employees of the following local entities:

a. Area mental health, developmental disabilities, and substance abuse ~~authorities.~~authorities, except as otherwise provided in Chapter 122C of the General Statutes.
b. Local social services departments.
c. County health departments and district health departments.
d. Local emergency management agencies that receive federal grant-in-aid funds.

An employee of a consolidated county human services agency created pursuant to G.S. 153A-77(b) is not considered an employee of an entity listed in this subdivision.

(3) County employees not included under subdivision (2) of this subsection as the several boards of county commissioners may from time to time determine."

SECTION 11.(b) G.S. 122C-154 reads as rewritten:

"**§ 122C-154. Personnel.**

Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. Employees appointed by the county program director are employees of the county. In a multicounty program, employment of county program staff shall be as agreed upon in the interlocal agreement adopted pursuant to G.S. 122C-115.1. Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the employee. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 11.(c) G.S. 122C-121(a1) reads as rewritten:

"(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. ~~An area board may request an adjustment to the salary ranges under G.S. 126-9(b). The request shall include specific information supporting the need for the adjustment, including comparative salary and patient caseload data for other LMEs, and shall also include the specific amount the area board proposes to pay the director. The area board shall not request a salary adjustment that is more than ten percent (10%) above the normal allowable salary range as determined by the State Personnel Commission.~~Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the director. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 12.(a) G.S. 122C-122 is repealed.

SECTION 12.(b) G.S. 35A-1202(4) reads as rewritten:

"**§ 35A-1202. Definitions.**

When used in the Subchapter, unless a contrary intent is indicated or the context requires otherwise:

...

(4) "Disinterested public agent" ~~means:~~means

~~a.~~ ~~The~~the director or assistant directors of a ~~local human services agency, or~~county department of social services.

~~b. An adult officer, agent, or employee of a State human services agency. The~~Except as provided in G.S. 35A-1213(f), the fact that a disinterested public agent ~~is employed by a State or local human services agency that~~ provides financial assistance, services, or treatment to a ward does not disqualify that person from being appointed as guardian.

...."

SECTION 12.(c) G.S. 35A-1213 reads as rewritten:

"**§ 35A-1213. Qualifications of guardians.**

(a) The clerk may appoint as guardian an adult individual, a corporation, or a disinterested public agent. The applicant may submit to the clerk the name or names of potential guardians, and the clerk may consider the recommendations of the next of kin or other persons.

(b) A nonresident of the State of North Carolina, to be appointed as general guardian, guardian of the person, or guardian of the estate of a North Carolina resident, must indicate in writing his willingness to submit to the jurisdiction of the North Carolina courts in matters relating to the guardianship and must appoint a resident agent to accept service of process for the guardian in all actions or proceedings with respect to the guardianship. Such appointment must be approved by and filed with the clerk, and any agent so appointed must notify the clerk of any change in the agent's address or legal residence. The clerk shall require a nonresident guardian of the estate or a nonresident general guardian to post a bond or other security for the faithful performance of the guardian's duties. The clerk may require a nonresident guardian of the person to post a bond or other security for the faithful performance of the guardian's duties.

(c) A corporation may be appointed as guardian only if it is authorized by its charter to serve as a guardian or in similar fiduciary capacities. A corporation shall meet the requirements outlined in Chapters 55 and 55D of the General Statutes. A corporation will provide a written copy of its charter to the clerk of superior court. A corporation contracting with a public agency to serve as guardian is required to attend guardianship training and provide verification of attendance to the contracting agency.

(d) A disinterested public agent who is appointed by the clerk to serve as guardian is authorized and required to do so; provided, if at the time of the appointment or any time subsequent thereto the disinterested public agent believes that his role or the role of his agency in relation to the ward is such that his service as guardian would constitute a conflict of interest, or if he knows of any other reason that his service as guardian may not be in the ward's best interest, he shall bring such matter to the attention of the clerk and seek the appointment of a different guardian. A disinterested public agent who is appointed as guardian shall serve in that capacity by virtue of his office or employment, which shall be identified in the clerk's order and in the letters of appointment. When the disinterested public agent's office or employment terminates, his successor in office or employment, or his immediate supervisor if there is no successor, shall succeed him as guardian without further proceedings unless the clerk orders otherwise.

(e) Notwithstanding any other provision of this section, an employee of a treatment facility, as defined in G.S. 35A-1101(16), may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works; provided, this subsection shall not apply to or affect the validity of any appointment of a guardian that occurred before October 1, 1987.

(f) An individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve as a guardian for a ward for whom the individual is providing such services."

SECTION 12.(d) G.S. 35A-1292(a) reads as rewritten:

"**§ 35A-1292. Resignation.**

(a) Any guardian who wishes to resign ~~may apply in writing to the clerk,~~shall file a motion with the clerk setting forth the circumstances of the case. If a general guardian or guardian of the estate, at the time of making the application, also exhibits his final account for settlement, and if the clerk is satisfied that the guardian has fully accounted, the clerk may accept the resignation of the guardian and discharge him and appoint a successor ~~guardian, but the~~guardian. The guardian so discharged and his sureties are still liable in relation to all matters connected with the guardianship before the ~~discharge.~~discharge and shall continue to ensure that the ward's needs are met until the clerk officially appoints a successor. The guardian shall attend the hearing to modify the guardianship, if physically able."

SECTION 12.(e) In order to achieve continuity of care and services, any successor guardian shall make diligent efforts to continue existing contracts entered into under the authority of G.S. 122C-122 where consistent with the best interest of the ward as required by Chapter 35A of the General Statutes.

SECTION 13.(a) Section 1(a)(3) of S.L. 2011-264 reads as rewritten:

"(3) Designate ~~a single entity~~an area authority for mental health, developmental disabilities, and substance abuse services to assume responsibility for all aspects of Waiver management. The following operational models are ~~acceptable options for Local Management Entity (LME) applicants:~~acceptable:

a. Merger model: A single larger LME is formed from the merger of two or more LMEs.

b. Interlocal agreement among LMEs: A single LME is identified as the leader for all Waiver operations, financial management, and accountability for performance measures."

SECTION 13.(b) Section 1(c) of S.L. 2011-264 reads as rewritten:

"**SECTION 1.(c)** The Department shall require LMEs that have not been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013, to merge with or be aligned through an interlocal agreement with an LME that has been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver. If any LME fails to comply with this requirement, or fails to meet performance requirements of an approved contract with the Department to operate a 1915(b)/(c) Medicaid Waiver, the Department shall assign responsibility for management of the 1915(b)/(c) Medicaid Waiver on behalf of the noncompliant LME to an LME that is successfully operating the Waiver and successfully meeting performance requirements of the contract with the Department. Those LMEs approved to operate the 1915(b)/(c) Medicaid Waiver under an interlocal agreement must have a single LME entity designated as responsible for all aspects of Waiver operations and solely responsible for meeting contract requirements."

SECTION 14.(a) Article 4 of Chapter 122C of the General Statutes is amended by adding a new Part to read:

"Part 2B. Behavioral Health Authority.

"**§ 122C-29. Behavioral Health Authority Creation; Approval and Oversight.**

A behavioral health authority may be created under the provisions of this Part whenever the governing board of the local management entity, which has been operating as a managed care organization under a 1915(b)/(c) Medicaid Waiver for at least three years, finds and adopts a resolution finding that it is in the interest of the public health and welfare to create a behavioral health authority in order to manage resources that may be available for mental health, intellectual and other developmental disabilities, and substance abuse services. An LME's organization as a behavioral health authority is subject to the approval of the Secretary which shall be based on the LME's demonstration of successful operation as a managed care

organization. The LME shall be subject to periodic review and may be revoked by the Secretary upon a finding that the LME is no longer successfully operating as an managed care organization as defined in 42 C.F.R 438.2.

"**§ 122C-29.1. Functions of a behavioral health authority.**

A behavioral health authority shall perform all the functions necessary to carry out the purposes of this Part, including, but not limited to, the following:

(1) Establish accountability for the development and management of a local system that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for individuals in need of mental health, intellectual and developmental disabilities, and substance abuse services.

(2) Operate the 1915(b)/(c) Medicaid Waiver, a proven system for the management of mental health, intellectual and developmental disabilities, and substance abuse services.

(3) Manage resources that are or become available for mental health, intellectual and developmental disabilities, and substance abuse services.

(4) Use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid program while ensuring medically necessary care and deploy a system for the allocation of resources based on the reliable assessment of intensity of need. These strategies shall efficiently direct individuals to appropriate services and shall ensure that they receive no more and no less than the amount of services determined to be medically necessary and at the appropriate funding level.

(5) Maintain a local presence in order to respond to the unique needs and priorities of localities.

(6) Ensure communication with consumers, families, providers, and stakeholders regarding disability-specific and general Waiver operations by implementing a process for feedback and exchange of information and ideas.

(7) Establish and maintain systems for ongoing communication and coordination regarding the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems such as local departments of social services, Community Care of North Carolina, hospitals, school systems, the Division of Juvenile Justice of the Department of Public Safety, and other community agencies.

(8) Maintain disability specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

(9) Conduct administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information technology systems, financial reporting, and staffing.

(10) Maintain full accountability of for all aspects of Waiver operations and for meeting all contract requirements specified by the Department of Health and Human Services.

(11) Authorize the utilization of State psychiatric hospitals and other State facilities.

(12) Authorize eligibility determination requests for the 1915(b)/(c) Medicaid Waiver.

"**§ 122C-29.2. Directors of a behavioral health authority.**

(a) Upon approval by the Secretary to organize under this part, the Area Board of the LME shall become the Board of Directors of the behavioral health authority. Directors shall serve out the term for which they were appointed to the Area Board. Thereafter, when a Director resigns, is removed from office, completes a term of office, or when there is an increase in the number of Directors, the election of Directors to the Board shall be in accordance with bylaws set forth for such purpose and may be amended as necessary or convenient to carry out the functions, powers, duties and responsibilities of the Behavioral Health Authority.

(b) At a minimum, the bylaws of the Behavioral Health Authority shall set the number, composition, term, and method of appointment of the Board of Directors. Membership of the Board of Directors shall take into account representation of the counties or geographic areas in which the behavioral health authority operates the 1915(b)/(c) Medicaid Waiver and manages resources for mental health, intellectual and developmental disabilities, and substance abuse services and should be comprised of a mix of individuals with the necessary expertise to govern Managed Care Organizations. When possible, the Directors should include a physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina, and who is board certified in psychiatry; a clinical professional from the fields of mental health, developmental disabilities, or substance abuse; an individual with financial expertise, including previous fiscal oversight experience with large organizations; and at least one family member or individual from a citizens' organization representing the interests of individuals with mental illness, intellectual and developmental disabilities, or substance abuse. An individual that contracts with a behavioral health authority for the delivery of behavioral healthcare services shall not serve on the Board of Directors during the period for which the contract for services is in effect.

(c) The Board of Directors shall be responsible for ensuring the behavioral health authority maintains a local presence and is responsive to the unique needs and priorities of localities.

"**§ 122C-29.3. Powers of the behavioral health authority.**

(a) A behavioral health authority shall have all powers necessary or convenient to carry out the purposes of this Part, including the following powers, which are in addition to those powers granted elsewhere in this Part:

(1) To engage in comprehensive planning, implementing, and monitoring of community based mental health, intellectual and developmental disabilities, and substance abuse services, including for individuals committed to the custody of the Department of Social Services and the Division of Juvenile Justice of the Department of Public Safety.

(2) To comply with federal requirements for Medicaid, Medicare, block grants, and other federally funded health care programs.

(3) To perform public relations and community advocacy functions.

(4) To maintain a 24-hour a day, seven day a week crisis response service. Crisis response shall include telephone and face-to-face capabilities. Crisis phone response shall include triage and referral to appropriate face-to-face crisis providers. Crisis services do not require prior authorization, but shall be delivered in compliance with appropriate policies and procedures. Crisis services shall be designed for prevention, intervention, and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety.

(5) To accept donations or money, personal property, or real estate for the benefit of the behavioral health authority and to take title to the same from any person, firm, corporation or society.
(6) To purchase, lease, obtain options upon, or otherwise acquire any real or personal property or any interest therein from any person, firm, corporation, city, county, government or society.
(7) To sell, exchange, transfer, assign, or pledge any real or personal property or any interest therein to any person, firm, corporation, city, county, government or society.
(8) To own, hold, clear and improve property.
(9) To appoint a Chief Executive Officer and to fix his or her compensation.
(10) To delegate to its agents or employees any powers or duties as it may deem appropriate.
(11) To employ its own counsel and legal staff.
(12) To adopt, amend and repeal bylaws for the conduct of its business.
(13) To enter into contracts for necessary supplies, equipment, or services for the operation of its business.
(14) To appoint committees or subcommittees as it shall deem advisable, to fix their duties and responsibilities, and to do all things necessary in connection with the management, supervision, control and operation of the behavioral health authority's business.
(15) To enter into any contracts or other arrangements with any municipality, other public agency of this or any other State or of the United States, or with any individual, private organization, corporation, or nonprofit association for the provision of behavioral health or other services.
(16) To act as an agent for the federal, State or local government in connection with the management of behavioral health services.
(17) To insure the property or the operations of the behavioral health authority against risks as the behavioral health authority may deem advisable.
(18) To invest any funds held in reserves or sinking funds, or any funds not required for immediate disbursement, in property or securities in which trustees, guardians, executors, administrators, and others acting in a fiduciary capacity may legally invest funds under their control.
(19) To sue and be sued.
(20) To have a seal and to alter it at pleasure.
(21) To have perpetual succession.
(22) To make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the behavioral health authority, including providing services to governmental or private entities, including Employee Assistance Programs.
(23) To provide teaching and instruction programs and schools for psychiatrists, psychologists, psychiatric nurses, technicians and students, interns, and other behavioral healthcare professionals.
(24) To agree to limitations upon the exercise of any powers conferred upon the behavioral health authority by this Part in connection with any loan by a government.

(b) A behavioral health authority may exercise any or all of the powers conferred upon it by this Part, either generally or directly, or through designated agents, including any corporation or corporations which are or shall be formed under the laws of this State.

(c) No provisions with respect to the acquisition, operation or disposition of property by other public bodies shall be applicable to a behavioral health authority unless otherwise specified by the General Assembly.

"**§ 122C-29.4. Compensation; Personnel Policies; Employee Benefits Plans.**

(a) For the purpose of personnel administration, a behavioral health authority is exempted from Chapter 126 of the General Statutes.

(b) A behavioral health authority shall determine the pay, expense allowances, and other compensation of its officers and employees, and may establish position classification and pay plans and incentive compensation plans.

(c) A behavioral health authority shall:

(1) Adopt personnel policies and procedures regarding, without limitation, vacations, personal leave, service award programs, other personnel policies and procedures, and any other measures that enhance the ability of a behavioral health authority to hire and retain employees.

(2) Determine the work hours, workdays, and holidays applicable to its employees.

(3) Establish and pay all or part of the cost of benefit plans for its employees and former employees, including without limitation, life, health and disability plans, pension, deferred compensation and other retirement plans, and other fringe benefit plans.

(4) Pay severance payments and provide other employee severance benefits to its employees and former employees pursuant to a severance plan established in connection with a reduction in the size of the workforce plan, or with respect to an individual employee, pursuant to an employment agreement entered into prior to the date the employee receives notice of termination of employment.

(5) Provide for biennial assessments of the behavioral health authority's personnel plans by an independent entity that specializes in human resources development and management. Such assessments shall be submitted to the Secretary and shall ensure that position classifications and compensation are appropriately matched to industry standards and local job market requirements.

(d) A behavioral health authority shall be subject to the same requirements and responsibilities regarding the disclosure and privacy of personnel records in accordance with G.S. 122C-158.

"**§ 122C-29.5. Limited Liability.**

(a) A person serving as a director, trustee, or officer of a behavioral health authority shall be immune individually from civil liability for monetary damages, except to the extent covered by insurance, for any act or failure to act arising out of this service, except where the person:

(1) Was not acting within the scope of his official duties;

(2) Was not acting in good faith;

(3) Committed gross negligence or willful or wanton misconduct that resulted in the damage or injury; or

(4) Derived an improper personal financial benefit from the transaction.

(b) The immunity in subsection (a) is personal to the directors, trustees, and officers, and does not immunize a behavioral health authority for liability for the acts or omissions of the directors, trustees, or officers.

(c) In addition to the immunity granted in subsection (a), a behavioral health authority may waive its governmental immunity from liability for damages caused by the negligence or

tort of any agent, employee, or Director of the behavioral health authority when acting within the scope of his authority or within the course of his duties or employment. Governmental immunity is waived by the act of obtaining this insurance, but it is waived only to the extent that the behavioral health authority is indemnified by insurance for the negligence or tort.

(d) A behavioral health authority may incur liability pursuant to this section only with respect to a claim arising after the behavioral health authority has procured liability insurance pursuant to this section and during the time when the insurance is in force.

(e) No part of the pleadings that relate to or allege facts as to a defendant's insurance against liability may be read or mentioned in the presence of the trial jury in any action brought pursuant to this section. These issues shall be heard and determined by the judge, and the jury shall be absent during any motions, arguments, testimony, or announcement of findings of fact or conclusions of law with respect to insurance.

(f) Upon request by any agent, employee, or Director or former agent, employee, or Director, a behavioral health authority may provide for the defense of any civil or criminal action or proceeding brought against the agent, employee, or Director, either in his official or in his individual capacity, or both, on account of any act done or omission made, or any act allegedly done or omission allegedly made, in the scope and course of his duty as an agent, employee, or Director. The defense may be provided by employing counsel or by purchasing insurance that requires the insurer to provide the defense. Nothing in this section requires a behavioral health authority to provide for the defense of any action or proceeding of any nature.

"**§ 122C-29.6. Applicability of the Local Government Budget and Fiscal Control Act.**

(a) The Local Government Budget and Fiscal Control Act applies to behavioral health authorities, except that the provisions of Parts 1, 2, and 3 of Article 3 of the Act do not apply to behavioral health authorities, which shall instead be subject to the provisions of this section.

(b) A behavioral health authority shall appoint or designate a finance officer, who shall have the following powers and duties:

(1) Prepare the annual budget for presentation to the governing board of the behavioral health authority and shall administer the budget as approved by the board;

(2) Keep the accounts of the behavioral health authority in accordance with generally accepted principles of accounting;

(3) Prepare and file a statement of the financial condition of the behavioral health authority as revealed by its accounts upon the request of the behavioral health authority's governing board or the governing board of any county, city, or other unit of local government that has issued on behalf of the behavioral health authority and has outstanding its general obligation or revenue bonds or makes current appropriations to the behavioral health authority;

(4) Receive and deposit all moneys accruing to the behavioral health authority, or supervise the receipt and deposit of money by other duly authorized officers or employees of the behavioral health authority;

(5) Supervise the investment of idle funds of the behavioral health authority; and

(6) Maintain all records concerning the bonded debt of the behavioral health authority, if any, determine the amount of money that will be required for debt service during each fiscal year, and maintain all sinking funds, but shall not be responsible for records concerning the bonded debt of any county, city, or other unit of local government incurred on behalf of the behavioral health authority.

(c) The Local Government Commission has authority to issue rules and regulations governing procedures for the receipt, deposit, investment, transfer, and disbursement of money and other assets by behavioral health authorities, may inquire into and investigate the internal control procedures of a behavioral health authority, and may require any modifications in internal control procedures which, in the opinion of the Commission, are necessary or desirable to prevent embezzlements, mishandling of funds, or continued operating deficits.

(d) The accounting system of a behavioral health authority shall be so designed that the true financial condition of the behavioral health authority can be determined therefrom at any time. As soon as possible after the close of each fiscal year, the accounts shall be audited by a certified public accountant or by an accountant certified by the Local Government Commission as qualified to audit local government accounts. The auditor shall be selected by and shall report directly to the behavioral health authority's governing board. The audit contract or agreement shall be in writing, shall include all its terms and conditions, and shall be submitted to the secretary of the Local Government Commission for his approval as to form, terms and conditions. The terms and conditions of the audit shall include the scope of the audit, and the requirement that upon completion of the examination the auditor shall prepare a written report embodying financial statements and his opinion and comments relating thereto. The finance officer shall file a copy of the audit with the secretary of the Local Government Commission and with the finance officer of any county, city, or other unit of local government that has issued on behalf of the behavioral health authority and has outstanding its general obligation or revenue bonds or makes current appropriations to the behavioral health authority (other than appropriations for the cost of behavioral healthcare or programs).

(e) A behavioral health authority may deposit or invest at interest all or part of its cash balance pursuant to G.S. 159-30 and may deposit any funds held in reserves or sinking funds, or any funds not required for immediate disbursement, with the State Treasurer for investment pursuant to G.S. 147-69.2.

(f) A behavioral health authority is subject to G.S. 159-31 with regard to selection of an official depository and security of deposits.

(g) A behavioral health authority is subject to G.S. 159-32 with regard to daily deposits.

(h) A behavioral health authority may accept electronic payments pursuant to G.S. 159-32.1.

(i) A behavioral health authority is subject to G.S. 159-33 with regard to semiannual reports to the Local Government Commission on the status of deposits and investments.

(j) A behavioral health authority having outstanding general obligation or revenue bonds is subject to G.S. 159-35, 159-36, 159-37, and 159-38.

"**§ 122C-29.7. Revenue Bonds and Purchase Money Security Interests**

(a) A behavioral health authority shall have the power to issue revenue bonds under the Local Government Revenue Bond Act, Chapter 159 of the General Statutes, Article 5, or the bond and revenue anticipation provisions of Chapter 159 of the General Statutes, Article 9, for the purpose of acquiring, constructing, reconstructing, improving, enlarging, bettering, equipping, extending, or operating behavioral health facilities.

(b) A behavioral health authority shall have the power to borrow for the purposes above enumerated upon its notes or other evidences of indebtedness, subject to the approval of the Local Government Commission. Such approval shall be required regardless of the amount of any such borrowing.

(c) A behavioral health authority shall have the power and authority to purchase real or personal property under installment contracts, purchase money mortgages or deeds of trust, or other instruments, which create in the property purchased a security interest to secure payment of the purchase price and interest thereon. No deficiency judgment may be rendered against a behavioral health authority for breach of an obligation authorized by this section.

(d) A behavioral health authority may contract pursuant to this section in an amount less than five million dollars ($5,000,000) in any single transaction without the approval of the Local Government Commission; provided, however, that the approval of the Local Government Commission shall be required for any single contract pursuant to this section if the aggregate dollar amount of all such contracts outstanding after any such single transaction would exceed ten percent (10%) of the total operating revenues, as hereinafter defined, of the behavioral health authority for its most recently completed fiscal year as set forth in the audited financial statements of such behavioral health authority for such fiscal year.

(e) Approval of the Local Government Commission under this section shall be obtained in accordance with such rules and regulations as the Local Government Commission may prescribe and shall be evidenced by the Secretary of the Commission's certificate on the contract or note or other evidence of indebtedness. In determining whether to approve any such contract or borrowing, the Local Government Commission shall consider whether the behavioral health authority can demonstrate the financial responsibility and capability of the behavioral health authority to fulfill its obligations with respect to such contract or borrowing. Any contract or borrowing subject to this subsection requiring the approval of the Local Government Commission that does not bear the Secretary of the Commission's certificate thereon shall be void, and it shall be unlawful for any officer, employee or agent of a behavioral health authority to make any payments of money thereunder. An order of the Local Government Commission approving any such contract or borrowing shall not be regarded as an approval of the legality of the contract or borrowing in any respect.

(f) For purposes of this section, the "total operating revenues" of a behavioral health authority for a fiscal year means revenue, less provisions for contractual adjustments, plus other operating revenues, all as determined in accordance with generally accepted accounting principles.

"**§ 122C-29.8. Local Consumer and Family Advisory Committees**

A behavioral health authority shall establish Local Consumer and Family Advisory Committees in accordance with G.S. 122C-170.

"**§ 122C-29.9. Client Rights and Human Rights Committees**

A behavioral health authority shall adopt the State's policy on policy on client rights as contained in G.S. 122C-51 and establish client rights and human rights committees responsible for protecting the rights of clients in accordance with G.S. 122C-64.

"**§ 122C-29.10. Involuntary Commitments**

A behavioral health authority shall have the same duties and responsibilities for involuntary commitments as area authorities created pursuant to G.S. 122C-115(c).

"**§ 122C-29.11. Grievance System.**

(a) A behavioral health authority shall establish Medicaid grievance procedures as required by the federal Medicaid managed care rules and as approved by the Secretary. Such grievance procedures shall provide a process by which consumers and providers may challenge the Medicaid denial of coverage of, or payment for, mental health, intellectual and developmental disabilities, or substance abuse services.

(b) Medicaid State fair hearings involving the 1915(b)/(c) Medicaid Waiver shall be decided by a hearing officer at the Division of Medical Assistance in accordance with 10A N.C.A.C. 22H, which shall be amended to include rules specifically set forth for the adjudication of State fair hearings involving Medicaid managed care.

(c) A behavioral health authority shall comply with the provisions contained in G.S. 122C-151.4 for consumer and provider appeals related to State funded mental health, intellectual and developmental disabilities, and substance abuse services, except that G.S. 122C-151.4(f) shall not apply to appeals involving a behavioral health authority.

"**§ 122C-29.12. Public Guardians**

A behavioral health authority does not qualify as a disinterested public agent and may not serve as the guardian for an individual adjudicated incompetent under the provisions of Subchapter I of Chapter 35A of the General Statutes. A behavioral health authority may not contract with a third party to serve as a guardian for an individual that is, or would be, eligible to have behavioral healthcare managed by the behavioral health authority.

"**§ 122C-29.13. Confidentiality of Competitive Healthcare Information**

(a) A behavioral health authority is subject to all consumer confidentiality requirements and State public records laws, except that the disclosure of competitive healthcare information shall be pursuant to the provisions of this section.

(b) For purposes of this section, competitive healthcare information means information relating to competitive healthcare activities by or on behalf of a behavioral health authority. Competitive healthcare information shall be confidential and not a public record under Chapter 132 of the General Statutes.

(c) If a behavioral health authority is requested to disclose any material which the behavioral health authority believes in good faith contains or constitutes competitive healthcare information, the behavioral health authority may either redact the portions believed to constitute competitive healthcare information prior to disclosure, or refuse to disclose the material in its entirety. The person requesting disclosure may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decisions by the court shall be whether the material constitutes competitive healthcare information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure.

(d) Nothing in this section shall be deemed to prevent an elected public body, in closed session, which has responsibility for the behavioral health authority, the Attorney General, or the State Auditor from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information.

"**§ 122C-29.14. Part Controlling**

Insofar as the provisions of this Part are inconsistent with the provisions of any other law, the provisions of this Part shall be controlling. Except as provided for in this Part, the provisions of G.S. 122C do not apply to behavioral health authorities created under this Part.

SECTION 14.(b) G.S. 122C-3(21) reads as rewritten:

"(20b) "Local management entity" or "LME" means an area authority, county program, behavioral health authority, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure."

SECTION 15. This act is effective when it becomes law.

HOUSE BILL 1075: LME/MCO Governance

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 6, 2012
Introduced by:	Reps. Dollar, Burr	**Prepared by:**	Shawn Parker Committee Counsel
Analysis of:	PCS to Second Edition H1075-CSSQ-83		

SUMMARY: ***House Bill 1075 amends the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 and other statutes to address identified barriers to the implementation of Statewide expansion of the 1915(b)/(c) Medicaid Waiver as recommended by the Joint Legislative Oversight Committee on Health and Human Services.***

The Senate Proposed Committee Substitute (i) removes the provision relating to consolidation of human service agencies, and (ii) adds a provision to establish behavioral health authorities.

CURRENT LAW:

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. Further, State and local governments are directed to develop and maintain a unified system of services centered in area authorities or county programs.

Session Law 2011-264 (HB 916) directed the Department of Health and Human Services to restructure the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders by expanding operation of 1915(b)/(c) Medicaid Waivers statewide. The 1915(b) authority limits freedom of choice, and 1915(c) authority targets eligibility for the program and provides home and community-based services. States must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver.

Sections 1915(b) and(c) of the Social Security Act authorizes the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid statutory requirements. The waivers allow states to cover a broad array of home and community-based services for certain populations as an alternative to institutional care. Section 1915(b) waivers are commonly known as "freedom of choice" or managed care waivers. Section 1915(c) waivers allow the provision of home and community-based services in lieu of institutional care. Section 1915(b)/(c) waivers combine all Medicaid-funded mental health/developmental disability/substance abuse (MH/DD/SAS) services to allow a single capitated managed care system as a vehicle for service delivery to Medicaid recipients at the community level.

BILL ANALYSIS:

Sections 1 and 2 provide that all area authorities are considered local political subdivisions of the State and that a county's responsibility for the provision of mh/dd/sa services includes adhering to rules, policies, and guidelines developed pursuant to a statewide expansion of a 1915(b)/(c) Medicaid Waiver.

Section 3 directs the Boards of County Commissioners within an area authority's catchment to appoint an area board that consists of no fewer than 11 and no more than 21 voting members, of which the following categories must be represented:

- *At least one county commissioner*
- *The chair of the Consumer and Family Advisory Committee (CFAC)*
- *A family member who is also a member of CFAC*

- *A consumer who is also a member of CFAC*
- *A person with healthcare expertise and experience in mh/dd/sas*
- *A person with social service expertise and experience in mh/dd/sas*
- *A person with financial experience consistent with scale and nature of MCO*
- *A person with insurance experience consistent with scale and nature of MCO*
- *An attorney with health care experience*
- *A Member of public not employed/affiliated with DHHS- appointed by Secretary*
- *The President of LME/MCO Provider Council or Designee (as non-voting- limited to open session)*

Members shall serve up to three consecutive three-year terms. The bill adds a provision to account for excessive absences. All area boards are to be in compliance by July 1, 2013. The Secretary is directed to appoint members consistent with the statute in the event a board of county commissioners fails to appoint each required category of membership.

Section 4 directs annual training for board members which includes, at a minimum, training in fiscal management, budget development, and fiscal accountability. The bill directs the Department in cooperation with the School of Government and LMEs to develop a standard curriculum for this training.

Section 5 authorizes a third term for members of a local CFAC to avoid conflicting with membership requirements of an area board.

Section 6 allows an LME to add counties to its catchment area without unanimous approval of every county within the current LME catchment area.

Section 7 provides a 2-year moratorium on single-county withdrawal from an LME. Further, the Secretary is directed to adopt rules for county disengagement that account for undisrupted services, catchment population requirements, capitation rates, and distribution of real property.

Section 8 authorizes an LME to hold title to real property. *Currently this requires approval from the board of commissioners from each county that comprises the area authority.*

Section 9 removes county commissioner approval for appointing an area director and explicitly gives an LME the authority to borrow money subject to the approval of the Local Government Commission. The section changes the manner in which quarterly fiscal reports are presented and allows the Secretary to waive any inconsistent or incompatible requirements of an LME's business plan based on active contracts to operate a 1915(b)/(c) waiver.

Section 10 provides that competitive health care information is not a public record under Chapter 132 and allows an LME acting in good faith to redact information believed to contain such information or not release the record. If the record is not released, the provision describes a process for judicial intervention.

Section 11 allows a board to approve salaries for directors and employees in excess of ranges established by the State Personnel Commission when supported by documentation of comparable salaries in comparable operations within the region approved by the Secretary.

Section 12 repeals the provision of law authorizing qualified area directors, officers, or employees of an area authority to serve as a guardian for adults adjudicated incompetent under Chapter 35A. The section redefines *disinterested public agent* to mean the director or assistant director of a county department of social services (was local human services agency). Further, the section adds training requirements for corporations contracting with the disinterested public agent and prohibits providers from serving as guardians to individuals to whom it also provides mh/dd/sa services pursuant to a contract with the LME.

Section 13 clarifies that only an LME may manage a 1915(b)/(c) Medicaid Waiver.

Section 14 authorizes the creation of behavioral health authorities as an operational model for contracting for and managing a local behavioral health program under a 1915(b)/(c) Medicaid waiver. A local management entity which has operated as a managed care organization for three years and whose governing board makes a finding and adopts a resolution that it would be in the best interest of the public health and welfare to do so may establish a behavioral health authority to manage all mh/dd/sas resources that may be available. The authority is subject to the Secretary's approval and may be revoked. A newly created Part 2A of Article for of Chapter 122C would provide all powers, duties, functions, and exemptions for a behavioral health authority.

H1075-SMSQ-76(CSSQ-83) v1

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. CSSQ-83(v.1)

H. B. No. 1075 DATE June 6, 2012

S. B. No. _____ Amendment No. _____
(to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE 1

Rep.) / Sen.) Tucker

1 moves to amend the bill on page 7, line 27
2 ( ) WHICH CHANGES THE TITLE
3 by rewriting the line to read:
4 "range without obtaining prior
5 approval from the Director of Office of
6 State Personnel.";
7 and on page 7, line 41 by
8 rewriting the line to read:
9 "above the normal allowable salary
10 range without obtaining prior approval
11 from the Director of the Office of
12 State Personnel.".
13
14
15
16
17
18
19

SIGNED W. J. Tucker

ADOPTED _____ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

Morning Meeting

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee

June 6, 2012
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Virginia Wooten	UNC Law
Doug Misken	PSG
Belina Aparo	PHHS
JAY PETERS	CSS
Kris Horton	DHHS
Melissa Daniel	Mission Hospitals
Cassandra Massenburg	Empowering Lives PO Box 20786 WS 27120
Stacey Stradoski	Guardianship Services, LLC
Teresa Carter	NaDay
Carol Choate	A Caring Heart Case Management, Inc.
Andrea Smith	
Paula Cox Fishman	Volunteer advocate and sister/guardian of adult with IDD
Mary + Katie Short	Parent/Participant

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee

June 6, 2012
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	MWC
TRACY GOLVARD	AHHC
Matt Wolfe	PPAB
	PBH
	NCSNA
	TARGETMAN JUDGES
RICHARD TOPPING	PBH
HUGH TILLSON	NCAHA
JOEL MAYNARD	GPM & ASSOC
JOHN THOMPSON	CCNC
JODI SCHUR	UNC LAW

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee

June 6, 2012
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carrie Scott	Covenant Case Management
Paul Peters	Covenant Case Management
Larry Brown	Consumer
Christina Webb	Personal Support Specialist/caregiver
Casey Wiegand	Consumer
Jason Wiegand	Consumer
Pat Wiegand	Parent
Jamie A.H.C	Policy Group
Meredith Snider	Re Policy Group
Valerie Hennicke	Fox Co. Mental Health / PBH
Katherine Ross	PPAB

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee

June 6, 2012
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Beth Stalvey	NC Council on Developmental Disabilities
Holly Riddle	"
Crystal Forcyan	"
Dan Rabon	The Arc
Jim Edgerton	Alliance Behavioral Health
Kelly Casbie	DHHS/DMA
Tracy Hayes	NCDOJ on behalf of DHHS
Kay Parkay	NASW-NC
Steve JORDAN	DMH DDSAS
Rhett Forman	Civitas
[illegible]	AOC

VISITOR REGISTRATION SHEET

Mental Health & Youth Services
Name of Committee

June 6, 2012
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peyton Mayne	

SENATE MENTAL HEALTH & YOUTH SERVICES COMMITTEE
Thursday, June 7, 2012 at 9:30 - 10:00
Room 414, Legislative Office Building

MINUTES

The Senate Mental Health & Youth Services Committee met at 9:30 on June 7, 2012, in Room 414 of the Legislative Office Building with five members of the committee present. Senator Fletcher Hartsell, Chair, presided.

Senator Hartsell recognized pages Ruth Jackson, Ryan Phillips and Tristan Gordon and thanked them for their assistance to the Committee.

HB 1075 – LME/MCO Governance. Senator Hartsell presented and explained an amendment. Senator Bingham moved for adoption. All voted and the motion carried. Ms. Tracy Hayes of the North Carolina Department of Justice representing the Department of Health and Human Services spoke on the bill. Mr. Jim Edgerton of Alliance Behavioral Health also made comments. Senator Bingham moved for a favorable report of the Proposed Committee Substitute as amended, unfavorable to the original bill, and rolled into a new Committee Substitute. All voted and the motion carried.

There being no further business, the committee was adjourned.

Fletcher L. Hartsell, Jr., Presiding

Gerry Johnson, Committee Assistant

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Mental Health & Youth Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Thursday	June 7, 2012	9:30 A.M. to 10:00 A.M.	414 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1075	LME/MCO Governance.	Representative Dollar Representative Burr

Senator Fletcher L. Hartsell, Jr., Chair

Senate Mental Health & Youth Services Committee
Thursday, June 7, 2012, 9:30 - 10:00
414 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bill HB 1075

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

MENTAL HEALTH & YOUTH SERVICES COMMITTEE REPORT
Senator Fletcher L. Hartsell, Jr., Chair

Thursday, June 07, 2012

Senator HARTSELL, JR.,
submits the following with recommendations as to passage:

FAVORABLE

H.B. **1055** Eliminate LME Provider Endorsement.-AB
Sequential Referral: None
Recommended Referral: None

H.B. **1056** Partnership for Children Participant Records.
Sequential Referral: None
Recommended Referral: None

H.B. **1081** Provisional Licensure Changes Medicaid.-AB
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **423** Enact First Evaluation Program.
Draft Number: PCS 11365
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

TOTAL REPORTED: 4

Committee Clerk Comments:

Sen. Hartsell will present all House bills on the Floor.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

MENTAL HEALTH & YOUTH SERVICES COMMITTEE REPORT
Senator Fletcher L. Hartsell, Jr., Chair

Thursday, June 07, 2012

Senator HARTSELL, JR.,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.	**1075**	LME/MCO Governance.		
			Draft Number:	80384
			Sequential Referral:	None
			Recommended Referral:	None
			Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

Sen. Hartsell will handle on the floor

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1075*

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H1075-ASQ-123 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
H1075-CSSQ-83

Date June 7 ,2012

Senator Hartsell

moves to amend the bill on page 8, line 47, by rewriting the line to read:
"(f) An individual employed by an entity that contracts with a local management entity (LME) for the delivery";

And on page 13, lines 4-35, by deleting the lines;

And on page 16, lines 37-49, by rewriting the lines to read:
"(a) A behavioral health authority shall establish Medicaid grievance procedures as required by the federal Medicaid managed care rules and as approved by the Secretary. Such grievance procedures shall provide a process by which consumers and providers may challenge the Medicaid denial of coverage of, or payment for, mental health, intellectual and developmental disabilities, or substance abuse services.
(b) A behavioral health authority shall comply with the provisions contained in G.S. 122C-151.4 for consumer and provider appeals. ".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

H1075-ASQ-123-V-1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H 2

HOUSE BILL 1075*
Committee Substitute Favorable 6/5/12

Short Title: LME/MCO Governance. (Public)

Sponsors:

Referred to:

May 24, 2012

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN GOVERNANCE OF LOCAL MANAGEMENT ENTITIES WITH RESPECT TO THE IMPLEMENTATION OF STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-115(a) reads as rewritten:

"**§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.**

(a) A county shall provide mental health, developmental disabilities, and substance abuse services in accordance with rules, policies, and guidelines adopted pursuant to statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver through an area authority or through a county program established pursuant to G.S. 122C-115.1. Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control."

SECTION 2.(a) G.S. 122C-116 reads as rewritten:

"**§ 122C-116. Status of area authority; status of consolidated human services agency.**

(a) An area authority is a local political subdivision of the ~~State except that a single county area authority is considered a department of the county in which it is located for the purposes of Chapter 159 of the General Statutes.~~State.

(b) A consolidated human services agency is a department of the county."

SECTION 2.(b) G.S. 122C-115.1(i) reads as rewritten:

"(i) Except as otherwise specifically provided, this Chapter applies to counties that provide mental health, developmental disabilities, and substance abuse services through a county program. As used in the applicable sections of this Article, the terms "area authority", "area program", and "area facility" shall be construed to include "county program". ~~The following sections of this Article do not apply to county programs:~~

~~(1) G.S. 122C-115.3, 122C-116, 122C-117, and 122C-118.1.~~

~~(2) G.S. 122C-119 and G.S. 122C-119.1.~~

~~(3) G.S. 122C-120 and G.S. 122C-121.~~

~~(4) G.S. 122C-127.~~

~~(5) G.S. 122C-147.~~
~~(6) G.S. 122C-152 and G.S. 122C-153.~~
~~(7) G.S. 122C-156.~~
~~(8) G.S. 122C-158.~~"

SECTION 3.(a) G.S. 122C-118.1 reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) ~~An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties may have up to 30 members. In a single-county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include two individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.~~ An area board shall have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or the boards of county commissioners within the area, shall appoint members consistent with the requirements provided in subsection (b) of this section. The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category. A member of the board may be removed with or without cause by the initial appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chairman of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) ~~Except as otherwise~~Within the maximum membership provided in ~~this subsection, not more than fifty percent (50%) of~~subsection (a) of this section, the ~~members~~membership of the area board shall reside within the catchment area and ~~represent the following:~~ be composed as follows:

(1) ~~A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.~~At least one member who is a current county commissioner.

(2) ~~A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.~~The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.

(3) At least one family member ~~or individual from a citizens' organization composed primarily of consumers or their family members,~~of the local

CFAC, as recommended by the local CFAC, representing the interests of ~~individuals:~~the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~In~~Individuals in recovery from ~~addiction; or~~addiction, or

c. ~~With~~ Individuals with intellectual or other developmental disabilities.

(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~With~~Individuals with intellectual or other developmental ~~disabilities; or~~disabilities, or

c. ~~In~~ Individuals in recovery from addiction.

(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.

(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.

(8) An individual with insurance expertise consistent with the scale and nature of the managed care organization.

(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(10) An attorney with health care expertise.

(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.

(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

~~An~~Except as provided in subdivision (12) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on an area authority board. Of the members described in subdivisions (2) through (4) of this subsection, the boards of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than two categories of membership if the member has the qualifications or attributes of the two categories of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the member's service as a county commissioner. Any member of an area board who is a county manager serves on the board at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the duration of the member's employment as a county manager. The terms of ~~the other~~members on the area board shall be for three years, except that upon the initial formation of an area board in compliance with subsection (a) of this section, one-third shall be appointed for one year, one-third for two years,

and all remaining members for three years. ~~Members, other than county commissioners and county managers,~~ Members shall not be appointed for more than ~~two~~three consecutive terms. ~~Board members serving as of July 1, 2006, may remain on the board for one additional term. This subsection applies to all area authority board members regardless of the procedure used to appoint members under subsection (a) of this section.~~

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes."

SECTION 3.(b) All area boards shall meet the requirements of G.S. 122C-118.1, as amended by subsection (a) of this section, no later than July 1, 2013.

SECTION 4.(a) G.S. 122C-119.1 reads as rewritten:

"**§ 122C-119.1. Area Authority board members' training.**

All members of the governing body for an area authority shall receive initial orientation on board members' responsibilities and annual training provided by the Department ~~in~~which shall include fiscal management, budget development, and fiscal accountability. A member's refusal to be trained shall be grounds for removal from the board."

SECTION 4.(b) The North Carolina Department of Health and Human Services, in cooperation with the School of Government and the local management entities, shall develop a standardized core curriculum for the training described in subsection (a) of this section.

SECTION 5. G.S. 122C-170(b) reads as rewritten:

"Part 4A. Consumer and Family Advisory Committees.

"**§ 122C-170. Local Consumer and Family Advisory Committees.**

...

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than ~~two~~three consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, developmental disabilities, and substance abuse services.

(2) Family members of consumers of mental health, developmental disabilities, and substance abuse services.

...."

SECTION 6. Area authorities may add one or more additional counties to their existing catchment area by agreement of a majority of the existing member counties.

SECTION 7.(a) Beginning July 1, 2012, and for a period of two years thereafter, the Department of Health and Human Services shall not approve any county's request to withdraw from a multicounty area authority operating under the 1915(b)/(c) Medicaid Waiver. Not later than January 1, 2014, the Secretary shall adopt rules to establish a process for county disengagement that shall at a minimum ensure the following:

(1) Provisions of service are not disrupted by the disengagement.

(2) The disengaging county is either in compliance or plans to merge with an area authority that is in compliance with population requirements provided in G.S. 122C-155(a).

(3) The timing of the disengagement is accounted for and does not conflict with setting capitation rates.

(4) Adequate notice is provided to the affected counties, the Department of Health and Human Services, and the General Assembly.

(5) Provisions for distribution of any real property no longer within the catchment area of the area authority.

SECTION 7.(b) G.S. 122C-112.1 is amended by adding a new subdivision to read:

"(38) Adopt rules establishing a procedure for single-county disengagement from an area authority operating under a 1915(b)/(c) Medicaid Waiver."

SECTION 8. G.S. 122C-147(c) reads as rewritten:

"**§ 122C-147. Financing and title of area authority property.**

...

(c) All real property purchased for use by the area authority shall be provided by local or federal funds unless otherwise allowed under subsection (b) of this section or by specific capital funds appropriated by the General Assembly. The title to this real property and the authority to acquire it is held by the ~~county where the property is located. The authority to hold title to real property and the authority to acquire it, including the area authority's authority to finance its acquisition by an installment contract under G.S. 160A-20, may be held by the area authority or by the contracting governmental entity with the approval of the board or boards of commissioners of all the counties that comprise the area authority. The approval of a board of county commissioners shall be by resolution of the board and may have any necessary or proper conditions, including provisions for distribution of the proceeds in the event of disposition of the property by the area authority.~~ area authority. Real property may not be acquired by means of an installment contract under G.S. 160A-20 unless the Local Government Commission has approved the acquisition. No deficiency judgment may be rendered against any unit of local government in any action for breach of a contractual obligation authorized by this subsection, and the taxing power of a unit of local government is not and may not be pledged directly or indirectly to secure any moneys due under a contract authorized by this subsection.

...."

SECTION 9.(a) G.S. 122C-117 reads as rewritten:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

...

(7) Appoint an area director in accordance with G.S. 122C-121(d). ~~The appointment is subject to the approval of the board of county commissioners except that one or more boards of county commissioners may waive its authority to approve the appointment. The appointment shall be based on a selection by a search committee of the area authority board. The search committee shall include consumer board members, a county manager, and one or more county commissioners. The Secretary shall have the option to appoint one member to the search committee.~~

...

(17) Have the authority to borrow money with the approval of the Local Government Commission.

...

(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. The county finance officer shall provide the quarterly report to the board of county commissioners at the next regularly scheduled meeting of the board. The clerk of the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period of time. This information shall be ~~presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners.~~ delivered to the county and, at the request of the board of county commissioners, may be presented in person by the area director or the director's designee.

...."

SECTION 9.(b) G.S. 122C-115.2 is amended by adding a new subsection to read:

"(e) The Secretary may waive any requirements of this section that are inconsistent with or incompatible with contracts entered into between the Department and the area authority for the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver."

SECTION 10. Part 2 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-126.1. Confidentiality of competitive health care information.**

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of the area authority. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of an area authority shall be a public record, unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section.

(b) If an area authority is requested to disclose any contract that the area authority believes in good faith contains or constitutes competitive health care information, the area authority may either redact the portions of the contract believed to constitute competitive health care information prior to disclosure or, if the entire contract constitutes competitive health care information, refuse disclosure of the contract. The person requesting disclosure of the contract may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decision by the court shall be whether the contract, or portions of the contract withheld, constitutes competitive health care information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure. Before rendering a decision, the court shall review the contract in camera and hear arguments from the parties. If the court finds that the contract constitutes or contains competitive health care information, the court may either deny disclosure or may make such other appropriate orders as are permitted under Rule 26(c) of the Rules of Civil Procedure.

(c) Nothing in this section shall be deemed to prevent the Attorney General, the State Auditor, or an elected public body, in closed session, which has responsibility for the area authority, from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information."

SECTION 11.(a) G.S. 126-5(a) reads as rewritten:

"**§ 126-5. Employees subject to Chapter; exemptions.**

(a) The provisions of this Chapter shall apply to:

(1) All State employees not herein exempt, and

(2) All employees of the following local entities:

a. Area mental health, developmental disabilities, and substance abuse ~~authorities.~~authorities, except as otherwise provided in Chapter 122C of the General Statutes.

b. Local social services departments.

c. County health departments and district health departments.

d. Local emergency management agencies that receive federal grant-in-aid funds.

An employee of a consolidated county human services agency created pursuant to G.S. 153A-77(b) is not considered an employee of an entity listed in this subdivision.

(3) County employees not included under subdivision (2) of this subsection as the several boards of county commissioners may from time to time determine."

SECTION 11.(b) G.S. 122C-154 reads as rewritten:

"**§ 122C-154. Personnel.**

Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. Employees appointed by the county program director are employees of the county. In a multicounty program, employment of county program staff shall be as agreed upon in the interlocal agreement adopted pursuant to G.S. 122C-115.1. Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the employee. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 11.(c) G.S. 122C-121(a1) reads as rewritten:

"(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. ~~An area board may request an adjustment to the salary ranges under G.S. 126-9(b). The request shall include specific information supporting the need for the adjustment, including comparative salary and patient caseload data for other LMEs, and shall also include the specific amount the area board proposes to pay the director. The area board shall not request a salary adjustment that is more than ten percent (10%) above the normal allowable salary range as determined by the State Personnel Commission.~~Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the director. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 12.(a) G.S. 153A-76 reads as rewritten:

"**§ 153A-76. Board of commissioners to organize county government.**

The board of commissioners may create, change, abolish, and consolidate offices, positions, departments, boards, commissions, and agencies of the county government, may impose ex officio the duties of more than one office on a single officer, may change the composition and manner of selection of boards, commissions, and agencies, and may generally organize and reorganize the county government in order to promote orderly and efficient administration of county affairs, subject to the following limitations:

(1) The board may not abolish an office, position, department, board, commission, or agency established or required by law.

(2) The board may not combine offices or confer certain duties on the same officer when this action is specifically forbidden by law.

(3) The board may not discontinue or assign elsewhere a function or duty assigned by law to a particular office, position, department, board, commission, or agency.

(4) The board may not change the composition or manner of selection of a local board of education, ~~the board of health, the board of social services,~~the board of elections, or the board of alcoholic beverage control.

(5) A board may not consolidate an area mental health, developmental disabilities, and substance abuse services board into a consolidated human

services board. The board may not abolish an area mental health, developmental disabilities, and substance abuse board, except as provided in Chapter 122C of the General Statutes. This subdivision shall not apply to any board that has exercised the powers and duties of an area mental health, developmental disabilities, and substance abuse services board as of January 1, 2012."

SECTION 12.(b) G.S. 153A-77 reads as rewritten:

"**§ 153A-77. Authority of boards of commissioners in certain counties over commissions, boards, agencies, etc.**

(a) In the exercise of its jurisdiction over commissions, boards and agencies, the board of county commissioners may assume direct control of any activities theretofore conducted by or through any commission, board or agency by the adoption of a resolution assuming and conferring upon the board of county commissioners all powers, responsibilities and duties of any such commission, board or agency. This ~~subsection~~section shall apply to the board of health, the social services board, area mental health, developmental disabilities, and substance abuse area board ~~and~~or any other commission, board or agency appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners of said county except as provided in G.S. 153A-76. A board of county commissioners exercising the power and authority under this subsection may, notwithstanding G.S. 130A-25, enforce public health rules adopted by the board through the imposition of civil penalties. If a public health rule adopted by a board of county commissioners imposes a civil penalty, the provisions of G.S. 130A-25 making its violation a misdemeanor shall not be applicable to that public health rule unless the rule states that a violation of the rule is a misdemeanor. The board of county commissioners may exercise the power and authority herein conferred only after a public hearing held by said board pursuant to 30 days' notice of said public hearing given in a newspaper having general circulation in said county.

The board of county commissioners may also appoint advisory boards, committees, councils and agencies composed of qualified and interested county residents to study, interpret and develop community support and cooperation in activities conducted by or under the authority of the board of county commissioners of said county.

(b) In the exercise of its jurisdiction over commissions, boards, and agencies, the board of county commissioners of a county having a county manager pursuant to G.S. 153A-81 may:

(1) Consolidate ~~the provision~~certain provisions of human services in the county under the direct control of a human services director appointed and supervised by the county manager in accordance with subsection (e) of this section;

(2) Create a consolidated human services board having the powers conferred by subsection (c) of this section;

(3) Create a consolidated county human services agency having the authority to carry out the functions of any combination of commissions, boards, or agencies appointed by the board of county commissioners or acting under and pursuant to authority of the board of county commissioners, including the local health department, the county department of social services, ~~and~~or the area mental health, developmental disabilities, and substance abuse services authority; and

(4) Assign other county human services functions to be performed by the consolidated human services agency under the direction of the human services director, with policy-making authority granted to the consolidated human services board as determined by the board of county commissioners.

(c) A consolidated human services board appointed by the board of county commissioners shall serve as the policy-making, rule-making, and administrative board of the

consolidated human services agency. The consolidated human services board shall be composed of no more than 25 members. The composition of the board shall reasonably reflect the population makeup of the county and shall include:

(1) Eight persons who are consumers of human services, public advocates, or family members of clients of the consolidated human services agency, including: one person with mental illness, one person with a developmental disability, one person in recovery from substance abuse, one family member of a person with mental illness, one family member of a person with a developmental disability, one family member of a person with a substance abuse problem, and two consumers of other human services.

(1a) Notwithstanding subdivision (1) of this subsection, a consolidated human services board not exercising powers and duties of an area mental health, developmental disabilities, and substance abuse services board shall include four persons who are consumers of human services.

(2) Eight persons who are professionals, each with qualifications in one of these categories: one psychologist, one pharmacist, one engineer, one dentist, one optometrist, one veterinarian, one social worker, and one registered nurse.

(3) Two physicians licensed to practice medicine in this State, one of whom shall be a psychiatrist.

(4) One member of the board of county commissioners.

(5) Other persons, including members of the general public representing various occupations.

The board of county commissioners may elect to appoint a member of the consolidated human services board to fill concurrently more than one category of membership if the member has the qualifications or attributes of more than one category of membership.

All members of the consolidated human services board shall be residents of the county. The members of the board shall serve four-year terms. No member may serve more than two consecutive four-year terms. The county commissioner member shall serve only as long as the member is a county commissioner.

The initial board shall be appointed by the board of county commissioners upon the recommendation of a nominating committee comprised of members of the preconsolidation board of health, social services board, and area mental health, developmental disabilities, and substance abuse services board. In order to establish a uniform staggered term structure for the board, a member may be appointed for less than a four-year term. After the subsequent establishment of the board, its board shall be appointed by the board of county commissioners from nominees presented by the human services board. Vacancies shall be filled for any unexpired portion of a term.

A chairperson shall be elected annually by the members of the consolidated human services board. A majority of the members shall constitute a quorum. A member may be removed from office by the county board of commissioners for (i) commission of a felony or other crime involving moral turpitude; (ii) violation of a State law governing conflict of interest; (iii) violation of a written policy adopted by the county board of commissioners; (iv) habitual failure to attend meetings; (v) conduct that tends to bring the office into disrepute; or (vi) failure to maintain qualifications for appointment required under this subsection. A board member may be removed only after the member has been given written notice of the basis for removal and has had the opportunity to respond.

A member may receive a per diem in an amount established by the county board of commissioners. Reimbursement for subsistence and travel shall be in accordance with a policy set by the county board of commissioners. The board shall meet at least quarterly. The chairperson or three of the members may call a special meeting.

(d) The consolidated human services board shall have authority to:

(1) Set fees for departmental services based upon recommendations of the human services director. Fees set under this subdivision are subject to the same restrictions on amount and scope that would apply if the fees were set by a county board of health, a county board of social services, or a mental health, developmental disabilities, and substance abuse area authority.
(2) Assure compliance with laws related to State and federal programs.
(3) Recommend creation of local human services programs.
(4) Adopt local health regulations and participate in enforcement appeals of local regulations.
(5) Perform regulatory health functions required by State law.
(6) Act as coordinator or agent of the State to the extent required by State or federal law.
(7) Plan and recommend a consolidated human services budget.
(8) Conduct audits and reviews of human services programs, including quality assurance activities, as required by State and federal law or as may otherwise be necessary periodically.
(9) Advise local officials through the county manager.
(10) Perform public relations and advocacy functions.
(11) Protect the public health to the extent required by law.
(12) Perform comprehensive mental health services ~~planning.~~planning if the county is exercising the powers and duties of an area mental health, developmental disabilities, and substance abuse services board under the consolidated human services board.
(13) Develop dispute resolution procedures for human services contractors and clients and public advocates, subject to applicable State and federal dispute resolution procedures for human services programs, when applicable.

Except as otherwise provided, the consolidated human services board shall have the powers and duties conferred by law upon a board of health, a social services board, and an area mental health, developmental disabilities, and substance abuse services board.

Local employees who serve as staff of a consolidated county human services agency are subject to county personnel policies and ordinances only and are not subject to the provisions of the State Personnel ~~Act.~~Act, unless the county board of commissioners elects to subject the local employees to the provisions of that Act. All consolidated county human services agencies shall comply with all applicable federal laws, rules, and regulations requiring the establishment of merit personnel systems.

(e) The human services director of a consolidated county human services agency shall be appointed and dismissed by the county manager with the advice and consent of the consolidated human services board. The human services director shall report directly to the county manager. The human services director shall:

(1) Appoint staff of the consolidated human services agency with the county manager's approval.
(2) Administer State human services programs.
(3) Administer human services programs of the local board of county commissioners.
(4) Act as secretary and staff to the consolidated human services board under the direction of the county manager.
(5) Plan the budget of the consolidated human services agency.
(6) Advise the board of county commissioners through the county manager.
(7) Perform regulatory functions of investigation and enforcement of State and local health regulations, as required by State law.
(8) Act as an agent of and liaison to the State, to the extent required by law.

Except as otherwise provided by law, the human services director or the director's designee shall have the same powers and duties as a social services director, a local health director, ~~and~~or a director of an area mental health, developmental disabilities, and substance abuse services authority.

(f) This section applies to counties with a population in excess of 425,000."

SECTION 13.(a) G.S. 122C-122 is repealed.

SECTION 13.(b) G.S. 35A-1202(4) reads as rewritten:

"**§ 35A-1202. Definitions.**

When used in the Subchapter, unless a contrary intent is indicated or the context requires otherwise:

...

(4) "Disinterested public agent" ~~means:~~means

~~a.~~ ~~The~~the director or assistant directors of a ~~local human services agency, or~~county department of social services.

~~b.~~ ~~An adult officer, agent, or employee of a State human services agency. The~~Except as provided in G.S. 35A-1213(f), the fact that a disinterested public agent ~~is employed by a State or local human services agency that~~ provides financial assistance, services, or treatment to a ward does not disqualify that person from being appointed as guardian.

...."

SECTION 13.(c) G.S. 35A-1213 reads as rewritten:

"**§ 35A-1213. Qualifications of guardians.**

(a) The clerk may appoint as guardian an adult individual, a corporation, or a disinterested public agent. The applicant may submit to the clerk the name or names of potential guardians, and the clerk may consider the recommendations of the next of kin or other persons.

(b) A nonresident of the State of North Carolina, to be appointed as general guardian, guardian of the person, or guardian of the estate of a North Carolina resident, must indicate in writing his willingness to submit to the jurisdiction of the North Carolina courts in matters relating to the guardianship and must appoint a resident agent to accept service of process for the guardian in all actions or proceedings with respect to the guardianship. Such appointment must be approved by and filed with the clerk, and any agent so appointed must notify the clerk of any change in the agent's address or legal residence. The clerk shall require a nonresident guardian of the estate or a nonresident general guardian to post a bond or other security for the faithful performance of the guardian's duties. The clerk may require a nonresident guardian of the person to post a bond or other security for the faithful performance of the guardian's duties.

(c) A corporation may be appointed as guardian only if it is authorized by its charter to serve as a guardian or in similar fiduciary capacities. A corporation shall meet the requirements outlined in Chapters 55 and 55D of the General Statutes. A corporation will provide a written copy of its charter to the clerk of superior court. A corporation contracting with a public agency to serve as guardian is required to attend guardianship training and provide verification of attendance to the contracting agency.

(d) A disinterested public agent who is appointed by the clerk to serve as guardian is authorized and required to do so; provided, if at the time of the appointment or any time subsequent thereto the disinterested public agent believes that his role or the role of his agency in relation to the ward is such that his service as guardian would constitute a conflict of interest, or if he knows of any other reason that his service as guardian may not be in the ward's best interest, he shall bring such matter to the attention of the clerk and seek the appointment of a different guardian. A disinterested public agent who is appointed as guardian shall serve in that capacity by virtue of his office or employment, which shall be identified in the clerk's order and

in the letters of appointment. When the disinterested public agent's office or employment terminates, his successor in office or employment, or his immediate supervisor if there is no successor, shall succeed him as guardian without further proceedings unless the clerk orders otherwise.

(e) Notwithstanding any other provision of this section, an employee of a treatment facility, as defined in G.S. 35A-1101(16), may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works; provided, this subsection shall not apply to or affect the validity of any appointment of a guardian that occurred before October 1, 1987.

(f) An individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve as a guardian for a ward for whom the individual is providing such services."

SECTION 13.(d) G.S. 35A-1292(a) reads as rewritten:

"**§ 35A-1292. Resignation.**

(a) Any guardian who wishes to resign ~~may apply in writing to the clerk,~~shall file a motion with the clerk setting forth the circumstances of the case. If a general guardian or guardian of the estate, at the time of making the application, also exhibits his final account for settlement, and if the clerk is satisfied that the guardian has fully accounted, the clerk may accept the resignation of the guardian and discharge him and appoint a successor ~~guardian, but the~~guardian. The guardian so discharged and his sureties are still liable in relation to all matters connected with the guardianship before the ~~discharge.~~discharge and shall continue to ensure that the ward's needs are met until the clerk officially appoints a successor. The guardian shall attend the hearing to modify the guardianship, if physically able."

SECTION 13.(e) In order to achieve continuity of care and services, any successor guardian shall make diligent efforts to continue existing contracts entered into under the authority of G.S. 122C-122 where consistent with the best interest of the ward as required by Chapter 35A of the General Statutes.

SECTION 14.(a) Section 1(a)(3) of S.L. 2011-264 reads as rewritten:

"(3) Designate ~~a single entity~~an area authority for mental health, developmental disabilities, and substance abuse services to assume responsibility for all aspects of Waiver management. The following operational models are ~~acceptable options for Local Management Entity (LME) applicants:~~acceptable:

a. Merger model: A single larger LME is formed from the merger of two or more LMEs.

b. Interlocal agreement among LMEs: A single LME is identified as the leader for all Waiver operations, financial management, and accountability for performance measures."

SECTION 14.(b) Section 1(c) of S.L. 2011-264 reads as rewritten:

"**SECTION 1.(c)** The Department shall require LMEs that have not been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013, to merge with or be aligned through an interlocal agreement with an LME that has been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver. If any LME fails to comply with this requirement, or fails to meet performance requirements of an approved contract with the Department to operate a 1915(b)/(c) Medicaid Waiver, the Department shall assign responsibility for management of the 1915(b)/(c) Medicaid Waiver on behalf of the noncompliant LME to an LME that is successfully operating the Waiver and successfully meeting performance requirements of the contract with the Department. Those LMEs approved to operate the 1915(b)/(c) Medicaid Waiver under an interlocal agreement must have a single LME entity designated as responsible for all aspects of Waiver operations and solely responsible for meeting contract requirements."

SECTION 15. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE BILL 1075*
Committee Substitute Favorable 6/5/12
PROPOSED SENATE COMMITTEE SUBSTITUTE H1075-CSSQ-83 [v.1]

6/6/2012 10:34:26 AM

Short Title: LME/MCO Governance. (Public)

Sponsors:

Referred to:

May 24, 2012

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES IN GOVERNANCE OF LOCAL MANAGEMENT ENTITIES WITH RESPECT TO THE IMPLEMENTATION OF STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-115(a) reads as rewritten:

"**§ 122C-115. Duties of counties; appropriation and allocation of funds by counties and cities.**

(a) A county shall provide mental health, developmental disabilities, and substance abuse services in accordance with rules, policies, and guidelines adopted pursuant to statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver through an area ~~authority or~~ authority, through a county program established pursuant to ~~G.S. 122C-115.1.~~G.S. 122C-115.1, or through a behavioral health authority established pursuant to Part 2B of this Chapter. Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control."

SECTION 2.(a) G.S. 122C-116 reads as rewritten:

"**§ 122C-116. Status of area authority; status of consolidated human services agency.**

(a) An area authority is a local political subdivision of the ~~State except that a single county area authority is considered a department of the county in which it is located for the purposes of Chapter 159 of the General Statutes.~~State.

(b) A consolidated human services agency is a department of the county."

SECTION 2.(b) G.S. 122C-115.1(i) reads as rewritten:

"(i) Except as otherwise specifically provided, this Chapter applies to counties that provide mental health, developmental disabilities, and substance abuse services through a county program. As used in the applicable sections of this Article, the terms "area authority", "area program", and "area facility" shall be construed to include "county program". ~~The following sections of this Article do not apply to county programs:~~

~~(1) G.S. 122C-115.3, 122C-116, 122C-117, and 122C-118.1.~~
~~(2) G.S. 122C-119 and G.S. 122C-119.1.~~
~~(3) G.S. 122C-120 and G.S. 122C-121.~~
~~(4) G.S. 122C-127.~~
~~(5) G.S. 122C-147.~~
~~(6) G.S. 122C-152 and G.S. 122C-153.~~
~~(7) G.S. 122C-156.~~
~~(8) G.S. 122C-158.~~"

SECTION 3.(a) G.S. 122C-118.1 reads as rewritten:

"**§ 122C-118.1. Structure of area board.**

(a) ~~An area board shall have no fewer than 11 and no more than 25 members. However, the area board for a multicounty area authority consisting of eight or more counties may have up to 30 members. In a single-county area authority, the members shall be appointed by the board of county commissioners. Except as otherwise provided, in areas consisting of more than one county, each board of county commissioners within the area shall appoint one commissioner as a member of the area board. These members shall appoint the other members. The boards of county commissioners within the multicounty area shall have the option to appoint the members of the area board in a manner other than as required under this section by adopting a resolution to that effect. The boards of county commissioners in a multicounty area authority shall indicate in the business plan each board's method of appointment of the area board members in accordance with G.S. 122C-115.2(b). These appointments shall take into account sufficient citizen participation, representation of the disability groups, and equitable representation of participating counties. Individuals appointed to the board shall include two individuals with financial expertise, an individual with expertise in management or business, and an individual representing the interests of children. A member of the board may be removed with or without cause by the initial appointing authority. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.~~ An area board shall have no fewer than 11 and no more than 21 voting members. The board of county commissioners, or the boards of county commissioners within the area, shall appoint members consistent with the requirements provided in subsection (b) of this section. The process for appointing members shall ensure participation from each of the constituent counties of a multicounty area authority. If the board or boards fail to comply with the requirements of subsection (b) of this section, the Secretary shall appoint the unrepresented category. A member of the board may be removed with or without cause by the initial appointing authority. The area board may declare vacant the office of an appointed member who does not attend three consecutive scheduled meetings without justifiable excuse. The chairman of the area board shall notify the appropriate appointing authority of any vacancy. Vacancies on the board shall be filled by the initial appointing authority before the end of the term of the vacated seat or within 90 days of the vacancy, whichever occurs first, and the appointments shall be for the remainder of the unexpired term.

(b) ~~Except as otherwise~~Within the maximum membership provided in ~~this subsection, not more than fifty percent (50%) of~~subsection (a) of this section, the ~~members~~membership of the area board shall reside within the catchment area and ~~represent the following:~~ be composed as follows:

(1) ~~A physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina who, when possible, is certified as having completed a residency in psychiatry.~~At least one member who is a current county commissioner.

(2) ~~A clinical professional from the fields of mental health, developmental disabilities, or substance abuse.~~The chair of the local Consumer and Family Advisory Committee (CFAC) or the chair's designee.

(3) At least one family member ~~or individual from a citizens' organization composed primarily of consumers or their family members;~~of the local CFAC, as recommended by the local CFAC, representing the interests of ~~individuals:~~the following:

a. ~~With~~Individuals with mental ~~illness:~~illness, or

b. ~~In~~Individuals in recovery from ~~addiction; or~~addiction, or

c. ~~With~~ Individuals with intellectual or other developmental disabilities.

(4) At least one openly declared consumer member of the local CFAC, as recommended by the local CFAC, representing the interests of the following:

a. ~~With~~Individuals with mental ~~illness;~~illness, or

b. ~~With~~Individuals with intellectual or other developmental ~~disabilities; or~~disabilities, or

c. ~~In~~ Individuals in recovery from addiction.

(5) An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(6) An individual with health care administration expertise consistent with the scale and nature of the managed care organization.

(7) An individual with financial expertise consistent with the scale and nature of the managed care organization.

(8) An individual with insurance expertise consistent with the scale and nature of the managed care organization.

(9) An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.

(10) An attorney with health care expertise.

(11) A member who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services, as appointed by the Secretary.

(12) The President of the LME/MCO Provider Council or the President's designee to serve as a nonvoting member who shall participate only in Board activities that are open to the public.

~~An~~Except as provided in subdivision (12) of this subsection, an individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve on the board of the LME for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes shall be appointed to or serve on an area authority board. Of the members described in subdivisions (2) through (4) of this subsection, the boards of county commissioners shall ensure there is at least one member representing the interest of each of the following: (i) individuals with mental illness, (ii) individuals with intellectual or other developmental disabilities, and (iii) individuals in recovery from addiction.

(c) The board of county commissioners may elect to appoint a member of the area authority board to fill concurrently no more than two categories of membership if the member has the qualifications or attributes of the two categories of membership.

(d) Any member of an area board who is a county commissioner serves on the board in an ex officio capacity at the pleasure of the initial appointing authority, for a term not to exceed

the earlier of three years or the member's service as a county commissioner. Any member of an area board who is a county manager serves on the board at the pleasure of the initial appointing authority, for a term not to exceed the earlier of three years or the duration of the member's employment as a county manager. The terms of ~~the other~~members on the area board shall be for three years, except that upon the initial formation of an area board in compliance with subsection (a) of this section, one-third shall be appointed for one year, one-third for two years, and all remaining members for three years. ~~Members, other than county commissioners and county managers.~~ Members shall not be appointed for more than ~~two~~three consecutive terms. ~~Board members serving as of July 1, 2006, may remain on the board for one additional term. This subsection applies to all area authority board members regardless of the procedure used to appoint members under subsection (a) of this section.~~

(e) Upon request, the board shall provide information pertaining to the membership of the board that is a public record under Chapter 132 of the General Statutes."

SECTION 3.(b) All area boards shall meet the requirements of G.S. 122C-118.1, as amended by subsection (a) of this section, no later than July 1, 2013.

SECTION 4.(a) G.S. 122C-119.1 reads as rewritten:

"**§ 122C-119.1. Area Authority board members' training.**

All members of the governing body for an area authority shall receive initial orientation on board members' responsibilities and annual training provided by the Department ~~in~~which shall include fiscal management, budget development, and fiscal accountability. A member's refusal to be trained shall be grounds for removal from the board."

SECTION 4.(b) The North Carolina Department of Health and Human Services, in cooperation with the School of Government and the local management entities, shall develop a standardized core curriculum for the training described in subsection (a) of this section.

SECTION 5. G.S. 122C-170(b) reads as rewritten:

"Part 4A. Consumer and Family Advisory Committees.

"**§ 122C-170. Local Consumer and Family Advisory Committees.**

...

(b) Each of the disability groups shall be equally represented on the CFAC, and the CFAC shall reflect as closely as possible the racial and ethnic composition of the catchment area. The terms of members shall be three years, and no member may serve more than ~~two~~three consecutive terms. The CFAC shall be composed exclusively of:

(1) Adult consumers of mental health, developmental disabilities, and substance abuse services.

(2) Family members of consumers of mental health, developmental disabilities, and substance abuse services.

...."

SECTION 6. Area authorities may add one or more additional counties to their existing catchment area by agreement of a majority of the existing member counties.

SECTION 7.(a) Beginning July 1, 2012, and for a period of two years thereafter, the Department of Health and Human Services shall not approve any county's request to withdraw from a multicounty area authority operating under the 1915(b)/(c) Medicaid Waiver. Not later than January 1, 2014, the Secretary shall adopt rules to establish a process for county disengagement that shall at a minimum ensure the following:

(1) Provisions of service are not disrupted by the disengagement.

(2) The disengaging county is either in compliance or plans to merge with an area authority that is in compliance with population requirements provided in G.S. 122C-155(a).

(3) The timing of the disengagement is accounted for and does not conflict with setting capitation rates.

(4) Adequate notice is provided to the affected counties, the Department of Health and Human Services, and the General Assembly.

(5) Provisions for distribution of any real property no longer within the catchment area of the area authority.

SECTION 7.(b) G.S. 122C-112.1 is amended by adding a new subdivision to read:

"(38) Adopt rules establishing a procedure for single-county disengagement from an area authority operating under a 1915(b)/(c) Medicaid Waiver."

SECTION 8. G.S. 122C-147(c) reads as rewritten:

"**§ 122C-147. Financing and title of area authority property.**

...

(c) All real property purchased for use by the area authority shall be provided by local or federal funds unless otherwise allowed under subsection (b) of this section or by specific capital funds appropriated by the General Assembly. The title to this real property and the authority to acquire it is held by the ~~county where the property is located. The authority to hold title to real property and the authority to acquire it, including the area authority's authority to finance its acquisition by an installment contract under G.S. 160A-20, may be held by the area authority or by the contracting governmental entity with the approval of the board or boards of commissioners of all the counties that comprise the area authority. The approval of a board of county commissioners shall be by resolution of the board and may have any necessary or proper conditions, including provisions for distribution of the proceeds in the event of disposition of the property by the area authority.~~ area authority. Real property may not be acquired by means of an installment contract under G.S. 160A-20 unless the Local Government Commission has approved the acquisition. No deficiency judgment may be rendered against any unit of local government in any action for breach of a contractual obligation authorized by this subsection, and the taxing power of a unit of local government is not and may not be pledged directly or indirectly to secure any moneys due under a contract authorized by this subsection.

...."

SECTION 9.(a) G.S. 122C-117 reads as rewritten:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

...

(7) Appoint an area director in accordance with G.S. 122C-121(d). ~~The appointment is subject to the approval of the board of county commissioners except that one or more boards of county commissioners may waive its authority to approve the appointment. The appointment shall be based on a selection by a search committee of the area authority board. The search committee shall include consumer board members, a county manager, and one or more county commissioners. The Secretary shall have the option to appoint one member to the search committee.~~

...

(17) Have the authority to borrow money with the approval of the Local Government Commission.

...

(c) Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer of the area authority shall provide the quarterly report of the area authority to the county finance officer. The county finance officer shall provide the quarterly report to the board of county commissioners at the next regularly scheduled meeting of the board. The clerk of the board of commissioners shall notify the area director and the county finance officer if the quarterly report required by this subsection has not been submitted within the required period

of time. This information shall be ~~presented in a format prescribed by the county. At least twice a year, this information shall be presented in person and shall be read into the minutes of the meeting at which it is presented. In addition, the area director or finance officer of the area authority shall provide to the board of county commissioners ad hoc reports as requested by the board of county commissioners.~~delivered to the county and, at the request of the board of county commissioners, may be presented in person by the area director or the director's designee.

...."

SECTION 9.(b) G.S. 122C-115.2 is amended by adding a new subsection to read:

"(e) The Secretary may waive any requirements of this section that are inconsistent with or incompatible with contracts entered into between the Department and the area authority for the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver."

SECTION 10. Part 2 of Article 4 of Chapter 122C of the General Statutes is amended by adding a new section to read:

"**§ 122C-126.1. Confidentiality of competitive health care information.**

(a) For the purposes of this section, competitive health care information means information relating to competitive health care activities by or on behalf of the area authority. Competitive health care information shall be confidential and not a public record under Chapter 132 of the General Statutes; provided that any contract entered into by or on behalf of an area authority shall be a public record, unless otherwise exempted by law, or the contract contains competitive health care information, the determination of which shall be as provided in subsection (b) of this section.

(b) If an area authority is requested to disclose any contract that the area authority believes in good faith contains or constitutes competitive health care information, the area authority may either redact the portions of the contract believed to constitute competitive health care information prior to disclosure or, if the entire contract constitutes competitive health care information, refuse disclosure of the contract. The person requesting disclosure of the contract may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decision by the court shall be whether the contract, or portions of the contract withheld, constitutes competitive health care information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure. Before rendering a decision, the court shall review the contract in camera and hear arguments from the parties. If the court finds that the contract constitutes or contains competitive health care information, the court may either deny disclosure or may make such other appropriate orders as are permitted under Rule 26(c) of the Rules of Civil Procedure.

(c) Nothing in this section shall be deemed to prevent the Attorney General, the State Auditor, or an elected public body, in closed session, which has responsibility for the area authority, from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information."

SECTION 11.(a) G.S. 126-5(a) reads as rewritten:

"**§ 126-5. Employees subject to Chapter; exemptions.**

(a) The provisions of this Chapter shall apply to:

(1) All State employees not herein exempt, and

(2) All employees of the following local entities:

a. Area mental health, developmental disabilities, and substance abuse ~~authorities.~~authorities, except as otherwise provided in Chapter 122C of the General Statutes.
b. Local social services departments.
c. County health departments and district health departments.
d. Local emergency management agencies that receive federal grant-in-aid funds.

An employee of a consolidated county human services agency created pursuant to G.S. 153A-77(b) is not considered an employee of an entity listed in this subdivision.

(3) County employees not included under subdivision (2) of this subsection as the several boards of county commissioners may from time to time determine."

SECTION 11.(b) G.S. 122C-154 reads as rewritten:

"**§ 122C-154. Personnel.**

Employees under the direct supervision of the area director are employees of the area authority. For the purpose of personnel administration, Chapter 126 of the General Statutes applies unless otherwise provided in this Article. Employees appointed by the county program director are employees of the county. In a multicounty program, employment of county program staff shall be as agreed upon in the interlocal agreement adopted pursuant to G.S. 122C-115.1. Notwithstanding G.S. 126-9(b), an employee of an area authority may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the employee. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 11.(c) G.S. 122C-121(a1) reads as rewritten:

"(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. ~~An area board may request an adjustment to the salary ranges under G.S. 126-9(b). The request shall include specific information supporting the need for the adjustment, including comparative salary and patient caseload data for other LMEs, and shall also include the specific amount the area board proposes to pay the director. The area board shall not request a salary adjustment that is more than ten percent (10%) above the normal allowable salary range as determined by the State Personnel Commission.~~Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Personnel Commission. Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the director. The area board shall not authorize any salary adjustment that is above the normal allowable salary range without obtaining prior approval from the Secretary."

SECTION 12.(a) G.S. 122C-122 is repealed.

SECTION 12.(b) G.S. 35A-1202(4) reads as rewritten:

"**§ 35A-1202. Definitions.**

When used in the Subchapter, unless a contrary intent is indicated or the context requires otherwise:

...

(4) "Disinterested public agent" ~~means:~~means

~~a.~~ ~~The~~the director or assistant directors of a ~~local human services agency, or~~county department of social services.

~~b. An adult officer, agent, or employee of a State human services agency. The~~Except as provided in G.S. 35A-1213(f), the fact that a disinterested public agent ~~is employed by a State or local human services agency that~~ provides financial assistance, services, or treatment to a ward does not disqualify that person from being appointed as guardian.

...."

SECTION 12.(c) G.S. 35A-1213 reads as rewritten:

"**§ 35A-1213. Qualifications of guardians.**

(a) The clerk may appoint as guardian an adult individual, a corporation, or a disinterested public agent. The applicant may submit to the clerk the name or names of potential guardians, and the clerk may consider the recommendations of the next of kin or other persons.

(b) A nonresident of the State of North Carolina, to be appointed as general guardian, guardian of the person, or guardian of the estate of a North Carolina resident, must indicate in writing his willingness to submit to the jurisdiction of the North Carolina courts in matters relating to the guardianship and must appoint a resident agent to accept service of process for the guardian in all actions or proceedings with respect to the guardianship. Such appointment must be approved by and filed with the clerk, and any agent so appointed must notify the clerk of any change in the agent's address or legal residence. The clerk shall require a nonresident guardian of the estate or a nonresident general guardian to post a bond or other security for the faithful performance of the guardian's duties. The clerk may require a nonresident guardian of the person to post a bond or other security for the faithful performance of the guardian's duties.

(c) A corporation may be appointed as guardian only if it is authorized by its charter to serve as a guardian or in similar fiduciary capacities. A corporation shall meet the requirements outlined in Chapters 55 and 55D of the General Statutes. A corporation will provide a written copy of its charter to the clerk of superior court. A corporation contracting with a public agency to serve as guardian is required to attend guardianship training and provide verification of attendance to the contracting agency.

(d) A disinterested public agent who is appointed by the clerk to serve as guardian is authorized and required to do so; provided, if at the time of the appointment or any time subsequent thereto the disinterested public agent believes that his role or the role of his agency in relation to the ward is such that his service as guardian would constitute a conflict of interest, or if he knows of any other reason that his service as guardian may not be in the ward's best interest, he shall bring such matter to the attention of the clerk and seek the appointment of a different guardian. A disinterested public agent who is appointed as guardian shall serve in that capacity by virtue of his office or employment, which shall be identified in the clerk's order and in the letters of appointment. When the disinterested public agent's office or employment terminates, his successor in office or employment, or his immediate supervisor if there is no successor, shall succeed him as guardian without further proceedings unless the clerk orders otherwise.

(e) Notwithstanding any other provision of this section, an employee of a treatment facility, as defined in G.S. 35A-1101(16), may not serve as guardian for a ward who is an inpatient in or resident of the facility in which the employee works; provided, this subsection shall not apply to or affect the validity of any appointment of a guardian that occurred before October 1, 1987.

(f) An individual that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve as a guardian for a ward for whom the individual is providing such services."

SECTION 12.(d) G.S. 35A-1292(a) reads as rewritten:

"**§ 35A-1292. Resignation.**

(a) Any guardian who wishes to resign ~~may apply in writing to the clerk,~~shall file a motion with the clerk setting forth the circumstances of the case. If a general guardian or guardian of the estate, at the time of making the application, also exhibits his final account for settlement, and if the clerk is satisfied that the guardian has fully accounted, the clerk may accept the resignation of the guardian and discharge him and appoint a successor ~~guardian, but the~~guardian. The guardian so discharged and his sureties are still liable in relation to all matters connected with the guardianship before the ~~discharge.~~discharge and shall continue to ensure that the ward's needs are met until the clerk officially appoints a successor. The guardian shall attend the hearing to modify the guardianship, if physically able."

SECTION 12.(e) In order to achieve continuity of care and services, any successor guardian shall make diligent efforts to continue existing contracts entered into under the authority of G.S. 122C-122 where consistent with the best interest of the ward as required by Chapter 35A of the General Statutes.

SECTION 13.(a) Section 1(a)(3) of S.L. 2011-264 reads as rewritten:

"(3) Designate ~~a single entity~~an area authority for mental health, developmental disabilities, and substance abuse services to assume responsibility for all aspects of Waiver management. The following operational models are ~~acceptable options for Local Management Entity (LME) applicants:~~acceptable:

a. Merger model: A single larger LME is formed from the merger of two or more LMEs.

b. Interlocal agreement among LMEs: A single LME is identified as the leader for all Waiver operations, financial management, and accountability for performance measures."

SECTION 13.(b) Section 1(c) of S.L. 2011-264 reads as rewritten:

"**SECTION 1.(c)** The Department shall require LMEs that have not been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013, to merge with or be aligned through an interlocal agreement with an LME that has been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver. If any LME fails to comply with this requirement, or fails to meet performance requirements of an approved contract with the Department to operate a 1915(b)/(c) Medicaid Waiver, the Department shall assign responsibility for management of the 1915(b)/(c) Medicaid Waiver on behalf of the noncompliant LME to an LME that is successfully operating the Waiver and successfully meeting performance requirements of the contract with the Department. Those LMEs approved to operate the 1915(b)/(c) Medicaid Waiver under an interlocal agreement must have a single LME entity designated as responsible for all aspects of Waiver operations and solely responsible for meeting contract requirements."

SECTION 14.(a) Article 4 of Chapter 122C of the General Statutes is amended by adding a new Part to read:

"Part 2B. Behavioral Health Authority.

"**§ 122C-29. Behavioral Health Authority Creation; Approval and Oversight.**

A behavioral health authority may be created under the provisions of this Part whenever the governing board of the local management entity, which has been operating as a managed care organization under a 1915(b)/(c) Medicaid Waiver for at least three years, finds and adopts a resolution finding that it is in the interest of the public health and welfare to create a behavioral health authority in order to manage resources that may be available for mental health, intellectual and other developmental disabilities, and substance abuse services. An LME's organization as a behavioral health authority is subject to the approval of the Secretary which shall be based on the LME's demonstration of successful operation as a managed care

organization. The LME shall be subject to periodic review and may be revoked by the Secretary upon a finding that the LME is no longer successfully operating as an managed care organization as defined in 42 C.F.R 438.2.

"**§ 122C-29.1. Functions of a behavioral health authority.**

A behavioral health authority shall perform all the functions necessary to carry out the purposes of this Part, including, but not limited to, the following:

(1) Establish accountability for the development and management of a local system that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for individuals in need of mental health, intellectual and developmental disabilities, and substance abuse services.

(2) Operate the 1915(b)/(c) Medicaid Waiver, a proven system for the management of mental health, intellectual and developmental disabilities, and substance abuse services.

(3) Manage resources that are or become available for mental health, intellectual and developmental disabilities, and substance abuse services.

(4) Use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid program while ensuring medically necessary care and deploy a system for the allocation of resources based on the reliable assessment of intensity of need. These strategies shall efficiently direct individuals to appropriate services and shall ensure that they receive no more and no less than the amount of services determined to be medically necessary and at the appropriate funding level.

(5) Maintain a local presence in order to respond to the unique needs and priorities of localities.

(6) Ensure communication with consumers, families, providers, and stakeholders regarding disability-specific and general Waiver operations by implementing a process for feedback and exchange of information and ideas.

(7) Establish and maintain systems for ongoing communication and coordination regarding the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems such as local departments of social services, Community Care of North Carolina, hospitals, school systems, the Division of Juvenile Justice of the Department of Public Safety, and other community agencies.

(8) Maintain disability specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

(9) Conduct administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information technology systems, financial reporting, and staffing.

(10) Maintain full accountability of for all aspects of Waiver operations and for meeting all contract requirements specified by the Department of Health and Human Services.

(11) Authorize the utilization of State psychiatric hospitals and other State facilities.

(12) Authorize eligibility determination requests for the 1915(b)/(c) Medicaid Waiver.

"§ 122C-29.2. Directors of a behavioral health authority.

(a) Upon approval by the Secretary to organize under this part, the Area Board of the LME shall become the Board of Directors of the behavioral health authority. Directors shall serve out the term for which they were appointed to the Area Board. Thereafter, when a Director resigns, is removed from office, completes a term of office, or when there is an increase in the number of Directors, the election of Directors to the Board shall be in accordance with bylaws set forth for such purpose and may be amended as necessary or convenient to carry out the functions, powers, duties and responsibilities of the Behavioral Health Authority.

(b) At a minimum, the bylaws of the Behavioral Health Authority shall set the number, composition, term, and method of appointment of the Board of Directors. Membership of the Board of Directors shall take into account representation of the counties or geographic areas in which the behavioral health authority operates the 1915(b)/(c) Medicaid Waiver and manages resources for mental health, intellectual and developmental disabilities, and substance abuse services and should be comprised of a mix of individuals with the necessary expertise to govern Managed Care Organizations. When possible, the Directors should include a physician licensed under Chapter 90 of the General Statutes to practice medicine in North Carolina, and who is board certified in psychiatry; a clinical professional from the fields of mental health, developmental disabilities, or substance abuse; an individual with financial expertise, including previous fiscal oversight experience with large organizations; and at least one family member or individual from a citizens' organization representing the interests of individuals with mental illness, intellectual and developmental disabilities, or substance abuse. An individual that contracts with a behavioral health authority for the delivery of behavioral healthcare services shall not serve on the Board of Directors during the period for which the contract for services is in effect.

(c) The Board of Directors shall be responsible for ensuring the behavioral health authority maintains a local presence and is responsive to the unique needs and priorities of localities.

"§ 122C-29.3. Powers of the behavioral health authority.

(a) A behavioral health authority shall have all powers necessary or convenient to carry out the purposes of this Part, including the following powers, which are in addition to those powers granted elsewhere in this Part:

(1) To engage in comprehensive planning, implementing, and monitoring of community based mental health, intellectual and developmental disabilities, and substance abuse services, including for individuals committed to the custody of the Department of Social Services and the Division of Juvenile Justice of the Department of Public Safety.

(2) To comply with federal requirements for Medicaid, Medicare, block grants, and other federally funded health care programs.

(3) To perform public relations and community advocacy functions.

(4) To maintain a 24-hour a day, seven day a week crisis response service. Crisis response shall include telephone and face-to-face capabilities. Crisis phone response shall include triage and referral to appropriate face-to-face crisis providers. Crisis services do not require prior authorization, but shall be delivered in compliance with appropriate policies and procedures. Crisis services shall be designed for prevention, intervention, and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety.

(5) To accept donations or money, personal property, or real estate for the benefit of the behavioral health authority and to take title to the same from any person, firm, corporation or society.

(6) To purchase, lease, obtain options upon, or otherwise acquire any real or personal property or any interest therein from any person, firm, corporation, city, county, government or society.

(7) To sell, exchange, transfer, assign, or pledge any real or personal property or any interest therein to any person, firm, corporation, city, county, government or society.

(8) To own, hold, clear and improve property.

(9) To appoint a Chief Executive Officer and to fix his or her compensation.

(10) To delegate to its agents or employees any powers or duties as it may deem appropriate.

(11) To employ its own counsel and legal staff.

(12) To adopt, amend and repeal bylaws for the conduct of its business.

(13) To enter into contracts for necessary supplies, equipment, or services for the operation of its business.

(14) To appoint committees or subcommittees as it shall deem advisable, to fix their duties and responsibilities, and to do all things necessary in connection with the management, supervision, control and operation of the behavioral health authority's business.

(15) To enter into any contracts or other arrangements with any municipality, other public agency of this or any other State or of the United States, or with any individual, private organization, corporation, or nonprofit association for the provision of behavioral health or other services.

(16) To act as an agent for the federal, State or local government in connection with the management of behavioral health services.

(17) To insure the property or the operations of the behavioral health authority against risks as the behavioral health authority may deem advisable.

(18) To invest any funds held in reserves or sinking funds, or any funds not required for immediate disbursement, in property or securities in which trustees, guardians, executors, administrators, and others acting in a fiduciary capacity may legally invest funds under their control.

(19) To sue and be sued.

(20) To have a seal and to alter it at pleasure.

(21) To have perpetual succession.

(22) To make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the behavioral health authority, including providing services to governmental or private entities, including Employee Assistance Programs.

(23) To provide teaching and instruction programs and schools for psychiatrists, psychologists, psychiatric nurses, technicians and students, interns, and other behavioral healthcare professionals.

(24) To agree to limitations upon the exercise of any powers conferred upon the behavioral health authority by this Part in connection with any loan by a government.

(b) A behavioral health authority may exercise any or all of the powers conferred upon it by this Part, either generally or directly, or through designated agents, including any corporation or corporations which are or shall be formed under the laws of this State.

(c) No provisions with respect to the acquisition, operation or disposition of property by other public bodies shall be applicable to a behavioral health authority unless otherwise specified by the General Assembly.

"**§ 122C-29.4. Compensation; Personnel Policies; Employee Benefits Plans.**

(a) For the purpose of personnel administration, a behavioral health authority is exempted from Chapter 126 of the General Statutes.

(b) A behavioral health authority shall determine the pay, expense allowances, and other compensation of its officers and employees, and may establish position classification and pay plans and incentive compensation plans.

(c) A behavioral health authority shall:

(1) Adopt personnel policies and procedures regarding, without limitation, vacations, personal leave, service award programs, other personnel policies and procedures, and any other measures that enhance the ability of a behavioral health authority to hire and retain employees.

(2) Determine the work hours, workdays, and holidays applicable to its employees.

(3) Establish and pay all or part of the cost of benefit plans for its employees and former employees, including without limitation, life, health and disability plans, pension, deferred compensation and other retirement plans, and other fringe benefit plans.

(4) Pay severance payments and provide other employee severance benefits to its employees and former employees pursuant to a severance plan established in connection with a reduction in the size of the workforce plan, or with respect to an individual employee, pursuant to an employment agreement entered into prior to the date the employee receives notice of termination of employment.

(5) Provide for biennial assessments of the behavioral health authority's personnel plans by an independent entity that specializes in human resources development and management. Such assessments shall be submitted to the Secretary and shall ensure that position classifications and compensation are appropriately matched to industry standards and local job market requirements.

(d) A behavioral health authority shall be subject to the same requirements and responsibilities regarding the disclosure and privacy of personnel records in accordance with G.S. 122C-158.

"**§ 122C-29.5. Limited Liability.**

(a) A person serving as a director, trustee, or officer of a behavioral health authority shall be immune individually from civil liability for monetary damages, except to the extent covered by insurance, for any act or failure to act arising out of this service, except where the person:

(1) Was not acting within the scope of his official duties;

(2) Was not acting in good faith;

(3) Committed gross negligence or willful or wanton misconduct that resulted in the damage or injury; or

(4) Derived an improper personal financial benefit from the transaction.

(b) The immunity in subsection (a) is personal to the directors, trustees, and officers, and does not immunize a behavioral health authority for liability for the acts or omissions of the directors, trustees, or officers.

(c) In addition to the immunity granted in subsection (a), a behavioral health authority may waive its governmental immunity from liability for damages caused by the negligence or

tort of any agent, employee, or Director of the behavioral health authority when acting within the scope of his authority or within the course of his duties or employment. Governmental immunity is waived by the act of obtaining this insurance, but it is waived only to the extent that the behavioral health authority is indemnified by insurance for the negligence or tort.

(d) A behavioral health authority may incur liability pursuant to this section only with respect to a claim arising after the behavioral health authority has procured liability insurance pursuant to this section and during the time when the insurance is in force.

(e) No part of the pleadings that relate to or allege facts as to a defendant's insurance against liability may be read or mentioned in the presence of the trial jury in any action brought pursuant to this section. These issues shall be heard and determined by the judge, and the jury shall be absent during any motions, arguments, testimony, or announcement of findings of fact or conclusions of law with respect to insurance.

(f) Upon request by any agent, employee, or Director or former agent, employee, or Director, a behavioral health authority may provide for the defense of any civil or criminal action or proceeding brought against the agent, employee, or Director, either in his official or in his individual capacity, or both, on account of any act done or omission made, or any act allegedly done or omission allegedly made, in the scope and course of his duty as an agent, employee, or Director. The defense may be provided by employing counsel or by purchasing insurance that requires the insurer to provide the defense. Nothing in this section requires a behavioral health authority to provide for the defense of any action or proceeding of any nature.

"**§ 122C-29.6. Applicability of the Local Government Budget and Fiscal Control Act.**

(a) The Local Government Budget and Fiscal Control Act applies to behavioral health authorities, except that the provisions of Parts 1, 2, and 3 of Article 3 of the Act do not apply to behavioral health authorities, which shall instead be subject to the provisions of this section.

(b) A behavioral health authority shall appoint or designate a finance officer, who shall have the following powers and duties:

(1) Prepare the annual budget for presentation to the governing board of the behavioral health authority and shall administer the budget as approved by the board;

(2) Keep the accounts of the behavioral health authority in accordance with generally accepted principles of accounting;

(3) Prepare and file a statement of the financial condition of the behavioral health authority as revealed by its accounts upon the request of the behavioral health authority's governing board or the governing board of any county, city, or other unit of local government that has issued on behalf of the behavioral health authority and has outstanding its general obligation or revenue bonds or makes current appropriations to the behavioral health authority;

(4) Receive and deposit all moneys accruing to the behavioral health authority, or supervise the receipt and deposit of money by other duly authorized officers or employees of the behavioral health authority;

(5) Supervise the investment of idle funds of the behavioral health authority; and

(6) Maintain all records concerning the bonded debt of the behavioral health authority, if any, determine the amount of money that will be required for debt service during each fiscal year, and maintain all sinking funds, but shall not be responsible for records concerning the bonded debt of any county, city, or other unit of local government incurred on behalf of the behavioral health authority.

(c) The Local Government Commission has authority to issue rules and regulations governing procedures for the receipt, deposit, investment, transfer, and disbursement of money and other assets by behavioral health authorities, may inquire into and investigate the internal control procedures of a behavioral health authority, and may require any modifications in internal control procedures which, in the opinion of the Commission, are necessary or desirable to prevent embezzlements, mishandling of funds, or continued operating deficits.

(d) The accounting system of a behavioral health authority shall be so designed that the true financial condition of the behavioral health authority can be determined therefrom at any time. As soon as possible after the close of each fiscal year, the accounts shall be audited by a certified public accountant or by an accountant certified by the Local Government Commission as qualified to audit local government accounts. The auditor shall be selected by and shall report directly to the behavioral health authority's governing board. The audit contract or agreement shall be in writing, shall include all its terms and conditions, and shall be submitted to the secretary of the Local Government Commission for his approval as to form, terms and conditions. The terms and conditions of the audit shall include the scope of the audit, and the requirement that upon completion of the examination the auditor shall prepare a written report embodying financial statements and his opinion and comments relating thereto. The finance officer shall file a copy of the audit with the secretary of the Local Government Commission and with the finance officer of any county, city, or other unit of local government that has issued on behalf of the behavioral health authority and has outstanding its general obligation or revenue bonds or makes current appropriations to the behavioral health authority (other than appropriations for the cost of behavioral healthcare or programs).

(e) A behavioral health authority may deposit or invest at interest all or part of its cash balance pursuant to G.S. 159-30 and may deposit any funds held in reserves or sinking funds, or any funds not required for immediate disbursement, with the State Treasurer for investment pursuant to G.S. 147-69.2.

(f) A behavioral health authority is subject to G.S. 159-31 with regard to selection of an official depository and security of deposits.

(g) A behavioral health authority is subject to G.S. 159-32 with regard to daily deposits.

(h) A behavioral health authority may accept electronic payments pursuant to G.S. 159-32.1.

(i) A behavioral health authority is subject to G.S. 159-33 with regard to semiannual reports to the Local Government Commission on the status of deposits and investments.

(j) A behavioral health authority having outstanding general obligation or revenue bonds is subject to G.S. 159-35, 159-36, 159-37, and 159-38.

"**§ 122C-29.7. Revenue Bonds and Purchase Money Security Interests**

(a) A behavioral health authority shall have the power to issue revenue bonds under the Local Government Revenue Bond Act, Chapter 159 of the General Statutes, Article 5, or the bond and revenue anticipation provisions of Chapter 159 of the General Statutes, Article 9, for the purpose of acquiring, constructing, reconstructing, improving, enlarging, bettering, equipping, extending, or operating behavioral health facilities.

(b) A behavioral health authority shall have the power to borrow for the purposes above enumerated upon its notes or other evidences of indebtedness, subject to the approval of the Local Government Commission. Such approval shall be required regardless of the amount of any such borrowing.

(c) A behavioral health authority shall have the power and authority to purchase real or personal property under installment contracts, purchase money mortgages or deeds of trust, or other instruments, which create in the property purchased a security interest to secure payment of the purchase price and interest thereon. No deficiency judgment may be rendered against a behavioral health authority for breach of an obligation authorized by this section.

(d) A behavioral health authority may contract pursuant to this section in an amount less than five million dollars ($5,000,000) in any single transaction without the approval of the Local Government Commission; provided, however, that the approval of the Local Government Commission shall be required for any single contract pursuant to this section if the aggregate dollar amount of all such contracts outstanding after any such single transaction would exceed ten percent (10%) of the total operating revenues, as hereinafter defined, of the behavioral health authority for its most recently completed fiscal year as set forth in the audited financial statements of such behavioral health authority for such fiscal year.

(e) Approval of the Local Government Commission under this section shall be obtained in accordance with such rules and regulations as the Local Government Commission may prescribe and shall be evidenced by the Secretary of the Commission's certificate on the contract or note or other evidence of indebtedness. In determining whether to approve any such contract or borrowing, the Local Government Commission shall consider whether the behavioral health authority can demonstrate the financial responsibility and capability of the behavioral health authority to fulfill its obligations with respect to such contract or borrowing. Any contract or borrowing subject to this subsection requiring the approval of the Local Government Commission that does not bear the Secretary of the Commission's certificate thereon shall be void, and it shall be unlawful for any officer, employee or agent of a behavioral health authority to make any payments of money thereunder. An order of the Local Government Commission approving any such contract or borrowing shall not be regarded as an approval of the legality of the contract or borrowing in any respect.

(f) For purposes of this section, the "total operating revenues" of a behavioral health authority for a fiscal year means revenue, less provisions for contractual adjustments, plus other operating revenues, all as determined in accordance with generally accepted accounting principles.

"**§ 122C-29.8. Local Consumer and Family Advisory Committees**

A behavioral health authority shall establish Local Consumer and Family Advisory Committees in accordance with G.S. 122C-170.

"**§ 122C-29.9. Client Rights and Human Rights Committees**

A behavioral health authority shall adopt the State's policy on policy on client rights as contained in G.S. 122C-51 and establish client rights and human rights committees responsible for protecting the rights of clients in accordance with G.S. 122C-64.

"**§ 122C-29.10. Involuntary Commitments**

A behavioral health authority shall have the same duties and responsibilities for involuntary commitments as area authorities created pursuant to G.S. 122C-115(c).

"**§ 122C-29.11. Grievance System.**

(a) A behavioral health authority shall establish Medicaid grievance procedures as required by the federal Medicaid managed care rules and as approved by the Secretary. Such grievance procedures shall provide a process by which consumers and providers may challenge the Medicaid denial of coverage of, or payment for, mental health, intellectual and developmental disabilities, or substance abuse services.

(b) Medicaid State fair hearings involving the 1915(b)/(c) Medicaid Waiver shall be decided by a hearing officer at the Division of Medical Assistance in accordance with 10A N.C.A.C. 22H, which shall be amended to include rules specifically set forth for the adjudication of State fair hearings involving Medicaid managed care.

(c) A behavioral health authority shall comply with the provisions contained in G.S. 122C-151.4 for consumer and provider appeals related to State funded mental health, intellectual and developmental disabilities, and substance abuse services, except that G.S. 122C-151.4(f) shall not apply to appeals involving a behavioral health authority.

"**§ 122C-29.12. Public Guardians**

A behavioral health authority does not qualify as a disinterested public agent and may not serve as the guardian for an individual adjudicated incompetent under the provisions of Subchapter I of Chapter 35A of the General Statutes. A behavioral health authority may not contract with a third party to serve as a guardian for an individual that is, or would be, eligible to have behavioral healthcare managed by the behavioral health authority.

"**§ 122C-29.13. Confidentiality of Competitive Healthcare Information**

(a) A behavioral health authority is subject to all consumer confidentiality requirements and State public records laws, except that the disclosure of competitive healthcare information shall be pursuant to the provisions of this section.

(b) For purposes of this section, competitive healthcare information means information relating to competitive healthcare activities by or on behalf of a behavioral health authority. Competitive healthcare information shall be confidential and not a public record under Chapter 132 of the General Statutes.

(c) If a behavioral health authority is requested to disclose any material which the behavioral health authority believes in good faith contains or constitutes competitive healthcare information, the behavioral health authority may either redact the portions believed to constitute competitive healthcare information prior to disclosure, or refuse to disclose the material in its entirety. The person requesting disclosure may institute an action pursuant to G.S. 132-9 to compel disclosure of the contract or any redacted portion thereof. In any action brought under this subsection, the issue for decisions by the court shall be whether the material constitutes competitive healthcare information, and in making its determination, the court shall be guided by the procedures and standards applicable to protective orders requested under Rule 26(c)(7) of the Rules of Civil Procedure.

(d) Nothing in this section shall be deemed to prevent an elected public body, in closed session, which has responsibility for the behavioral health authority, the Attorney General, or the State Auditor from having access to this confidential information. The disclosure to any public entity does not affect the confidentiality of the information. Members of the public entity shall have a duty not to further disclose the confidential information.

"**§ 122C-29.14. Part Controlling**

Insofar as the provisions of this Part are inconsistent with the provisions of any other law, the provisions of this Part shall be controlling. Except as provided for in this Part, the provisions of G.S. 122C do not apply to behavioral health authorities created under this Part.

SECTION 14.(b) G.S. 122C-3(21) reads as rewritten:

"(20b) "Local management entity" or "LME" means an area authority, county program, behavioral health authority, or consolidated human services agency. It is a collective term that refers to functional responsibilities rather than governance structure."

SECTION 15. This act is effective when it becomes law.

HOUSE BILL 1075: LME/MCO Governance

2011-2012 General Assembly

Committee:	Senate Mental Health & Youth Services	**Date:**	June 6, 2012
Introduced by:	Reps. Dollar, Burr	**Prepared by:**	Shawn Parker Committee Counsel
Analysis of:	PCS to Second Edition H1075-CSSQ-83		

SUMMARY: ***House Bill 1075 amends the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 and other statutes to address identified barriers to the implementation of Statewide expansion of the 1915(b)/(c) Medicaid Waiver as recommended by the Joint Legislative Oversight Committee on Health and Human Services.***

The Senate Proposed Committee Substitute (i) removes the provision relating to consolidation of human service agencies, and (ii) adds a provision to establish behavioral health authorities.

CURRENT LAW:

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. Further, State and local governments are directed to develop and maintain a unified system of services centered in area authorities or county programs.

Session Law 2011-264 (HB 916) directed the Department of Health and Human Services to restructure the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders by expanding operation of 1915(b)/(c) Medicaid Waivers statewide. The 1915(b) authority limits freedom of choice, and 1915(c) authority targets eligibility for the program and provides home and community-based services. States must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver.

Sections 1915(b) and(c) of the Social Security Act authorizes the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid statutory requirements. The waivers allow states to cover a broad array of home and community-based services for certain populations as an alternative to institutional care. Section 1915(b) waivers are commonly known as "freedom of choice" or managed care waivers. Section 1915(c) waivers allow the provision of home and community-based services in lieu of institutional care. Section 1915(b)/(c) waivers combine all Medicaid-funded mental health/developmental disability/substance abuse (MH/DD/SAS) services to allow a single capitated managed care system as a vehicle for service delivery to Medicaid recipients at the community level.

BILL ANALYSIS:

Sections 1 and 2 provide that all area authorities are considered local political subdivisions of the State and that a county's responsibility for the provision of mh/dd/sa services includes adhering to rules, policies, and guidelines developed pursuant to a statewide expansion of a 1915(b)/(c) Medicaid Waiver.

Section 3 directs the Boards of County Commissioners within an area authority's catchment to appoint an area board that consists of no fewer than 11 and no more than 21 voting members, of which the following categories must be represented:

- *At least one county commissioner*
- *The chair of the Consumer and Family Advisory Committee (CFAC)*
- *A family member who is also a member of CFAC*

- *A consumer who is also a member of CFAC*
- *A person with healthcare expertise and experience in mh/dd/sas*
- *A person with social service expertise and experience in mh/dd/sas*
- *A person with financial experience consistent with scale and nature of MCO*
- *A person with insurance experience consistent with scale and nature of MCO*
- *An attorney with health care experience*
- *A Member of public not employed/affiliated with DHHS- appointed by Secretary*
- *The President of LME/MCO Provider Council or Designee (as non-voting- limited to open session)*

Members shall serve up to three consecutive three-year terms. The bill adds a provision to account for excessive absences. All area boards are to be in compliance by July 1, 2013. The Secretary is directed to appoint members consistent with the statute in the event a board of county commissioners fails to appoint each required category of membership.

Section 4 directs annual training for board members which includes, at a minimum, training in fiscal management, budget development, and fiscal accountability. The bill directs the Department in cooperation with the School of Government and LMEs to develop a standard curriculum for this training.

Section 5 authorizes a third term for members of a local CFAC to avoid conflicting with membership requirements of an area board.

Section 6 allows an LME to add counties to its catchment area without unanimous approval of every county within the current LME catchment area.

Section 7 provides a 2-year moratorium on single-county withdrawal from an LME. Further, the Secretary is directed to adopt rules for county disengagement that account for undisrupted services, catchment population requirements, capitation rates, and distribution of real property.

Section 8 authorizes an LME to hold title to real property. *Currently this requires approval from the board of commissioners from each county that comprises the area authority.*

Section 9 removes county commissioner approval for appointing an area director and explicitly gives an LME the authority to borrow money subject to the approval of the Local Government Commission. The section changes the manner in which quarterly fiscal reports are presented and allows the Secretary to waive any inconsistent or incompatible requirements of an LME's business plan based on active contracts to operate a 1915(b)/(c) waiver.

Section 10 provides that competitive health care information is not a public record under Chapter 132 and allows an LME acting in good faith to redact information believed to contain such information or not release the record. If the record is not released, the provision describes a process for judicial intervention.

Section 11 allows a board to approve salaries for directors and employees in excess of ranges established by the State Personnel Commission when supported by documentation of comparable salaries in comparable operations within the region approved by the Secretary.

Section 12 repeals the provision of law authorizing qualified area directors, officers, or employees of an area authority to serve as a guardian for adults adjudicated incompetent under Chapter 35A. The section redefines *disinterested public agent* to mean the director or assistant director of a county department of social services (was local human services agency). Further, the section adds training requirements for corporations contracting with the disinterested public agent and prohibits providers from serving as guardians to individuals to whom it also provides mh/dd/sa services pursuant to a contract with the LME.

Section 13 clarifies that only an LME may manage a 1915(b)/(c) Medicaid Waiver.

Section 14 authorizes the creation of behavioral health authorities as an operational model for contracting for and managing a local behavioral health program under a 1915(b)/(c) Medicaid waiver. A local management entity which has operated as a managed care organization for three years and whose governing board makes a finding and adopts a resolution that it would be in the best interest of the public health and welfare to do so may establish a behavioral health authority to manage all mh/dd/sas resources that may be available. The authority is subject to the Secretary's approval and may be revoked. A newly created Part 2A of Article for of Chapter 122C would provide all powers, duties, functions, and exemptions for a behavioral health authority.

H1075-SMSQ-76(CSSQ-83) v1

VISITOR REGISTRATION SHEET

Mental Health & Youth Services / 6/7/2012
Name of Committee Date

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Glenda Pearce	DHHS - SS.
Amy Whited	NCMS
Jim Edgerton	Allison Bibb Healthcare
Holly Riddle	NC Council on Developmental Disabilities
Beth Stalvey	NC Council on Developmental Disabilities
Kelly Crisha	DHHS/DMA
Yvonne Copeland	NC Council of Comm Programs
Christine Wunsche	SOG Daily Bulletin
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TARA FIELDS	Benchmarks
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Annalise Dolph	DRNC
Colleen Kodanek	KLG
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Beth Melcher	DHHS
Bill Rowe	NC Justice Center
John Dern	DHHS
Jennifer Mahan	ASNC
Joe Lanier	Nelson Mullins
Wendy Kelley	Policy Group
Beth Stalvey	NC Council on Developmental Disabilities
Chip Bigger	NCMS

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Mental Health & Youth Services
Name of Committee

June 7, 2012
Date

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[illegible]	[illegible]
Susan Harrison	NCNA
David Baum	Troutman Sanders
[illegible]	MWC

Box #	Year	Chamber	Committee
13	2011-2012	Senate	Pensions & Retirement & Aging
13	2011-2012	Senate	Program Evaluation
13	2011	Senate	Redistricting (through July 21, 2011)