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Mental Health

This chapter discusses acts of the General Assembly affecting mental health, developmental disabilities, and substance abuse services. Particular attention is given to legislation affecting the publicly funded system of services, which is currently being reorganized and undergoing other changes mandated by S.L. 2001-437. The mental health system reform legislation of 2001 requires counties to administer services through either an area mental health, developmental disabilities, and substance abuse authority (area authority) or a county mental health, developmental disabilities, and substance abuse program (county program). The legislation further requires that county programs and area authorities develop a network of qualified providers to provide services that are arranged, approved, monitored, and largely paid for by the area authorities and county programs. Legislative enactments in 2003 affecting area authorities, county programs, and their provider networks include changes to

- statutes governing the confidentiality of client information;
- laws affecting the licensure of mental health, developmental disabilities, and substance abuse (MH/DD/SA) services and facilities; and
- the types of professionals that may, on a pilot basis, examine persons being evaluated for involuntary commitment.

Other legislation includes appropriations for MH/DD/SA services, restrictions on the sterilization of the mentally ill and mentally retarded, an extension of the deadline for funding a new consumer advocacy program, a ban on the use of "rebirthing" techniques in psychotherapy practice, and acts permitting marriage and family therapists and psychological associates to receive direct payment for services from third-party payers.

Appropriations

General Fund Appropriations

State funding to the Department of Health and Human Services (DHHS), about $3.3 billion for fiscal year 2003–2004, comprises about 23 percent of the of the state's General Fund budget. About 17 percent of the DHHS funding, or almost 4 percent of the state's General Fund budget for 2003–2004, is appropriated to the Division of MH/DD/SA Services. This appropriation, however,

does not include state funding for the Medicaid program, which accounts for a significant portion of the local government revenues devoted to MH/DD/SA services. (See "Medicaid Funding," below.)

The Current Operations and Capital Improvements Act of 2003, S.L. 2003-284 (H 397), appropriates $577,290,247 from the General Fund to the DHHS Division of MH/DD/SA Services for fiscal year 2003–2004 and $580,423,098 for 2004–2005, both more than the $573.3 million appropriated for 2002–2003 but less than the $581.4 million appropriated for 2001–2002. Prior to that, annual appropriations were $630.4 million (2000–2001), $614.3 million (1999–2000), $564.3 million (1998–1999), and $528.5 million (1997–1998).

Budget act provisions cut $268,664 in funding to the state-operated mental retardation centers by means of a 15 percent decrease in outreach expenditures and save $894,053 in contract costs by eliminating or reducing funding for MH/DD/SA services contracts with nonprofit organizations. S.L. 2003-284 also reduces projected state spending by the Division of MH/DD/SA Services by approximately $3.1 million for each fiscal year of the 2003–2005 biennium contingent on eliminating inflation-based increases associated with utility, vehicle, communications, and equipment costs.

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 as a nonreverting special trust fund in the Office of State Budget and Management. G.S. 143-15.3D provides that the trust fund must be used solely to meet the mental health, developmental disabilities, and substance abuse services needs of the state and must supplement, not supplant, existing state and local funding for these services. Specifically, the fund must be used only to

1. support community-based treatment programs;
2. facilitate compliance with the U.S. Supreme Court's *Olmstead*[1] 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.

Last year, the General Assembly authorized the expenditure of most of the 2002 appropriation to the trust fund for siting, design, and capital-planning costs associated with the construction of a new state-operated psychiatric hospital to replace the Dorothea Dix and John Umstead Hospitals. This year Section 2.1 of the budget bill allocates $12.5 million in nonrecurring funds to the MH/DD/SAS Trust Fund for fiscal year 2003–2004. Section 10.9 of the act provides that these funds can be used to expand or establish community-based services only if DHHS can identify sufficient recurring funds within its current budget for the continued support of these services.

HIPAA Reserve

The state budget includes a $2 million appropriation to a reserve to implement the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law that—among other things—requires health plans, health information clearinghouses, and health care providers to standardize electronic transactions of health information and protect the privacy and security of that information. Section 6.6 of S.L. 2003-284 directs that the reserve be located in the Office of State Budget and Management. Section 6.7 directs the Governor or his designee to oversee the

1. Olmstead v. L.C., 527 U.S. 581, 119 S. Ct. 2176, 144 L. Ed. 2d 540 (1999). 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.

state's implementation of HIPAA, including coordinating correspondence with the federal government, obtaining interpretations of the law from the N.C. Attorney General, and establishing deadlines for state agencies to provide the data to be used for monitoring compliance with the law.

Federal Block Grant Allocations

Section 5.1 of S.L. 2003-284 allocates federal block grant funds for fiscal year 2003–2004. The Mental Health Services (MHS) Block Grant provides federal financial assistance to states to subsidize community-based services for people with mental illnesses. This year, the General Assembly allocated $5,657,798 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, including school-based programs, family preservation programs, group homes, specialized foster care, therapeutic homes, and special initiatives for serving children and families of children having 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 $18,901,711 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. The budget bill also provides for an appropriation from the SAPT Block Grant of $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. 2003-284 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 and $422,003 for the Comprehensive Treatment Services Program for Children.

Among the appropriations from the Temporary Assistance to Needy Families (TANF) Block Grant, the General Assembly allocated $2 million to the Division of MH/DD/SA Services for regional residential substance abuse services for women with children. Section 5.1(j) of the budget act requires the Division of MH/DD/SA Services and the Division of Social Services, in consultation with local departments of social services, area mental health programs, and other organizations, to coordinate the expenditure of these funds to facilitate the expansion of regionally based substance abuse services for women and children.

Health Choice

Health Choice is North Carolina's health insurance program for uninsured children in low-income families. S.L. 2003-284 provides an additional $30.3 million in state funding for 2003–2005 to increase the number of children enrolled in Health Choice. Special provisions in the appropriations act affecting services covered by Health Choice and required prescription drug copayments are addressed in Chapter 21, "Social Services."

Medicaid Funding

The state's Medicaid program pays area and county mental health programs, hospitals, doctors, nursing homes, pharmacies, and other health care providers for the health care they provide to about one million low-income children, disabled persons, pregnant women, elderly persons, and recipients of public assistance. The Medicaid program accounts for a significant portion of area and county mental health program revenues.

State funding for the Medicaid program (approximately $4.4 billion for 2003–2005) comprises about 15 percent of the state's General Fund budget and about 61 percent of the DHHS budget. State funding pays approximately 32 percent of the Medicaid program's total cost, the federal government pays about 62 percent, and county funding (about $450 million per year) pays about 6 percent of program costs.

In May 2003 Congress enacted legislation (Pub. L. No. 108-27) providing $10 billion in additional temporary emergency federal funding for state Medicaid programs. S.L. 2003-284 makes a one-time reduction of $191.6 million in state Medicaid funding for fiscal year 2003–2004 due to receipt of this additional federal funding. The appropriations act also reduces projected state spending for Medicaid by approximately $213.3 million based on specified cost-containment measures and the elimination of inflation-based increases for specified services, and it authorizes DHHS to use up to $8 million in state Medicaid funds for additional cost-containment activities.

The Senate and House considered, but did not enact, several bills that would have reduced or eliminated the counties' responsibility for paying part of the nonfederal share of the cost of Medicaid benefits provided to county residents (S 55, S 467, H 410, H 411, H 451, H 640). A description of other provisions affecting Medicaid spending is included in Chapter 21, "Social Services."

Laws Affecting Local Program Expenditures

Area Mental Health Administrative Costs

S.L. 2003-284 duplicates a provision in the 2001 appropriations act requiring area authorities and county programs to develop and implement plans to reduce local administrative costs (sec. 21.65 of S.L. 2001-424). Section 10.17 of the 2003 budget act provides that administrative costs for area authorities and county programs must not exceed 13 percent of total expenditures and permits DHHS to implement alternative approaches for establishing administrative cost limitations for area authorities, county programs, and their service providers.

Private Agency Uniform Cost-Finding Requirement

Section 10.18 of S.L. 2003-284 duplicates a provision in the 2001 appropriations act authorizing the Division of MH/DD/SA Services to require private agencies providing contract services to an area authority or county program to complete an agency-wide uniform cost finding. The cost finding is intended to ensure uniformity in rates charged to area authorities and county programs for services paid for with state-allocated funds. DHHS may 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 remain suspended until an acceptable cost finding has been completed by the private agency and approved by the DHHS controller's office.

Prohibition of Rebirthing Technique in Psychotherapy Practice

Effective December 1, 2003, S.L. 2003-205 (S 251) makes it a criminal offense to reenact the birthing process in a manner that includes restraint and creates a situation in which the patient may suffer physical injury or death. Under new G.S. 14-401.21 the practice of rebirthing, whether known as "rebirthing technique" or referred to by another name, is punishable as a misdemeanor for the first offense and a felony for a second or subsequent offense. The legislation also amends G.S. 122C-60(a) to clarify that, although restraint and seclusion of a client is permitted when necessary as a measure of therapeutic treatment, a technique to reenact the birthing process as described in G.S. 14-401.21 is not a measure of therapeutic treatment.

Licensure Violations

In 2002 the General Assembly amended G.S. 122C-23 to prohibit the licensure of a new MH/DD/SA facility or service or the enrollment of any new provider for Medicaid services or Medicaid Home or Community Based services if the applicant for licensure or enrollment owned a licensable facility that had its license revoked, suspended, or downgraded during the preceding five years or had been assessed a penalty for certain specified violations within the preceding five years (S.L. 2002-164). The General Assembly amended the provision this year to reduce the period of time that licensure violations will disqualify an applicant and to provide a qualified exemption for area authorities and county programs. As amended by S.L. 2003-294 (S 926), G.S. 122C-23(e1)–(e3) now provides that the prohibition from licensure or enrollment applies to

1. an applicant that was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 that had its license revoked in the preceding sixty months.
2. an applicant that is the owner, principal, or affiliate of a licensable facility that has been assessed a penalty for a Type A or Type B violation, or any combination of those violations, under G.S. 122C-24.1 and
   - the penalty was assessed in the six months prior to the application,
   - two penalties have been assessed in the eighteen months prior to the application and eighteen months have not passed from the date of the most recent violation,
   - three penalties have been assessed in the thirty-six months prior to the application and thirty-six months have not passed from the date of the most recent violation, or
   - four or more penalties have been assessed in the sixty months prior to the application and sixty months have not passed from the date of the most recent violation.

The new provisions are not applicable to penalties assessed prior to October 23, 2002. However, licensure or enrollment must be denied if an applicant's history as a provider under Chapters 131D or 122C or Article 7 of Chapter 110 leads the Secretary of DHHS to conclude that the applicant will likely be unable to comply with licensing or enrollment statutes, rules, or regulations. Any denial of licensure on this basis, along with appeal rights pursuant to Article 3 of Chapter 150B, must be given to the provider in writing.

S.L. 2003-294 also provides that if an applicant is the owner, principal, or affiliate of a licensable facility whose license was summarily suspended or downgraded to provisional status as a result of violations under G.S. 122C-24.1(a) or Article 1A of Chapter 131D, DHHS may not enroll the applicant as a new provider of Medicaid services or issue the applicant a license for a new MH/DD/SA facility or service until sixty months after the original facility's license is reinstated or restored.

DHHS may enroll a provider that would otherwise be disqualified from enrollment under the foregoing provisions if (1) the applicant is an area authority or county program providing services under G.S. 122C-141 and there is no other provider of the service in the catchment area or (2) the

Secretary finds that the area authority or county program has shown good cause by clear and convincing evidence why the enrollment should be allowed.

S.L. 2003-294 became effective July 4, 2003.

Involuntary Commitment

North Carolina's involuntary commitment statutes set forth a procedure for evaluating an individual for court-ordered mental health or substance abuse treatment. Generally, before the district court may order involuntary commitment, the subject of the order must be examined by two different physicians or psychologists. S.L. 2003-178 (H 883) authorizes the Secretary of DHHS to permit up to five area authorities or county programs to substitute for the physician or psychologist a licensed clinical social worker, master's level psychiatric nurse, or master's level certified clinical addictions specialist to conduct the first examination in the commitment process. This waiver from the statutory requirements is limited to area authorities or county programs that are participating in the first phase of the public mental health system restructuring mandated by the 2001 mental health system reform legislation. Intended as a pilot program, the Secretary's waiver would be in effect for no more than three years or for the duration of the area or county program's business plan for system reform.

To apply for the waiver, an area authority or county program must submit, as part of its business plan approved by the Secretary, a description of

- how the purpose of the statutory requirement would be better served if waived;
- how the waiver will enable the authority or program to improve the delivery or management of services;
- how the services provided by the substituted clinicians are within the clinicians' scope of practice; and
- how the health, safety, and welfare of individuals subject to the examination will continue to be at least as well protected under the waiver as under the statutory requirement.

The Secretary must evaluate the effectiveness, quality, and efficiency of services provided under the waiver and the protection of individuals subject to it and must report his or her findings to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by July 1, 2006. In addition, DHHS must ensure that clinicians performing commitment examinations under the waiver are trained and privileged to perform the functions associated with the examination.

S.L. 2003-178 became effective July 1, 2003, and expires July 1, 2006.

Consumer Advocacy Program

In 2001 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 2001 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. The funds were not appropriated in 2002, but a special provision of the 2002 budget act amended S.L. 2001-437 to permit the program to become effective if funds were appropriated by the 2003 General Assembly. Unable to appropriate funds this year, the General Assembly once again inserted a special provision in the budget act to amend Section 4 of S.L. 2001-437 so that the consumer advocacy program can become effective if funds are appropriated by the 2005 General Assembly.

Licensed Professionals

Marriage and Family Therapists

Effective October 1, 2003, S.L. 2003-117 (H 462) amends G.S. 58-50-30 and the Marriage and Family Therapy Licensure Act to provide for direct payment to licensed marriage and family therapists for services covered by health insurance policies and plans. The act also amends the Professional Corporation Act to add marriage and family therapists to the list of professionals who may form a professional corporation. Specifically, the law now permits a professional corporation to be formed by or between a physician or psychologist, or both, and a licensed marriage and family therapist, a licensed clinical social worker, a licensed professional counselor, and a certified clinical specialist in psychiatric and mental health nursing, or each of them, to render psychotherapeutic and related services.

Psychological Associates

S.L. 2003-368 (H 1049) amends G.S. 58-50-30, effective January 1, 2004, to permit licensed psychological associates holding permanent licensure to receive direct payment from insurers for services covered by health insurance policies and plans.

Confidentiality

Implementation of Mental Health System Reform

S.L. 2003-313 (H 826) amends the confidentiality provisions of G.S. Chapter 122C to bring them into conformance with the mental health system reform legislation of 2001 (S.L. 2001-437). The changes to the confidentiality statutes permit area and county programs and their provider networks to exchange confidential client information as necessary to perform their respective functions under the new system of services. Under the new system, area and county mental health programs largely shed their roles as service providers and begin to function more as managed care organizations that arrange, approve, monitor, and pay for services provided directly to clients by a network of qualified providers.

Before July 10, 2003, the date the confidentiality amendments became effective, G.S. 122C-55(a) permitted any area facility, state facility, or the psychiatric service of UNC Hospitals to share confidential information regarding any client of that facility with any other area or state facility or the psychiatric service of UNC Hospitals "when necessary to coordinate appropriate and effective care, treatment or habilitation of the client." G.S. 122C-3(14) defined *area facility* to be a facility "operated by or under contract with" the area authority or county program. While these provisions permitted area and county mental health programs to exchange client information for treatment-related activities with an agency providing client services pursuant to a contractual agreement with the area or county program, there was no provision that explicitly permitted sharing confidential information for payment purposes. Nor did the confidentiality provisions permit the exchange of client information for purposes of the area or county program executing its duty to monitor and evaluate the performance of service providers, a duty that has expanded in scope under the mental health system reform measures and new administrative code rules adopted July 1, 2003 (10A NCAC 27G .0600).

To address these and other system reform issues, S.L. 2003-313 makes the following changes:

1. It amends the definition of *area facility* to clarify that the term *contract,* as used in that definition, refers to 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. This amendment brings within the scope of the term *area facility* any facility that agrees in writing to provide services to area or county

program clients. Thus the associated agreement need not include the exchange of money or other legal consideration.

2. It clarifies that for purposes of exchanging confidential information to coordinate care and treatment, *coordination* means the provision, coordination, or management of MH/DD/SA services and related services provided by one or more facilities and includes the referral of a client from one facility to another. The new definition clarifies that, even if an area authority is providing no direct care or treatment to a client but simply refers the client to a facility that has agreed to participate in the area authority's provider network, the area authority and provider may exchange client information so that the area authority may perform service management functions related to an individual client. Service management functions include reviewing and authorizing the client's treatment plan, evaluating the plan's effectiveness, and periodically monitoring the coordination of services among the client's direct service providers.
3. It creates new G.S. 122C-55(a2) to permit an area facility, state facility, and the psychiatric service of UNC Hospitals to share information regarding any client of that facility with any other area or state facility or the psychiatric service of UNC Hospitals when necessary to conduct payment activities relating to an individual served by the facility. *Payment activities* are activities undertaken by a facility to obtain or provide reimbursement for the provision of services and may include, but are not limited to,
   - determinations of eligibility or coverage;
   - coordination of benefits;
   - determinations of cost sharing amounts;
   - claims management, processing, adjudication, or appeals;
   - billing and collection activities;
   - medical necessity reviews;
   - utilization management and review;
   - precertification and preauthorization of services;
   - concurrent and retrospective review of services; and
   - appeals related to utilization management and review.
4. It creates new G.S. 122C-55(a4) to permit an area authority or county program and any area facility to share confidential information regarding any client of the area facility when the area authority or county program determines the disclosure of information is necessary to develop, manage, monitor, or evaluate the area authority's or county program's network of qualified providers in accordance with G.S. 122C-115.2 (b)(1)b., G.S. 122C-141(a), the State MH/DD/SA Plan, and the rules of the Secretary of DHHS. The purposes or activities for which confidential information may be disclosed include, but are not limited to,
   - quality assessment and improvement activities,
   - provider accreditation and staff credentialing,
   - contract development and rate negotiation,
   - investigation of and response to client grievances and complaints,
   - practitioner and provider performance evaluation,
   - audit functions,
   - on-site monitoring,
   - consumer satisfaction studies, and
   - collection and analysis of performance data.
5. It adds new G.S. 122C-55(a5) to permit any area facility to share confidential information with any other area facility regarding any applicant for services when necessary to determine whether the applicant is eligible for area facility services. *Applicant* is defined as an individual who contacts an area authority for services. Before this amendment, area facilities were limited to sharing information regarding clients only (*clients* being individuals admitted to and receiving a service from an area facility). Under the mental health system reform, area authorities and county programs must provide screening,

triage, and referral for individuals who contact the public service system for services. This may involve eliciting over the telephone information about the applicant that is protected from disclosure under the confidentiality statutes and then referring the applicant to a contract provider for an assessment of the applicant's need and eligibility for services. Until this assessment is conducted, the applicant for services is generally not yet a client. Thus, the new provision is necessary to permit the area or county program (or an agency contracting to provide screening and referral) to disclose confidential information obtained during the screening process to the network provider to which the applicant is referred for a face-to-face assessment.

6. It adds new G.S. 122C-55(a3) to permit an area facility, state facility, or the psychiatric service at UNC Hospitals to disclose confidential information regarding any client of the facility with the Secretary of DHHS and to permit the Secretary to disclose confidential information regarding any MH/DD/SA client to these facilities when there is reason to believe that a client is eligible for benefits through a DHHS program. This provision permits the disclosure of information necessary to establish initial eligibility for benefits, determine continued eligibility over time, and obtain reimbursement for the costs of services to the client.
7. It amends G.S. 122C-55(g) to permit a facility, when there is reason to believe that a client is eligible for financial benefits through a government agency, to disclose confidential information to a local government agency for the purpose of establishing financial benefits for a client. This provision, which previously permitted disclosures only to state and federal government agencies, now permits disclosures to local departments of social services for establishing Medicaid benefits for a client.

Child Fatality Task Force

G.S. 143B-150.20 establishes a State Child Fatality Review Team to conduct in-depth reviews of any child fatalities that have occurred involving children and families involved with child protective services of a local department of social services within the twelve months preceding the fatality. The statute grants the team access to medical records, hospital records, and records maintained by the state and any county or any local agency, including mental health records, as necessary to execute the purposes of the statute. Pursuant to this statute and G.S. 122C-54(h), mental health facilities must grant the team access to information that is otherwise confidential, except that information confidential under federal regulations governing substance abuse records can only be disclosed as permitted by those regulations.

Effective July 1, 2003, Section 6 of S.L. 2003-304 (S 421) amends G.S. 143B-150.20 to provide that if the team does not receive information within thirty days after requesting it, the team may apply for a court order compelling disclosure. The application must state the factors supporting the need for a court order and must be filed in the district court of the county where the investigation is being conducted. The court has jurisdiction to issue any orders compelling disclosure and subsequent proceedings must be given priority by the appellate courts.

Nurse Privilege

Currently, state law provides that certain communications are privileged, such as those between a physician and a patient, a psychologist and a patient, and a clergyperson and his or her communicants. If a communication is privileged, the possessor of the information—such as the physician—is not required to disclose information about the communications in court proceedings except in limited circumstances. S.L. 2003-342 (H 743) establishes a new privilege for nurses. Under the new law, information acquired while rendering professional nursing services and necessary to providing such services is now privileged. The nurse may not be required to disclose the information unless a court determines that disclosure is necessary to the proper administration of justice and disclosure is not prohibited by any other law.

Jail Health Information

S.L. 2003-392 (S 661) amends G.S. 153A-225 to provide that when a jail transfers an inmate to another jail, the transferring jail must provide the receiving jail with "any health information or medical records" the transferring jail has in its possession pertaining to the inmate.

Sterilization of the Mentally Ill and Mentally Retarded

Article 7 of Chapter 35 of the General Statutes had previously authorized certain public officials or the parent or guardian of a mentally ill or mentally retarded person to petition the district court for the sterilization of that person in the interests of the "public good" or of the "mental, moral, or physical improvement" of the mentally ill or mentally retarded person. Under these provisions the court could order sterilization without holding a hearing, and the sterilization procedure could be performed over the objections of the respondent and the respondent's next of kin. In addition, the provisions for obtaining court-ordered sterilization could apply to any mentally ill or mentally retarded person, regardless of whether a court had declared that person incompetent.

S.L. 2003-13 repeals Article 7 and creates a new sterilization procedure statute limited in application to mentally ill and mentally retarded persons who have been adjudicated incompetent and appointed a guardian of the person. Under new G.S. 35A-1245, a guardian cannot consent to the sterilization of a mentally ill or mentally retarded ward without an order of a clerk of court based on the findings that (1) the procedure is medically necessary and is not being performed solely for the purpose of sterilization or for hygiene or convenience; and (2) either (a) the ward is capable of comprehending the procedure and its consequences and has consented to the procedure or (b) the ward is incapable of comprehending the procedure and its consequences.

Guardianship

Effective December 1, 2003, S.L. 2003-236 (H 1123) amends G.S. Chapter 35A to clarify the clerk of superior court's authority to enter a limited guardianship order allowing an adult who has been adjudicated incompetent to retain certain legal rights and privileges when appropriate based on the nature and extent of the ward's capacity. S.L. 2003-236 also amends G.S. 35A-1107 to require the guardian ad litem appointed to represent an allegedly incompetent adult to

- visit the respondent as soon as possible following the guardian ad litem's appointment;
- make every reasonable effort to determine the respondent's wishes regarding the incompetency proceeding and proposed guardianship;
- present to the clerk the respondent's expressed wishes at all relevant stages of the incompetency and guardianship proceeding;
- make recommendations to the clerk concerning the respondent's best interests if those interests differ from the respondent's express wishes; and
- in cases in which limited guardianship may be appropriate, make recommendations to the clerk concerning the rights, powers, and privileges that the respondent should retain under a limited guardianship.

The Senate and House considered, but failed to enact, legislation (S 273, H 156, S 34, H 674) that would have authorized a study of North Carolina's guardianship law.

Disabled Adults

CAP-DA Audit and Review

Section 10.29B of S.L. 2003-284 requires the State Auditor, contingent on appropriation of state funds, to perform an audit of the Medicaid Community Alternatives Program for Disabled Adults (CAP-DA) to determine whether it is operating within waiver guidelines and program goals. The audit results must be reported to the North Carolina Study Commission on Aging by January 1, 2004. Section 10.29B also requires DHHS to report on the program to the Study Commission on Aging by January 1, 2004. The DHHS report must include a review of compliance with eligibility requirements, the current assessment process for clients, waiting list procedures, quality of care, and program costs.

In-Home Demonstration Project

Section 10.51 of S.L. 2003-284 continues, revises, and expands a demonstration project, established by S.L. 1999-237 and S.L. 2001-237, allowing the payment of State–County Special Assistance benefits to individuals who do not live in adult care homes but would otherwise be eligible to receive assistance under this program. The maximum payment under the demonstration project generally may not exceed 50 percent of the maximum payment provided to adult care home residents who receive State–County Special Assistance benefits. No more than eight hundred individuals may receive assistance under the demonstration project during each fiscal year. DHHS must make the demonstration project available to all counties on a voluntary basis but also must consider, to the extent possible, geographic balance in the distribution of payments under the project. In implementing the project, DHHS must require a functional assessment of participants, ensure that all participants are individuals who need and, but for the demonstration project, would seek placement in an adult care facility, and collect data to compare the quality of life of noninstitutionalized project participants to that of institutionalized recipients of State–County Special Assistance benefits. DHHS must submit a report on the demonstration project to specified legislative leaders by January 1, 2004 and January 1, 2005.

Medicaid Services

Prior Authorization of Services

Section 10.19(i) of S.L. 2003-284 prohibits DHHS from imposing prior authorization requirements or other restrictions with respect to medications prescribed for the treatment of HIV/AIDS or mental illnesses (including schizophrenia, bipolar disorder, and major depressive disorder).

Reduction of Transitional Coverage

Children, families, and elderly or disabled persons who are covered by Medicaid based on their receipt of public assistance (Supplemental Security Income or Work First) remain eligible for "transitional" Medicaid coverage if they lose their eligibility for public assistance due to increased earnings. S.L. 2003-284 reduces the maximum duration of transitional Medicaid coverage from twenty-four to twelve months.

Medicare-Eligible Recipients

The federal Medicaid law requires Medicaid recipients who are also eligible for coverage under the federal Medicare program to apply for Medicare so that Medicare, rather than Medicaid,

will pay some or all of the cost of medical care that is covered under both programs. Section 10.27 of S.L. 2003-284 codifies this requirement in state law by enacting new G.S. 108A-55.1. The new law also provides that if a Medicaid recipient qualifies for Medicare and fails to apply for Medicare, the Medicaid program will not pay for medical care that is covered under Medicare and a Medicaid provider may seek payment from the Medicaid recipient for this care.

Medicaid-Eligible Students with Disabilities

Section 10.29A of S.L. 2003-284 enacts new G.S. 108A-55.2 requiring DHHS to work with the Department of Public Instruction and local educational agencies to maximize funding for Medicaid-related services for Medicaid-eligible students with disabilities.

Fiscal Analysis of Proposed Medicaid Policy Changes

Section 10.19(z) of S.L. 2003-284 prohibits DHHS from changing Medicaid policies related to authorized Medicaid providers or the amount, sufficiency, scope, or duration of Medicaid services (unless federal law requires the change) unless the DHHS Division of Medical Assistance first prepares a five-year fiscal analysis of the cost of the proposed change. If the fiscal impact of the policy change exceeds $3 million, DHHS must submit the policy change proposal and fiscal analysis to the Office of State Budget and Management and the General Assembly's Fiscal Research Division for review and may not implement the change unless a source of state funding for the change is identified and approved by the Office of State Budget and Management. DHHS must provide quarterly reports to the Office of State Budget and Management and the Fiscal Research Division with respect to policy changes with a fiscal impact of less than $3 million.

A description of other provisions affecting Medicaid services is included in Chapter 21, "Social Services."

Insurance

Managed Care Patient Assistance Program

In 2001 the General Assembly established the Managed Care Patient Assistance Program to provide information and assistance to individuals enrolled in managed care plans. Among other things, the program must address consumer inquiries and assist managed care enrollees with grievance, appeal, and external review procedures. S.L. 2003-105 (H 744) directs health insurers to provide information to enrollees about the availability of the program, including the program's telephone number and address. Insurers are required to provide such information in several instances; for example, the information must be included in the member handbook and must be provided to enrollees at several different stages in the insurer's grievance process. S.L. 2003-105 also directs the Commissioner of Insurance to notify individuals of the availability of the Managed Care Patient Assistance Program after receiving a request for external review.

Claims Processing Fees

In general, when a provider submits a claim to an insurer, the insurer charges a fee for processing the claim. S.L. 2003-369 (H 1066) requires each insurer to make available to providers a schedule of the fees associated with the services or procedures for which bills are submitted. Schedules must be made available to contracted providers as well as prospective contracted providers. The law also requires insurers to disclose a description of its policies with respect to claims submission and reimbursement. Insurers must notify providers about changes to the schedule of fees or the claims submission or reimbursement policies. The law specifies two limited exceptions to these requirements. All insurers must submit to the Commissioner of

Insurance a written description of their policies and procedures for complying with the new requirements.

Joint Legislative Oversight Committee Studies and Reports

S.L. 2003-58 (H 80) creates G.S. 120-243 to require DHHS to report to the Joint Legislative Oversight Committee on MH/DD/SA Services whenever it is required by law to report to the General Assembly or the permanent committees or subcommittees of the General Assembly on matters affecting MH/DD/SA services. The act also makes changes to G.S. 122C-5, 131D-42, and 131D-10.6 to require DHHS to submit to the Joint Legislative Oversight Committee on MH/DD/SA Services the reports required by those statutes regarding the use of restraint and seclusion in adult care homes, child care facilities, and MH/DD/SA facilities.

S.L. 2003-396 (S 934) requires the Joint Legislative Oversight Committee on MH/DD/SA Services to study the programs of agencies assessing persons who must obtain a substance abuse assessment and certificate of completion of a substance abuse program for restoration of a driver's license. The study must examine the adequacy of the fees clients pay to assessing agencies for required substance abuse assessments.

Other Legislation

State Institution Settlement of Small Claims

S.L. 2003-285 (S 786) adds new G.S. 143-295.1 to the state's Tort Claims Act to permit a DHHS-operated institution to settle certain small claims without recourse to the procedures provided by the act. Specifically, the new legislation provides that when the property of a resident of the institution is lost, destroyed, or otherwise damaged due to the negligence of the institution and the amount of damages is less than $500, the institution may make a direct payment or provide for the replacement of the item to the resident.

DHHS Administration

Section 10.2 of S.L. 2003-284 directs DHHS to establish an Office of Policy and Planning to promote coordinated policy development and strategic planning for health and human services programs. The director of the office will have the authority to instruct other components of DHHS to conduct periodic reviews of policies, plans, and rules and will advise the Secretary about any recommended changes.

Traumatic Brain Injury Advisory Committee

S.L. 2003-114 (S 704) establishes the North Carolina Traumatic Brain Injury Advisory Committee. The committee is charged with, among other things, studying the needs of individuals with traumatic brain injuries and making recommendations to the Governor, the General Assembly, and the Secretary of DHHS regarding a comprehensive statewide service delivery system for persons suffering from traumatic brain injuries.

Nursing Home Medication Management

S.L. 2003-393 (S 1016), which requires nursing homes to establish medication management advisory committees and to take certain steps to reduce medication-related errors, is addressed in Chapter 20, "Senior Citizens."

Physician Registration to Prescribe Buprenorphine

Effective October 1, 2003, S.L. 2003-335 (S 876) amends the North Carolina Controlled Substances Act to require any physician who prescribes or dispenses Buprenorphine for the treatment of opiate dependence to register annually with DHHS in accordance with rules adopted by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services.

Exemption of Detoxification Facilities from Certificate of Need Requirements

S.L. 2003-390 (H 815) amends G.S. 131E-176 to provide that social setting detoxification facilities and medical detoxification facilities are not chemical dependency treatment facilities for purposes of the Certificate of Need requirements. It also amends G.S. 122C-23 to provide that social setting detoxification facilities and medical detoxification facilities subject to licensure under G.S. Chapter 122C must not deny admission or treatment to an individual solely because of the individual's inability to pay.

DWI Service Providers

G.S. 122C-142.1 requires area authorities to provide, directly or by contract, the substance abuse services needed to obtain a certificate of completion for restoration of a driver's license under G.S. 20-17.6. Although the statute permits private facilities to provide these substance abuse services, S.L. 2003-396 amends the statute, effective October 1, 2003, to require that these facilities obtain DHHS authorization before doing so. Authorization requires the private facility to pay DHHS a fee, based on the number of persons served, for authorizing and monitoring the quality of the facility's services.

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