

Mental Health

One year after the enactment of legislation requiring the most significant reform of the mental health system in decades, the legislative focus turned to the state budget crisis. While providers of publicly funded services, service advocates, and client groups worked with the Department of Health and Human Services (DHHS) on the enormously complicated task of implementing the 2001 reform legislation, questions arose as to whether anticipated cuts in funding would undermine the reform and threaten the continuation of basic services. The final reductions to mental health, developmental disabilities, and substance abuse services for fiscal year 2002–2003 were much less than initially proposed, although administrators responsible for implementing reform on the local level remain concerned that insufficient state funding will compromise the effort. Perhaps because providers, consumers, administrators, and legislators remained largely focused on the 2001 reform legislation and the 2002–2003 budget, the 2002 session was less active in nonbudget mental health areas than usual.

This chapter discusses acts of the General Assembly affecting mental health, developmental disabilities, and substance abuse services. Particular attention is given to legislation that affects local government administration of the public-sector system of services. The mental health system reform legislation reorganized these local government administration units into area mental health, developmental disabilities, and substance abuse authorities (area authorities) and county-administered mental health, developmental disabilities, and substance abuse programs (county programs). Legislative enactments that could potentially affect area authorities and county programs include

- a change in the composition of the commission that adopts rules for administering mental health, developmental disabilities, and substance abuse services;
- the creation of an expedited process for seeking a waiver of rules;
- an extension of the deadline for funding a new consumer advocacy program;
- an amendment to the statute that prohibits the application of exclusionary zoning practices to group homes for the mentally and physically disabled; and
- a bioterrorism law that permits the State Health Director and local health directors to access confidential records.

Appropriations

General Fund Appropriations

The Current Operations, Capital Improvements, and Finance Act of 2002, S.L. 2002-126 (S 1115), appropriates \$573,361,612 from the General Fund to the DHHS Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) for fiscal year 2002–2003. This represents a \$7,707,015 reduction from the \$581,068,627 appropriated for 2002–2003 in the 2001 appropriations act (S.L. 2001-424). Appropriations for the past five fiscal years were \$581.4 million (2001–2002), \$630.4 million (2000–2001), \$614.3 million (1999–2000), \$564.3 million (1998–1999), and \$528.5 million (1997–1998).

Cuts in funding, all recurring, include

- \$3 million to area authorities;
- \$630,487 to the five state-operated mental retardation centers by decreasing outreach expenditures and eliminating 6.5 positions;
- \$184,818 to state-operated substance abuse facilities by eliminating 15.25 positions;
- \$2,895,097 to state psychiatric hospitals by eliminating 61 positions;
- \$129,135 to state-operated child and family facilities;
- \$1 million by budgeting for increased institutional receipts;
- \$835,628 to central office administration;
- \$419,674 by eliminating or reducing a number of contracts for training, education, and other services;
- \$295,229 by reducing expenditures for patient advocacy in the state psychiatric hospitals by 25 percent, eliminating 5 patient advocate positions;
- \$96,947 by reducing expenditures for patient advocacy in the state-operated mental retardation centers, eliminating 6 patient advocate positions.

Section 10.23 of S.L. 2002-126 directs MH/DD/SAS to allocate the reductions to central administration to items of expenditure that have the least impact on (1) direct services provided by state facilities and local programs; (2) the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services; and (3) the state's ability to monitor program performance or otherwise comply with the oversight and reporting requirements of state and federal law. The budget act also requires that reductions to state-operated facilities be allocated (1) so that maximum resources are transferred to local programs for building local service capacity while the state reduces the population of state facilities and shifts principal service functions to community-based programs and (2) in a manner having the least possible impact on the state's ability to comply with *Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176, 144 L. Ed. 2d 540 (1999)¹ and the Civil Rights of Institutionalized Persons Act. DHHS was to submit a plan for allocating the foregoing reductions by November 1, 2002, to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division of the General Assembly.

Nonrecurring increases in funding include \$280,000 for residential services to autistic children; \$500,000 to expand housing support placements for the mentally ill; and \$1 million for nine therapeutic homes programs for women with substance abuse or dependency diagnoses.

1. In *Olmstead*, the Court held that the unnecessary segregation of individuals with mental disabilities in institutions may constitute discrimination based on disability, in violation of the Americans with Disabilities Act. As a result of the ruling, states risk litigation if they do not develop a comprehensive plan for moving qualified persons with mental disabilities from institutions to less restrictive settings at a reasonable pace.

Mental Health Trust Fund

In 2001 the General Assembly established the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs and appropriated over \$47 million to the trust fund to be used solely for the state's service needs and to supplement, not supplant, existing state and local funding. Specifically the General Assembly directed that the trust fund be used only to (1) support community-based treatment programs; (2) facilitate compliance with the United States Supreme Court's *Olmstead* decision; (3) expand services to reduce waiting lists; (4) provide bridge funding to maintain client services during transitional periods of facility closings and departmental restructuring of services; and (5) construct, repair, and renovate state mental health, developmental disabilities, and substance abuse facilities.

Most of the \$47 million trust fund reserve was used to address the state budget shortfall for fiscal year 2001–2002 and was not used for the purposes for which it was originally intended. This year Section 2.1 of the budget bill allocates \$8 million to the trust fund reserve and authorizes the expenditure of up to \$7 million from the fund for siting, design, and capital planning costs associated with the construction of a new psychiatric hospital. (On September 25, 2002, the Secretary of DHHS announced that a new inpatient psychiatric facility would be built at Butner to replace the Dorothea Dix and John Umstead Hospitals, which will be closed when the new hospital opens.)

Federal Block Grant Allocations

Section 5.1 of S.L. 2002-126 allocates federal block grant funds for fiscal year 2002–2003. The Mental Health Services (MHS) Block Grant provides federal financial assistance to states to subsidize community-based services for people with mental illnesses. The General Assembly allocated \$5,442,798 from the MHS Block Grant for community-based services for adults with severe and persistent mental illness, including crisis stabilization and other services designed to prevent institutionalization of individuals when possible. From the same block grant the legislature appropriated \$2,513,141 for community-based mental health services for children, which include school-based programs, family preservation programs, group homes, specialized foster care, therapeutic homes, and special initiatives for serving children and families of children with serious emotional disturbances. The General Assembly allocated \$1.5 million of the MHS Block Grant funds for the Comprehensive Treatment Services Program for Children (formerly the Child Residential Treatment Services Program), which endeavors to provide residential treatment alternatives for children who are at risk of institutionalization or other out-of-home placement.

The Substance Abuse Prevention and Treatment (SAPT) Block Grant provides federal funding to states for substance abuse prevention and treatment services for children and adults. From the SAPT Block Grant the General Assembly allocated \$15,401,711 for the state-operated alcohol and drug abuse treatment centers (ADATCs) and adult alcohol and drug abuse services provided by community-based programs. Other allocations include \$7,740,611 for services for children and adolescents (for example, prevention, high-risk intervention, outpatient, and regional residential services) and \$8,069,524 for services for pregnant women and women with dependent children [including specialized services for women participating in the Temporary Assistance to Needy Families (TANF) program whose substance abuse is a barrier to self-sufficiency]. The budget bill also appropriates from the SAPT Block Grant \$4,616,378 for substance abuse services for intravenous drug abusers and others at risk of HIV disease and \$851,156 for prevention and treatment services for children who are affected by parental addiction.

From the Social Services Block Grant, which funds several DHHS divisions, S.L. 2002-126 allocates to MH/DD/SAS \$3,234,601 for unspecified purposes and another \$5 million to assist individuals who are on the state's developmental disabilities services waiting list. From the same block grant the General Assembly allocated \$213,128 to the Division of Facility Services for mental health licensure purposes.

Among the appropriations from the TANF Block Grant, the General Assembly allocated \$400,000 to MH/DD/SAS for substance abuse screening, diagnosis, treatment, and testing of Work First (TANF) participants and \$1,475,142 for residential substance abuse services for women with children.

Medicaid Expenditures

Medicaid is a state and federally funded entitlement program that pays for health care services for low-income persons. It is an extremely important component of the state budget, accounting for more than 10 percent of total state expenditures each fiscal year. Further, it accounts for a significant portion of the local government revenues devoted to mental health, developmental disabilities, and substance abuse services.

The appropriations act, S.L. 2002-126, decreases funding to the Division of Medical Assistance (DMA) by reducing the Medicaid reimbursement rate for a number of health services. Cutbacks in Medicaid expenditures for fiscal year 2002–2003 include a recurring reduction of \$7,716,342 for case management services. Section 10.14 of S.L. 2002-126 requires DHHS to allocate this reduction across all state programs currently providing case management services reimbursed by Medicaid, including mental health, developmental disabilities, and substance abuse programs administered at the local level. A description of the budget provisions affecting Medicaid is included in Chapter 22, “Social Services.”

Laws Affecting Local Program Expenditures

Area Mental Health Administrative Costs

The 2001 appropriations act required area authorities and county programs to develop and implement plans to reduce local administrative costs (sec. 21.65 of S.L. 2001-424). Specifically, the law required that administrative costs for the 2001–2002 fiscal year not exceed 15 percent and capped the allowable administrative costs for 2002–2003 at 13 percent. A special provision in this year’s appropriations act, Section 10.27 of S.L. 2002-126, amends last year’s budget to permit DHHS, beginning with the 2002–2003 fiscal year, to implement alternative approaches for establishing administrative cost limitations for area authorities, county programs, and their service providers.

Private Agency Uniform Cost-Finding Requirement

For years the budget act has authorized MH/DD/SAS to require private agencies providing services under a contract with an area authority to complete an agency-wide uniform cost finding, the intent of which is to ensure uniformity in rates charged to area authorities for services paid for with state-allocated funds. Section 10.25 of this year’s budget act authorizes DHHS to suspend all funding and payment to a private agency if the agency fails to timely and accurately complete the required agency-wide uniform cost finding in a manner acceptable to the DHHS controller’s office. Funding may be suspended until an acceptable cost finding has been completed by the private agency and approved by the DHHS controller’s office. The provision also clarifies that the requirement applies to providers who contract with counties administering services through a county program.

State Government Organization

Patient Advocates at State Institutions

Section 10.31 of S.L. 2002-126 directs DHHS to reorganize patient advocate positions at the state-operated psychiatric hospitals and mental retardation centers so that patient advocates are supervised by and report directly to DHHS officials rather than to the directors of these facilities. The act also directs DHHS to consider contracting for patient advocate services and to submit a report, by December 1, 2002, to the House and Senate Appropriations Committees on Health and Human Services and the General Assembly's Fiscal Research Division. The report must include information relating to

- the various organizational structures within DHHS potentially appropriate for the patient advocate positions,
- the organizational framework recommended by DHHS,
- the DHHS officials responsible for supervising patient advocates under the new organizational scheme, and
- the final DHHS decision on contracting for advocacy services and the reasons for that decision.

Office of Substance Abuse Prevention

Section 10.24 of S.L. 2002-126 directs MH/DD/SAS to create an Office of Substance Abuse Prevention with responsibility for implementing the Comprehensive Strategic Plan for Substance Abuse Prevention. In addition, this office must maintain the Interagency Agreement for Substance Abuse Prevention Services and ensure continuing collaboration between agencies that are parties to the agreement. The legislation also requires MH/DD/SAS to propose to the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services licensure rules for prevention programs that ensure the quality of service delivery in local communities. MH/DD/SAS must ensure that services are provided by qualified prevention professionals, implement an outcome-based system utilizing standard risk assessments and data elements, and provide only evidence-based prevention services determined to be effective in preventing alcohol or other drug problems.

Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services

This session the General Assembly amended G.S. 143B-148, the statute governing member appointment to and the composition of the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, to increase the number of commission members who are service consumers, family members of consumers, and mental health, developmental disabilities, and substance abuse professionals. S.L. 2002-61 (H 1515) increases the number of commission members from twenty-nine to thirty, lengthens the term of office from two to three years, and limits the number of terms to two consecutive terms. Further, to ensure the coordination of rules and policies adopted by the Secretary of DHHS and the commission and to assist the commission in carrying out its duties and responsibilities, the law requires the secretary to appoint to the commission an individual having knowledge of and experience with the commission's and the secretary's rule-making processes and with mental health, developmental disabilities, and substance abuse programs.

S.L. 2002-61 also requires that when the Speaker of the House of Representatives and the President Pro Tempore of the Senate make recommendations for appointments to the commission by the House and Senate, they consider balancing these recommendations between persons who have expertise in adult issues and those who have expertise in children's issues. Of the three

appointees recommended by the President Pro Tempore, one must be a physician licensed to practice medicine in North Carolina, with preference given to a psychiatrist, and two must be members of the public. Of the three appointees recommended by the Speaker of the House, one must be either a physician or a professional with a doctorate having expertise in the field of developmental disabilities, and two must be members of the public.

The twenty-four members appointed by the Governor must represent the following categories:

- Three professionals licensed or certified under G.S. Chapter 90 or 90B who are practicing, teaching, or conducting research in the field of mental health.
- Four consumers, or immediate family members of consumers, of mental health services. At least one must be a consumer and at least one must be an immediate family member of a consumer. No more than two of the consumers or immediate family members may be selected from nominations submitted by Coalition 2001 or its successor organization.
- Two professionals licensed or certified under G.S. Chapter 90 or 90B who are practicing, teaching, or conducting research in the field of developmental disabilities and a *qualified professional*, as defined in G.S. 122C-3(31), experienced in the field of developmental disabilities.
- Four consumers, or immediate family members of consumers, of developmental disabilities services. At least one must be a consumer and at least one must be an immediate family member of a consumer. No more than two of the consumers or immediate family members may be selected from nominations submitted by Coalition 2001 or its successor organization.
- Two professionals licensed or certified under G.S. Chapter 90 or 90B who are practicing, teaching, or conducting research in the field of substance abuse and one professional who is a certified prevention specialist or who specializes in addiction education.
- An individual knowledgeable and experienced in the field of controlled substances regulation and enforcement selected from recommendations made by the Attorney General of North Carolina.
- A physician licensed to practice medicine in North Carolina who has expertise and experience in the field of substance abuse, with preference given to a physician who is certified by the American Society of Addiction Medicine.
- Four consumers, or immediate family members of consumers, of substance abuse services. At least one must be a consumer and at least one must be an immediate family member of a consumer. No more than two of the consumers or immediate family members may be selected from nominations submitted by Coalition 2001 or its successor organization.
- A licensed attorney.

The appointments of professionals licensed or certified under G.S. Chapters 90 or 90B, including physicians appointed by the General Assembly, must be selected from nominations submitted to the appointing authority by the respective professional associations.

Rule Making

Waiver Process for Secretary and Commission Rules

Section 7 of S.L. 2002-160 (H 1777) creates an expedited review process for an area authority or county program that requests a waiver of rules on the basis that the waiver is necessary for the area authority or county program to implement its business plan developed under G.S. 122C-115.2. The expedited process applies to rules adopted by the Secretary of DHHS and the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services under the rule-making authority granted in G.S. 122C-112.1 and G.S. 122C-114. The secretary must review a request to ensure that the waiver furthers the purposes of mental health reform, does not compromise the quality of care or the effectiveness and efficiency of program administration and

service delivery, and meets the requirements of the business plan under G.S. 122C-115.2. Upon a finding that the waiver complies with these requirements, the secretary must refer to the commission a request for waiver of one or more rules adopted by the commission or conduct further review if the request seeks a waiver of one or more rules adopted by the secretary. The secretary must review and approve or deny a request for waiver of secretary-adopted rules within ten days of receipt of the request. The commission must review and approve or deny a request for waiver of one or more commission rules no later than its next regularly scheduled meeting following receipt of the request. The waiver must comply with regulations governing the waiver of rules adopted under G.S. 122C-112.1 and G.S. 122C-11, except that if the time allowed for review of a waiver under these regulations is longer than the time limits set out in S.L. 2002-160, then S.L. 2002-160 applies.

If the request for waiver is denied, the denial must be made in writing and state the grounds for the denial. Appeals of waiver denials must accord with applicable rules. If the waiver request is approved, the waiver will be in effect for a period not to exceed three years or for the period for which the business plan to which the waiver applies is in effect, whichever is shorter. Section 7 of S.L. 2002-160 expires July 1, 2005. On October 1, 2002, and annually thereafter, the secretary is to report activities related to the expedited review process to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

Coordination of Rules Affecting Local Services

Section 10.31 of S.L. 2002-126 directs the Secretary of DHHS and specified commission chairs to develop a process for coordinating rule making affecting area authorities. The process must address how to identify on a routine basis:

- proposed rules that duplicate in whole or in part other proposed or adopted rules,
- methods of avoiding such duplication without interfering with an agency's statutory duty to adopt a rule or impairing a rule's effectiveness as part of a statutory mandate.

The process must also address how to identify

- rules that are in conflict,
- proposed rules that conflict with other proposed or adopted rules, and
- methods of addressing such conflicts without interfering with an agency's statutory duty to adopt a rule or impairing the rule's effectiveness as part of a statutory mandate.

The secretary and the following commissions must collaborate on the development of this process:

- the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services;
- the Social Services Commission;
- the Commission for Health Services;
- the Medical Care Commission; and
- other commissions adopting rules that affect area authorities and that must be implemented by the Secretary of DHHS.

The secretary must also involve a representative of the DHHS Division of Medical Assistance.

The coordination process was to be implemented no later than November 1, 2002. The secretary was to report on the following to the Joint Legislative Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services by November 15, 2002:

- the status of the review of rules for determining any existing ambiguity, duplication, or conflict;
- specific rules that are in conflict and the recommended action for resolving the conflict; and
- the statutory changes necessary to accomplish the purposes for which the rules review process is intended.

Zoning and Group Homes

G.S. Chapter 168, the Handicapped Persons Act, prohibits discrimination against individuals with physical, mental, or visual disabilities. Article 3 of the act declares that for zoning purposes a “family care home” is a residential use of property and is a permissible use in all residential districts. G.S. 168-22 specifically prohibits a political subdivision from requiring a family care home or its owner or operator to obtain a conditional use permit, special use permit, special exception, or variance from any such zoning ordinance or plan. The statute, however, does allow a political subdivision to prevent a family care home from being located within a one-half-mile radius of an existing family care home.

Before 1995 G.S. 168-21(1) defined *family care home* as a home staffed by support and supervisory personnel that provides room and board, personal care, and habilitation services in a family environment for not more than six resident handicapped persons. In 1995 the General Assembly enacted a law to replace the archaic term “domiciliary” care with the term “adult” care throughout the General Statutes. This new law inadvertently swept G.S. 168-21(1) into its scope and altered the definition of “family care home” by replacing the term “a home” with the words “an adult care home.” (sec. 36 of S.L.1995-536.) This change led to confusion over whether the family care home provisions applied to homes for handicapped minors or only to homes for handicapped adults. This year the General Assembly clarified that the law applies to both homes for minors and homes for adults by restoring the definition of *family care home* to its pre-1995 text. [sec. 24 of S.L 2002-159 (S 1217).]

State Psychiatric Hospitals

Section 86 of S.L. 2002-159 requires DHHS to spend \$2 million of its 2002–2003 appropriations on planning and preliminary design for facilities to replace Cherry and Broughton psychiatric hospitals. DHHS must ensure that the identification and use of funds for this purpose do not adversely impact direct services, area authorities, or county programs. The replacement hospitals for Cherry Hospital and Broughton Hospital must be located in Wayne and Burke Counties and serve the eastern and western regions of the state.

Section 91 of S.L. 2002-159 requires DHHS to maintain all existing educational and research programs in psychology and psychiatry managed by The University of North Carolina (UNC) at Dorothea Dix and John Umstead Hospitals, unless the programs are otherwise modified by UNC. The provision applies to psychiatry and psychology programs conducted by the UNC School of Medicine and the Psychology Department within the School of Arts and Sciences at UNC Chapel Hill. At these hospitals and any new state psychiatric hospital, the School of Medicine must retain authority over all educational and research programs in psychiatry, and the School of Arts and Sciences must retain authority over all educational and research programs in psychology. The provision further directs the Secretary of DHHS to consult with the School of Medicine in programmatic, operational, and facility planning of the new psychiatric hospital to ensure appropriate patient treatment and continuation of the School of Medicine’s educational and research programs. Similarly, the secretary must consult with the School of Arts and Sciences to ensure appropriate continuation of its educational and research programs.

Laws Affecting Confidentiality

The laws discussed in this section either provide for access to confidential information or make certain information confidential by limiting its disclosure. However, confidentiality is not the sole feature of these laws. This chapter focuses exclusively on the provisions affecting the disclosure of confidential information since this issue is likely to be of most interest to consumers, providers, and administrators of mental health, developmental disabilities, and substance abuse

services. When a more complete description of a law is available in other chapters of this book, relevant references are provided.

Public Health Bioterrorism Preparedness

S.L. 2002-179 (H 1508) adds new Article 22 to G.S. Chapter 130A to grant the State Health Director broad authority to respond to a public health threat that may be caused by certain types of terrorist incidents. The new law gives the State Health Director the authority to issue a temporary order requiring health care providers to report symptoms, diseases, conditions, or trends in the use of health care services or other health-related information when necessary to conduct a public health investigation or surveillance of an illness, condition, or health hazard that may have been caused by a terrorist incident involving nuclear, biological, or chemical agents. The term *health care provider* is defined to include physicians or “person[s] who [are] licensed, certified, or credentialed to practice or provide health care services, including, but not limited to, pharmacists, dentists, physician assistants, registered nurses, licensed practical nurses, advanced practice nurses, chiropractors, respiratory care therapists, and emergency medical technicians.”

The new law also permits a health care provider, a person in charge of a health care facility, or a unit of state or local government to report to the state or local health director any events that may indicate the existence of a case or outbreak of an illness, condition, or health hazard that may have been caused by a terrorist incident involving nuclear, biological, or chemical agents. “To the extent practicable,” the person making a report must not disclose personally identifiable information. *Health care facility* is defined to include “hospitals, skilled nursing facilities, intermediate care facilities, psychiatric facilities, rehabilitation facilities, home health agencies, ambulatory surgical facilities, or any other health care related facility, whether publicly or privately owned.” Unless the State Health Director orders it, reporting is not mandatory, and a person acting in good faith and without malice is immune from civil or criminal liability for reporting or not reporting. The immunity from liability is not available, however, when the health care provider or unit of state or local government has actual knowledge that a condition or illness was caused by the use of a nuclear, biological, or chemical weapon of mass destruction as defined in G.S. 14-288.21(c).

When a report is made under either of the two provisions described above—the mandatory report in response to a temporary order or the permissive report in response to suspicion or actual knowledge of a terrorist incident—the state or local health director may examine and copy records pertaining to the report that contain confidential or protected health information. For further information on the disclosure of confidential information and other provisions of the law, including provisions authorizing the detention and examination of persons or animals and the evacuation or closing of facilities, see Chapter 10, “Health.”

Address Confidentiality for Domestic Violence, Sexual Offense, and Stalking Victims

S.L. 2002-171 (H 1402) creates a program in the Office of the Attorney General to protect the confidentiality of the address of a relocated victim of domestic violence, sexual offense, or stalking so that a potential assailant may be prevented from finding the victim. Under this program, codified at new G.S. 15C-1 through -16.1, the Office of the Attorney General designates a substitute address for a program participant and acts as the agent of the program participant for purposes of receiving and forwarding first class, certified, or registered mail and receiving service of process. The program permits a participant to request state and local agencies to use the address designated by the Attorney General and, with a few exceptions, requires agencies to accept the designated address when requested to do so. The law prohibits employees of state and local agencies from disclosing a program participant’s actual address and telephone number except as authorized by the law itself. For a detailed discussion of the address confidentiality program, see Chapter 5, “Courts and Civil Procedure.”

Managed Care Patient Assistance Program

In 2001 the General Assembly enacted a Patients' Bill of Rights (S.L. 2001-446) that, among other things, authorizes patients to sue managed care organizations for failing to exercise due care in making treatment decisions, establishes a binding procedure for independent review of coverage decisions adverse to insured persons, and creates a new program to assist patients in exercising their rights under the law. The Managed Care Patient Assistance Program, established by the act, provides information and assistance to individuals enrolled in managed care plans. Among other things, the program must address consumer inquiries and assist managed care plan enrollees with grievance, appeal, and external review procedures.

This year, in Section 45 of S.L. 2002-159, the General Assembly amended G.S. 143-730 to make all health information in the possession of the Managed Care Assistance Program confidential and exempt from the public records law. The act defines *health information* as

1. information relating to an individual's past, present, or future physical or mental health or condition;
2. information relating to the provision of an individual's health care;
3. information relating to the past, present, or future payment for the provision of an individual's health care;
4. information in any form that identifies or may be used to identify an individual that is created by, provided by, or received from
 - an individual or an individual's spouse, parent, legal guardian, or designated representative; or
 - a health care provider, health plan, employer, health care clearinghouse, or any entity doing business with these entities.

Other Laws

Consumer Advocacy Program

Last year the General Assembly enacted legislation to establish the Mental Health, Developmental Disabilities, and Substance Abuse Consumer Advocacy Program (sec. 2 of S.L. 2001-437). The program is to furnish consumers, their families, and providers with the information and advocacy needed to locate services, resolve complaints, address common concerns, and promote community involvement. (*Consumer* is defined as a client or potential client of public services provided by an area or state facility.) The legislation contained a provision, however, that made it effective only if the 2001 General Assembly appropriated funds for the program in the 2002 Regular Session. Although these funds were not appropriated, Section 10.30 of S.L. 2002-126 amends S.L. 2001-437 to permit the consumer advocacy program to become effective if funds are appropriated by the 2003 General Assembly.

Alcohol and Drug Screening Tests

Effective December 1, 2002, S.L. 2002-183 (S 910) creates new G.S. 14-401.20 to make it a crime to sell or otherwise distribute urine to defraud a drug or alcohol test; to substitute or spike a sample to be used to defraud a test; or to use, possess, or sell an adulterating substance intended to be used to defraud a test. The first violation is a Class 1 misdemeanor; a second or subsequent offense is a Class I felony.

Inpatient Substance Abuse Facilities Serving Prison Inmates

In 2001 the General Assembly created an exemption from licensure under G.S. Chapter 122C, and from certificate-of-need requirements under G.S. Chapter 131E, for inpatient chemical dependency or substance abuse facilities that provide services exclusively to Department of

Correction inmates. (sec. 25.19 of S.L. 2001-424.) The law provided that if a facility serves both inmates and the general public, the portion of the facility that serves inmates is exempt from licensure. The law further provided that if a facility is built without a certificate of need, it may not admit anyone other than inmates until a certificate of need is obtained. Section 41 of S.L. 2002-159 amends G.S. 131E-184(d) again to clarify that if an inpatient chemical dependency or substance abuse facility provides services both to Department of Correction inmates and to the general public, only the portion of the facility serving inmates will be exempt from certificate of need review.

Studies and Reports

Criminal History Record Checks

Section 2.1A of S.L. 2002-180 (S 98) authorizes the Legislative Research Commission to study how federal law affects the distribution of national criminal history record check information requested for area authorities, nursing homes, home care agencies, adult care homes, and assisted living facilities and how it restricts implementation of state-required criminal record checks. The study may include a review of advantages and disadvantages, including costs, of various ways to obtain national record checks and an examination of solutions adopted by other states to implement their criminal record check requirements.

Homelessness

Section 2.1E of S.L. 2002-180 authorizes the Legislative Research Commission to study ways to decrease homelessness in the state. If the commission undertakes the study it must examine, among other things, the types of housing support systems required to ease or end homelessness for persons discharged from correctional facilities, mental health and substance abuse services, foster care, family income supports, and other institutions and systems. In addition, the report must consider the coordinated services necessary to end homelessness among individuals and families, including substance abuse and mental health counseling and treatment, adult education, employment training and placement, family stabilization and reunification services, child care and after school services, primary and preventive health care services, the Head Start program, post-criminal justice rehabilitation and reintegration services, transportation services, housing and rental assistance, energy and conservation assistance, nutrition assistance, group adult foster care, and other elder home care services.

Prescription Drug Access

Section 5.1 of S.L. 2002-180 requires DHHS to study ways the state can coordinate and facilitate public access to public and private free and discount prescription drug programs for senior citizens. DHHS must report its finding and recommendations by January 1, 2003, to the North Carolina Study Commission on Aging.

Mark Ford Botts

