

# 19

## Mental Health

---

This chapter discusses acts of the General Assembly affecting mental health, developmental disabilities, and substance abuse (MH/DD/SA) services, with particular attention given to legislation affecting publicly funded services. Although these services are largely governed by policy administered on the state level by the Department of Health and Human Services' (DHHS) Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, they are primarily delivered at the community level through a service network managed by local governments. Due to the array of local government structures used for this task and the variety of statutory terms applicable to these entities, an explanation of the terminology used in this chapter is in order.

A county must provide, manage, and oversee publicly funded mental health, developmental disabilities, and substance abuse services through an area authority, county program, or consolidated human services agency. Each of these three agencies performs the same basic functions, though each has a different governance structure and, therefore, a different relationship to the county governments of the counties it serves. In 2006 the General Assembly enacted legislation (S.L. 2006-142) codifying the term *local management entity* and its acronym, LME, as a means for referring collectively to area authorities, county programs, and consolidated human services agencies based on their common functional responsibilities. The terms *area authority*, *county program*, and *consolidated human services agency* retain their statutory meaning and continue to denote the specific and distinct governance and administrative structures available to a county or group of counties for carrying out the local management entity functions codified at G.S. 122C-115.4.

This chapter uses the term *local management entity* or its acronym, LME, when discussing legislation that utilizes these references or when referring to area authorities, county programs, and consolidated human services agencies collectively. However, when the legislation being discussed does not apply to all local management entities or applies only to one of the three entities, this chapter uses the more specific reference.

Some significant features of the 2007 legislative session include a continued emphasis on crisis services and acute care at the community level and housing assistance for persons with mental health, developmental, and substance abuse disabilities. The 2007 General Assembly specifically targeted substance abuse services, appropriating money for drug courts, substance abuse treatment for criminal offenders, and community services that utilize the American Society

of Addiction Medicine model of care. On the perennial topic of mental health insurance parity, the General Assembly finally enacted legislation requiring insurers to offer mental health benefits commensurate with physical health benefits but excluded substance abuse treatment from the scope of the act. The General Assembly continued the involuntary commitment pilot and amended the laws affecting LME funding, reporting requirements, business planning, and service waivers.

## **Appropriations**

### **General Fund Appropriations**

The 2007 General Assembly appropriated \$713,081,821 for 2007–08 and \$721,639,723 for 2008–09 from the General Fund to the DHHS Division of MH/DD/SA Services. Annual appropriations for the past five years were \$662.8 million (2006–07), \$603.3 million (2005–06), \$574.4 million (2004–05), \$577.3 million (2003–04), and \$573.3 million (2002–03).

The Current Operations and Capital Improvements Appropriations Act of 2007, S.L. 2007-323 (H 1473), reduces state appropriations to the Division of MH/DD/SA Services by \$2.33 million in each year of the fiscal biennium based on the availability of unexpended funds in various funding accounts for MH/DD/SA services. According to the Conference Report on the Continuation, Capital, and Expansion Budget, this reduction is not expected to reduce funding received by local management entities.

For the 2007–09 biennium S.L. 2007-323 cuts \$180 million in funding to Dorothea Dix Hospital and John Umstead Hospital in anticipation of their closings in fall 2007 and allocates approximately \$176 million of this savings to fund the new Central Regional Hospital scheduled to open in late fall 2007. The remainder of the savings, approximately \$4.4 million, along with an additional \$500,000, is allocated for local management entity (LME) administrative costs in 2008–09. (LMEs receive state funding for administrative functions, often called “management functions,” which include developing and monitoring a provider network, implementing and maintaining a system for citizens to access services, and authorizing and coordinating individual client care. State funding to LMEs for these administrative activities is separate from state funding allocated to LMEs for covering the cost of services provided to indigent, non–Medicaid-eligible MH/DD/SA clients.)

In 2006 the General Assembly made a nonrecurring appropriation of \$5.25 million for the development and implementation of crisis services—both local crisis services and regional crisis facilities—for individuals with mental illness, developmental disabilities, and substance abuse addictions (S.L. 2006-66). The 2006 appropriations act also allocated \$225,000 to DHHS to hire a consultant to provide technical assistance to LMEs as they develop and implement a “crisis plan” for local crisis services and regional crisis facilities. This year the General Assembly made a recurring appropriation of \$13,737,856 in each year of the 2007–09 fiscal biennium for LMEs to continue to implement their crisis plans. (Section 10.49 of S.L. 2007-323.) DHHS may use up to \$250,000 of these funds in each fiscal year to extend its contract with the crisis services consultant. Although the \$13.7 million appropriation for crisis services expands funding for crisis services, it does not represent an expansion of total funding to the Division of MH/DD/SA Services because the money is made available by reducing, or moving money from, existing funding for mental health services.

In a matter related to funding for crisis services, S.L. 2007-323 appropriates \$2.5 million for 2007–08 and \$5 million for 2008–09 for a pilot program to test mechanisms for increasing community capacity for handling psychiatric crises and reducing patient admissions to the state psychiatric hospitals. This legislative provision is discussed in more detail in the section below entitled “Crisis and Acute Care Services.”

In an attempt to increase the availability of substance abuse treatment, the budget act appropriates \$6 million in each year of the 2007–09 biennium to “regionally-funded, locally-hosted” substance abuse services that utilize the American Society of Addiction Medicine

continuum of care model for community services. Most of this money, \$5 million in each fiscal year, is made available by “realigning” existing funding. Section 10.49 of the budget act directs that a portion of the realigned funding—\$500,000 in 2007–08 and \$700,000 in 2008–09—be used for residential substance abuse programs with a vocational component and “encourages” LMEs to use a “portion” of the funds for prevention and education activities. In addition, LMEs may use up to 1 percent of the substance abuse treatment funds to provide nominal incentives for consumers who achieve specified treatment benchmarks.

S.L. 2007-323 appropriates \$2 million in each year of the 2007–09 fiscal biennium for LMEs to provide substance abuse services for adult offenders and to increase the number of Treatment Alternatives For Safer Communities (TASC) case managers. The appropriations act also appropriates \$2 million in each year of the 2007–09 fiscal biennium for services to treatment courts, including pre- and post-plea mental health courts, DWI courts, and adult and family drug courts for adult offenders.

In 2006 the General Assembly targeted the housing needs of individuals with disabilities by making a \$10.9 million nonrecurring appropriation to the North Carolina Housing Trust Fund to finance the construction of 400 independent and supportive living apartments for individuals with disabilities with incomes at the Supplemental Security Income level. An additional \$1.2 million in recurring funding was provided to subsidize the operating costs associated with the apartments. This year the General Assembly appropriated \$7.5 million in nonrecurring funds to the North Carolina Housing Trust Fund for additional independent and supportive living apartments for persons with disabilities.

S.L. 2007-323 appropriates \$2.5 million in each year of the fiscal biennium for long-term supported employment for individuals with mental illness, developmental disabilities, and substance abuse addictions. The money is made available by cutting \$2.5 million in other funding for mental health and developmental disabilities services. Funding is to be distributed among the LMEs in proportion to the number of residents in an LME’s catchment area living below the federal poverty level.

For mental health services to returning war veterans S.L. 2007-323 makes a \$343,130 nonrecurring and \$35,797 recurring appropriation for 2007–08, and it designates a \$47,728 recurring appropriation for 2008–09. This money must be used to support one mental health manager position to lead the Division of MH/DD/SA Services’ response to the mental health service needs of returning veterans and their families, to expand the North Carolina Health Information Portal, an educational and social marketing tool directed at veterans and their families, and for statewide training to providers regarding the mental health and substance abuse service needs of this population. Of the money in this appropriation, \$40,782 in 2007–08 and \$47,728 in 2008–09 is obtained by realigning existing funding for mental health services.

The appropriations act also

- Moves \$512,835 for 2007–08 and \$633,920 for 2008–09 from the Atypical Antipsychotic Drug program in the Division of MH/DD/SA Services to the Medication Access and Review Program of the Office of Rural Health and Community Care.
- Appropriates \$300,000 for each year of the fiscal biennium to DHHS, Office of the Secretary, for allocation to the North Carolina Institute of Medicine to hire new staff and undertake studies at the request of the General Assembly and to convene a task force to study substance abuse services in North Carolina.
- Reduces funding to the Division of Medical Assistance for Medicaid provider inflationary increases by \$35,441,213 for fiscal year 2007–08 and \$37,707,413 for 2008–09.
- Moves \$4.5 million in existing funding for developmental disabilities services from the Division of MH/DD/SA Services to the Division of Medical Assistance for 300 additional slots in the Community Alternatives Program for persons with mental retardation or other developmental disabilities.
- For 2007–08 only, directs \$2 million in existing funding for developmental disabilities services to be used to develop three model programs of early intervention for autism.

- Provides \$3.5 million for 2007–08 and \$4.5 million for 2008–09 in recurring funds to the Division of MH/DD/SA Services for subsidizing the operational costs of independent and supportive living apartments for persons with disabilities.
- Appropriates \$267,883 for 2007–08 and \$357,117 for 2008–09 to increase the number of personnel positions in the Division of MH/DD/SA Services dedicated to the oversight, management, and delivery of community-based services.
- Allocates \$121,988 in 2007–08 and \$724,065 in 2008–09 to increase staffing at the state-operated North Carolina Special Care Center.
- Dedicates \$60,000 in nonrecurring funding for 2007–08 to the North Carolina Council of Community Programs to establish a statewide consumer support and networking organization that promotes the role of consumers in contributing to the design, function, and oversight of the MH/DD/SA service system.
- Provides \$100,000 for 2007–08 (nonrecurring) for Consumer and Family Advisory Committee training.
- Appropriates \$100,000 in 2007–08 and \$100,000 in 2008–09 to fund the development of Crisis Intervention Teams by local management entities and for the Division of MH/DD/SA Services to develop the capacity to provide Crisis Intervention Team training statewide.

### **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 fund must be used solely to meet the mental health, developmental disabilities, and substance abuse services needs of the state. Since 2001, money from the trust fund has been expended on both community-based treatment services and state-operated facilities, including construction and personnel positions at state-operated facilities. S.L. 2007-323 amends G.S. 143-15.3D to provide that, beginning July 1, 2007, the trust fund must be allocated solely to local management entities to increase community-based services. For fiscal year 2007–08, however, DHHS may spend trust fund monies for purposes other than community-based services as long as those purposes were included in the department’s 2006–07 Mental Health Trust Fund Plan. The act further directs that money in the trust fund designated by DHHS in its 2006–07 Mental Health Trust Fund Plan for increasing community-based services must be disbursed in full to local management entities for community-based services no later than October 1, 2007. These funds, if not expended by LMEs for community-based services by June 30, 2009, will revert to the Mental Health Trust Fund on that date.

In spite of the emphasis on community-based services, the act permits DHHS to use money from the trust fund to support up to sixty-six positions at the state-operated Julian F. Keith Alcohol and Drug Abuse Treatment Center if the center opens before July 1, 2008. In addition, the act authorizes DHHS to use up to \$1.5 million in each of the 2007–08 and 2008–09 fiscal years for community-based services without allocating that money to local management entities.

### **Federal Block Grant Allocations**

Section 10.55 of S.L. 2007-323 allocates federal block grant funds for fiscal year 2007–08. 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 \$5,654,932 (down from \$7,184,481 in 2006–07) 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 \$3,921,991 (the same amount as in 2006–07) 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. As it did last year, the General Assembly allocated \$1.5 million of the MHS Block Grant funds for the Comprehensive Treatment Services Program for Children (CTSP), which provides 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. This year's SAPT Block Grant funding generally matched the funding levels of 2006–07. The General Assembly allocated \$20,287,390 for alcohol and drug treatment services for adults. Other allocations include \$4,940,500 for services for children and adolescents, \$5,835,701 for child substance abuse prevention, and \$8,069,524 for services for pregnant women and women with dependent children. The budget act also appropriates \$4,816,378 from the SAPT Block Grant for substance abuse services for treatment of intravenous drug abusers and others at risk of HIV disease and \$851,156 for prevention and treatment services for children affected by parental addiction.

From the Social Services Block Grant (SSBG), which funds several DHHS divisions, S.L. 2007-323 allocates \$3,234,601 to the Division of MH/DD/SA Services for mental health and substance abuse services for adults, mental health services for children, and for developmental disabilities programs. An additional allocation of \$5 million is made to the developmental disabilities services program. From the same block grant, the General Assembly allocated \$205,668 to the DHHS Division of Health Service Regulation (formerly, the Division of Facility Services) for mental health licensure purposes and \$422,003 to the Division of Social Services for the CTSP for Children. The SSBG allocations match the allocations made for 2006–07.

## **Local Management Entities**

The 2007 acts discussed in this section amend the laws governing the functions, consolidation, board composition, business planning, services, provider relationships, reporting requirements, and funding of local management entities.

### **LME Functions**

S.L. 2007-504 (H 627) amends G.S. 122C-115.4 to clarify that the primary LME functions enumerated in that section must not be conducted by an entity other than an LME unless an LME chooses to contract with another entity to perform those functions or unless the LME fails to adequately perform a function after receiving technical assistance from the state. This clarification was in response to a rule proposed by the Secretary of DHHS that would have permitted the secretary to designate other entities, in addition to LMEs including private entities, to perform LME functions.

LME functions include the review and approval of the person-centered plan developed for a consumer by the consumer's primary provider. This particular function includes the review and approval of the person-centered plan for each consumer who receives non-Medicaid state funded services. For all consumers in the LME's catchment area who receive Medicaid services, the review is concurrent with the review performed by the fiscal agent hired by the state to authorize Medicaid services. S.L. 2007-504 amends G.S. 122C-115.4, the statute that enumerates and describes LME functions, to provide that the LME's utilization management and review function includes the authority to participate in the development of any consumer's person-centered plan and the duty to monitor all person-centered plans. With regard to the LME's provider-monitoring function, the new law adds that the authority to endorse and monitor contracted providers of services includes the authority to remove a provider's endorsement if the provider fails to adequately document the provision of services or fails to provide required staff training. Without

the LME's endorsement, a provider cannot provide and obtain reimbursement for services to LME clients.

S.L. 2007-504 rewrites G.S. 122C-115.4(b)(5), the provision addressing the LME's care coordination and quality management function. The act expands the concept of care coordination beyond the mere monitoring of the effectiveness of person-centered plans by explaining that care coordination "involves individual client care decisions at critical treatment junctures to assure clients' care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results." Care coordination must be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, link clients to higher levels of care when necessary, resolve disagreements between providers and clinicians, and consult with clinicians, providers, case managers, and reviewers. The new law also enumerates the activities that must be included in care coordination for high-risk, high-cost consumers.

### **LME Consolidation**

To force greater consolidation of area authorities and county programs the General Assembly, in a special provision of the 2006 appropriations act, set a minimum size for LME catchment areas, the geographic areas served by LMEs. Specifically, section 10.32(c) of S.L. 2006-66 amended G.S. 122C-115 to provide that the catchment area of an area authority or county program must contain either a minimum population of 200,000 or a minimum of six counties. In addition, beginning July 1, 2007, DHHS was directed to reduce by 10 percent annually the state funding for LME functions to any LME that did not comply with the catchment area size requirement. Since the enactment of the legislation and the resulting flurry of LME mergers, some counties have chosen to break away from the LME that they were participating in and join a new one, rather than stay with the original LME as it merged wholesale with another LME. As a result, at least one LME was left with fewer counties than it originally had and it fell below the catchment area size requirement. S.L. 2007-504 amends G.S. 122C-115 to provide a twelve-month grace period from the size requirement for any LME that fails to meet the requirement due to change in county membership.

### **LME Board Composition**

G.S. 122C-118.1 provides that the area board for a multicounty area authority consisting of eight or more counties and serving a population of more than 500,000 can have up to thirty board members, exceeding the twenty-five member maximum applicable to other area authorities. With the merger of the Smoky Mountain Center area authority and the New River area authority, the resulting twelve-county area authority met the eight-county threshold but did not meet the 500,000 population threshold. To permit the new Smoky Mountain Center area authority to have more than twenty-five board members, S.L. 2007-504 amends G.S. 122C-118.1 to drop the 500,000 population requirement.

The act also amends G.S. 122C-118.1 to provide that any individual who contracts with an LME for the delivery of client services may not serve on the LME board during the period that the service contract is in effect.

### **LME Business Plan**

Every county, through its local management entity, must develop, review, and approve a business plan for the management and delivery of mental health, developmental disabilities, and substance abuse services. Pursuant to G.S. 122C-115.2, the business plan must be submitted to the Secretary of DHHS for approval. The statute requires the plan to address particular subjects and sets forth a procedure for submission and approval. To assist LMEs in developing their business plans, S.L. 2007-504 amends G.S. 122C-115.2 to require the secretary to develop a model business plan that illustrates compliance with the statute and any applicable state rules and

standards. A business plan that demonstrates substantial compliance with the model business plan developed by the secretary will be deemed as meeting state law and standards. The amended statute also provides that if the secretary, upon reviewing a business plan, determines that the plan needs substantial changes in order to be approved, the secretary must provide the LME with detailed information on each area of the plan that is in need of change, the particular state law or standard that has not been met, and instructions or assistance on what changes need to be made for the plan to be approved.

### **LME Services**

G.S. 122C-141 requires area authorities and county programs to provide MH/DD/SA services to their clients by contracting with other agencies or institutions for the provision of those services. The area authority or county program itself may not provide services to clients unless the Secretary of DHHS approves the direct provision of services. S.L. 2007-504 amends G.S. 122C-141 to provide that any approval of direct service provision granted by the secretary must be for no less than one year, unless the area authority of county program requests otherwise.

### **LME Service Providers**

G.S. 122C-141(a) authorizes the area authority or county program to contract with any “qualified public or private provider,” defined as a provider that meets the provider qualifications as defined by rules adopted by the Secretary of DHHS. Most contracted providers of MH/DD/SA services are private incorporated organizations, but a few are public entities. The 2006 General Assembly amended G.S. 122C-141 to impose specific requirements on providers and LMEs if the public provider of MH/DD/SA services is a multicounty agency formed as a result of two or more counties entering into an interlocal agreement under Article 20 of G.S. Chapter 160A. Among other things, the 2006 law (S.L. 2006-142) amended G.S. 122C-141(d) to clarify that this kind of provider, like other public and private providers, must meet all provider qualifications as defined by rules adopted by the secretary. S.L. 2007-504 amends subsections (d) and (e) of G.S. 122C-141 to replace references to the secretary with references to the Commission for MH/DD/SA Services as the rulemaking entity responsible for promulgating rules defining provider qualifications. S.L. 2007-504 also amends G.S. 122C-114 to add to the powers and duties of the rulemaking commission the duty to adopt rules establishing the qualifications necessary to be a qualified provider. While it appears that the General Assembly intended to move the authority to adopt rules setting provider qualifications from the secretary to the commission, in an apparent oversight, S.L. 2007-504 left intact the language in G.S. 122C-141(a) that says provider qualifications are defined by the secretary.

### **LME Expenditure Reports**

To address the lack of information available to the General Assembly regarding the use of county general funds appropriated to LMEs for MH/DD/SA services, Section 10.49.(ff) of S.L. 2007-323 requires LMEs to report annually to the Division of MH/DD/SA Services all expenditures from county funds by the LME for (1) services, (2) start-up expenses, and (3) capital and operational expenses. Multicounty LMEs must report the amount of money expended on services for residents of each county participating in the LME, and all LMEs must gather income data for all individuals receiving services.

### **Single Stream Funding**

Historically, funding for client services has been allocated to LMEs according to funding categories that designate the clients and services for which a particular category of funds may be expended. Recently, the state has begun to experiment with “single stream funding,” which dissolves the categorical restraints of multiple funding streams so that LMEs have the flexibility to

shift available funds between traditional service categories to meet local needs and priorities. Section 10.49.(y) of S.L. 2007-323 requires DHHS, by September 1, 2007, to designate two additional local management entities to receive all state appropriations through single stream funding. In addition, by October 1, 2007, DHHS must develop and implement clear standards for how an LME can qualify for single-stream funding and award single stream funding to any other LME that meets these standards during the 2007–08 and 2008–09 fiscal years. DHHS must continue to provide state allocations to the Piedmont, Smoky Mountain, Guilford, Sandhills, Five County, and Mecklenburg LMEs through single-stream funding.

### **Area Authority Director**

Personnel administration for area authority employees must be conducted in accordance with the State Personnel Act and the rules and policies of the State Personnel Commission. These rules and policies govern things such as position classification, qualifications, recruitment, dismissal, and compensation. For example, employees who have satisfactorily completed a probationary period may not be demoted, suspended, or dismissed except for “just cause” or reduction in force. Under the just cause standard defined by the State Personnel Commission, area employees may not be discharged, suspended, or demoted for disciplinary reasons without adequate procedural due process and a demonstration that just cause for the disciplinary action—unacceptable job performance or personal conduct—exists.

The area director, the administrative head of an area authority, is appointed by the area board, the governing body for the area authority. S.L. 2007-323 amends G.S. 122C-121 to provide that the area director must “serve at the pleasure of the board.” Thus although the area director is otherwise subject to the State Personnel Act, effective July 30, 2007, the just cause standard no longer applies and the area director’s employment is “at the will” of either party, meaning that the area director or the area board may terminate the employment relationship at any time without explanation or legal penalty.

S.L. 2007-323 further amends G.S. 122C-121 to establish that, unless the State Personnel Commission deems the area authority’s personnel system to be substantially equivalent to the standards established under the State Personnel Act, the area director may not be paid a salary less than the minimum nor more than the maximum of the applicable salary range adopted in accordance with the State Personnel Act. However, the area board, subject to the approval of the State Personnel Commission, may adjust the salary range to make the level of pay conform to local financial ability and fiscal policy, as long as the adjustment is not more than 10 percent above the normal allowable salary range.

### **Involuntary Commitment Pilot**

North Carolina’s involuntary commitment statutes set forth the 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 at two different points in the process by either a physician or a psychologist. In 2003 the General Assembly authorized the Secretary of DHHS to permit up to five area authorities or county programs to use a professional other than a physician or psychologist, such as a licensed clinical social worker, master’s level psychiatric nurse, or master’s level certified clinical addictions specialist, to conduct the first examination (S.L. 2003-178). Intended as a pilot program, the waivers could be in effect for no more than three years or for the duration of the local management entity’s business plan. To prevent the law from expiring on July 1, 2006, the 2006 General Assembly extended the waiver program until October 1, 2007 (Section 10.27 of S.L. 2006-6). With that deadline approaching, the 2007 General Assembly, in S.L. 2007-504H, extended and expanded the waiver program by moving the expiration date of the law to October 1, 2010, and by

authorizing the secretary to approve up to ten LMEs to operate under the waiver from October 1, 2007, until October 1, 2010.

The secretary must evaluate and report on the effectiveness of services provided under the waiver and the waiver's effect on health, safety, and welfare. The report, including data gathered from the participating LMEs, must be submitted to the Joint Legislative Oversight Committee on MH/DD/SA Services by October 1, 2009. The oversight committee must review the report and recommend to the 2009 General Assembly whether to extend, discontinue, or make permanent the pilot program provisions.

## **Co-payment for Services**

S.L. 2007-410 (H 628) amends G.S. 122C-112.1 to add to the powers and duties of the Secretary of DHHS the duty to adopt rules for the implementation of a graduated co-payment schedule to be used by LMEs and contracted providers to require co-payments from families whose family income is 300 percent or greater of the federal poverty level. The secretary must identify the services to which the co-payment schedule applies. Effective July 1, 2008, the act amends G.S. 122C-146 to require LMEs and contracted provider agencies to implement the co-payment schedule developed by the secretary and apply the schedule to services provided on or after that date. The LME is responsible for determining the applicability of the co-payment to individuals that the LME authorizes to receive services. The act leaves intact the language in G.S. 122C-146 that says no individual may be refused services due to an inability to pay.

## **Confidentiality of Client Information**

S.L. 2007-115 (H 353) amends the law governing the State Health Director's authority to investigate and control disease and health hazards. New G.S. 130A-15 requires health care providers and persons in charge of health care facilities or laboratories to provide the State Health Director, upon request and with proper identification, access to privileged medical information, including information protected by the Health Information Portability and Accountability Act (HIPAA) privacy rule. The State Health Director has the right to examine, review, and obtain a copy of records that the director considers necessary to prevent, control, or investigate a disease or health hazard that may present a clear danger to the public health. Medical information privileged under state law or protected under the HIPAA privacy rule and received by the State Health Director under new G.S. 130A-15 is confidential and must not be released except pursuant to other law or when release is made to another public health agency, a court, or a law enforcement officer for the purpose of preventing, controlling, or investigating a disease or public health hazard.

S.L. 2007-115 amends G.S. 90-21.20B, governing health records, and G.S. 8-53.1, the physician-patient privilege, to make those provisions consistent with the HIPAA privacy rule's provisions governing the disclosure of protected health information to law enforcement officers and for purposes of treatment, payment, and health care operations. The provisions, however, do not apply to providers of MH/DD/SA services when client information is also confidential under G.S. Chapter 122C and 42 C.F.R. Part 2. Under the new law, a health care provider may disclose protected health information to a law enforcement officer to the extent that the information may be disclosed under the HIPAA privacy rule, unless the disclosure is prohibited by other state or federal law. In addition, a health care provider may disclose protected health information for purposes of treatment, payment, and health care operations to the same extent that the information may be disclosed under the HIPAA privacy rule, unless the disclosure is prohibited by other state or federal law. The state law governing MH/DD/SA records and the federal regulations governing substance abuse records do not permit disclosure as broadly as the HIPAA privacy rule in these circumstances. Providers of MH/DD/SA services, therefore, must continue to follow the prohibitions against disclosure found in other state and federal laws.

## Services

### Crisis and Acute Care Services

As noted in the section on appropriations above, the 2007 General Assembly appropriated \$13.7 million in each year of the 2007–09 fiscal biennium for LMEs to continue to implement the crisis service plans they were required to develop and implement under S.L. 2006-66. The 2006 legislation set forth the service components that must be included in a continuum of crisis services for all consumers. The 2007 appropriations act adds detoxification services as a required component.

Section 10.49 of S.L. 2007-323 provides that, until July 1, 2008, LMEs must report monthly to DHHS regarding (1) the use of state crisis funds, (2) whether there has been a reduction in the use of state psychiatric hospitals for acute admissions, and (3) any remaining gaps in local and regional crisis services. DHHS must report quarterly on each LME's proposed and actual use of funds to various legislative committees. Beginning with the 2007–08 fiscal year DHHS also must report quarterly to LMEs aggregate information regarding all visits to community hospital emergency departments due to a mental illness, developmental disability, or substance abuse disorder.

In a continuing search to find ways to reduce state psychiatric hospital admissions and increase the capacity of local governments to provide for the acute care and crisis services needs of individuals with mental illness at the community level, the General Assembly directed DHHS to select up to four LMEs to participate in an eighteen-month pilot program that tests whether giving LMEs greater financial and clinical responsibility for psychiatric hospital use permits them to reduce state hospital admissions. To increase community service capacity so that the LMEs participating in the pilot have alternatives to the state-operated hospitals, Section 10.49 of S.L. 2007-323 appropriates \$2.5 million for 2007–08 and \$5 million for 2008–09 for the pilot LMEs to use for start-up operations or payment for local services. A portion of this money, \$250,000 in each fiscal year, may be retained by DHHS.

In preparing for the pilot that must be implemented by January 1, 2008, DHHS must calculate the cost of every LME's 2006–07 use of state psychiatric hospital services based on each state hospital's total budget and the percentage of patients at the hospital admitted from each LME's catchment area. DHHS must also calculate a daily cost rate for hospital usage based on the statewide usage for 2006–07. An LME that wishes to participate in the pilot program must submit a proposal by October 15, 2007, that includes a plan to reduce hospital usage by a specified amount with an explanation of how the LME expects to accomplish that goal. DHHS must award pilot participation by November 1, 2007, to those LMEs that project the largest decrease in use and that have the greatest likelihood of succeeding.

Each LME selected for the pilot program will have a virtual budget account for January 1, 2008, through June 30, 2008, based on one-half of the LME's cost of psychiatric hospital use during the 2006–07 fiscal year minus the LME's proposed reduction in hospital use. Every bed day used by patients from the LME's catchment area will be debited against the LME's virtual account using the daily rate calculated by DHHS. The pilot LMEs must use the money appropriated to them under the pilot to build community service capacity, pay for an on-site representative at the state psychiatric hospital serving their region, and pay for patient bed days that are in excess of the hospital use projected in their proposal. The LME representative at the hospital will participate in patient admission, supervision, and treatment; treatment plan development; and the development and implementation of discharge plans.

Based on the experience of the pilot program, DHHS must develop a proposal for subsequent pilots to reduce hospital use and build community services. The Division of MH/DD/SA Services must submit to the Joint Legislative Oversight Committee on MH/DD/SA Services interim reports on its progress by October 15, 2007, and by February 1, 2008, and a final report by February 1, 2009. The final report must include a description of the pilot LMEs' success in working with local hospitals and the resulting reductions in the use of emergency rooms, jails, and state facilities. The appropriations act clarifies that the budgets for the state psychiatric hospitals must not be reduced

during the 2007–08 fiscal year as a result of the pilot program, but that budgets will be adjusted in following years to reflect the previous year’s use by the LMEs participating in the pilot program.

### **Substance Abuse Services**

As noted above S.L. 2007-323 appropriates \$2 million in each year of the 2007–09 fiscal biennium for LMEs to provide substance abuse services for adult offenders and to increase the number of Treatment Alternatives For Safer Communities (TASC) case managers. Section 10.49 of the act directs local management entities to consult with TASC to improve offender access to substance abuse treatment and match evidence-based interventions to individual needs at each stage of substance abuse treatment. Special emphasis must be placed on intermediate punishment offenders, community punishment offenders at risk for revocation, and Department of Corrections releasees who have completed substance abuse treatment while in custody.

S.L. 2007-323 also appropriates \$2 million in each year of the 2007–09 fiscal biennium for treatment court programs. Section 10.49 of S.L. 2007-323 directs LMEs, when providing Drug Treatment Court services to consult with the local drug treatment court team and select a treatment provider that meets all provider qualifications requirements and the Drug Treatment Court needs. A single treatment provider may be chosen for non-Medicaid-eligible participants. During the 52-week Drug Treatment Court program, each participant must receive an array of treatment and after-care services that meet the participant’s level of need, including step-down services that support continued recovery.

### **Housing Assistance and Residential Facilities**

Section 10.49 of the appropriations act provides \$7.5 million in non-recurring funds to DHHS to finance additional independent and supportive living apartments for persons with disabilities. The housing must be affordable to those with incomes at the Supplemental Security Income (SSI) level. DHHS must give first priority for these funds to apartments financed by the North Carolina Housing Finance Agency (NCHFA), second priority to other publicly subsidized apartments, and third priority to market-rate apartments. When awarding funds to finance apartments, NCHFA must give priority to those housing developments with an LME as a lead agency except where prohibited by federal law.

The act directs DHHS and NCHFA to develop a plan for the financing and development of additional independent and supportive living apartments for individuals with mental health, developmental, and substance abuse disabilities and to jointly submit, by March 1, 2008, an interim report to the Joint Legislative Oversight Committee on MH/DD/SA Services. The interim report must address how housing finance agencies and departments of health and human services in other states have worked together to address the housing needs of these populations and how other states have otherwise addressed disability-specific housing. A final report is due March 1, 2009.

The appropriations act also directs DHHS to

- develop a “Transitional Residential Treatment Program” service definition to provide 24-hour residential treatment and rehabilitation for adults who have a pattern of difficult behaviors related to mental illness and that exceed the capabilities of traditional community residential settings;
- develop a Uniform Screening Tool by January 1, 2008, to determine the mental health of any individual admitted to any long-term care facility.

S.L. 2007-323 reauthorizes the joint ad hoc subcommittee regarding the mentally ill in adult care homes, convened by the Joint Legislative Oversight Committee on MH/DD/SA Services and the Commission on Aging to study and identify rules and laws necessary to regulate facilities that provide housing for adults with mental illness in the same location with adults without mental illness.

### **Jail Services**

Section 10.49 of S.L. 2007-323 directs LMEs to work with public health departments and county sheriffs to provide medical assessments and medication, if appropriate, for inmates housed in county jails who are suicidal, hallucinating, or delusional. In addition to providing these services, LMEs must study ways to provide additional services to inmates who are psychotic, severely depressed, or suicidal, or who have substance abuse disorders. DHHS must develop an evidence-based standardized screening tool to be used when offenders are booked, and LMEs and county sheriffs must designate an LME employee who is responsible for screening the daily booking log for individuals who are known to receive mental health services. The LME and county sheriff must also develop protocols for effective communication between the LME and jail staff, including a medication management protocol, and training to help detention officers recognize symptoms of mental illness.

### **Children's Services**

Section 10.10 of S.L. 2007-323 directs the Department of Health and Human Services to continue the Comprehensive Treatment Services Program for Children (CTSP), in consultation with other agencies, to provide appropriate and medically necessary nonresidential and residential treatment alternatives for children who are at risk of institutionalization or other out-of-home placement. Section 10.9 continues the School-Based Child and Family Team Initiative to provide for agency collaboration in identifying and providing services for children who are at risk of school failure or out-of-home placement. Section 10.33 continues the Intensive Family Preservation Services Program.

### **Mental Health Insurance Parity**

Effective July 1, 2008, S.L. 2007-268 (H 973) amends G.S. Chapter 58 to require health insurers to offer benefits for the care and treatment of mental illnesses that are no less favorable than benefits for physical illness generally. With some exceptions, a health plan must apply to mental illnesses the same deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and other dollar limits and fees that apply to covered services for physical illnesses. Mental illnesses are those illnesses diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association. Excluded are mental disorders coded as substance related disorders (291.0 through 292.2 and 303.0 through 305.9) and sexual dysfunctions not due to organic disease (302.70 through 302.79).

Durational limits for the following specified mental illnesses must be subject to the same limits as benefits for physical illness generally: bipolar disorder, major depressive disorder, obsessive compulsive disorder, paranoid and other psychotic disorder, schizoaffective disorder, schizophrenia, post-traumatic stress disorder, anorexia nervosa, and bulimia. For other mental illnesses, a health benefit plan may apply durational limits that differ from the durational limits that apply to physical illnesses, but the plan must provide at least thirty combined inpatient and outpatient days per year and thirty office visits per year.

### **Rulemaking**

S.L. 2007-504 amends G.S. 143B-148 to require the General Assembly to appoint two additional members to the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services. The two new members must be attorneys licensed to practice in North Carolina. Initially appointed for two years, these appointees will thereafter serve three-year terms.

S.L. 2007-504 enhances the rulemaking authority of the commission by transferring from the Secretary of DHHS to the commission the authority to adopt rules governing the implementation of a uniform portal process and by granting the commission the authority to adopt rules governing

- the development of a process for screening, triage, and referral at the LME service level, including a uniform portal process, to be implemented by the secretary;
- the monitoring and endorsement of service providers by LMEs;
- the provision of technical assistance by LMEs to providers of client services; and
- the requirements of a qualified public or private provider as that term is used in G.S. 122C-141.

## State Facilities

The Secretary of DHHS is responsible for operating a number of state-owned facilities that provide mental health, developmental disabilities, and substance abuse services. S.L. 2007-177 (H 625) amends G.S. 122C-181 to rename some of those facilities, in part, to account for the prospective closing of the Dorothea Dix and John Umstead hospitals as they are replaced by the new Central Regional Hospital at Butner. The act also redesignates the state's mental retardation centers as developmental centers and renames the facilities known as "special care centers" by more specifically designating these facilities as either Neuro-Medical Treatment Centers or Residential Programs for Children.

## Studies

### Task Force on Substance Abuse Services

Section 10.53A of the appropriations act directs the North Carolina Institute of Medicine (Institute) to use a portion of the funds received under the act to convene a task force to study substance abuse services in North Carolina. Members of the task force must include, among others, providers of substance abuse services, academics and researchers with substance abuse expertise, representatives of DHHS and local management entities, members of the North Carolina Senate and House of Representatives, and representatives of the North Carolina Department of Justice, Office of Attorney General, Department of Public Instruction, and Community College System.

The act directs the task force to

1. Identify the continuum of services needed for the treatment of substance abuse, the services currently being provided, and the gaps in services.
2. Identify evidence-based models of care or promising practices and recommend how to incorporate these into the current service system.
3. Examine different financing options to pay for services at the local, regional, and state level.
4. Examine the adequacy of the current and future substance abuse workforce and develop, if needed, a workforce education plan to address current or future workforce shortages.
5. Develop strategies to identify people in need of substance abuse services, including people who are dually diagnosed with mental health and substance abuse problems.
6. Examine barriers that prevent people with substance abuse problems from accessing publicly funded services and explore strategies for improving access.
7. Examine current service outcome measures and identify other appropriate outcome measures to assess the effectiveness of services, if necessary.
8. Examine the economic impact of substance abuse in North Carolina and, if possible, the impact on the courts system, the health care system, social services, and worker productivity.

9. Make recommendations on the implementation of a cost-effective plan for prevention, early screening, diagnosis, and treatment of North Carolinians with substance abuse problems.

The task force must submit its interim report and recommendations to the 2008 session of the General Assembly and its final report to the 2009 General Assembly, at which time the task force will dissolve.

### **Legislative Study Commission on Children and Youth**

Section 10.10(i) of S.L. 2007-323 rewrites Article 24 of G.S. Chapter 120 to make the following changes in the Legislative Study Commission on Children and Youth:

- Requires the commission, in its study of the needs of children and youth, to determine the adequacy and appropriateness of services to children and youth served by the MH/DD/SA services system.
- Changes the membership of the commission by adding one additional member of the House of Representatives and one additional member of the Senate; requiring that there be at least one member who also serves on each of several specified legislative committees; requiring that one member be the parent of a child at risk for behavioral, social, health, or safety problems or academic failure; and requiring that one member be a representative of a local board of education.

A new section, G.S. 120-221, creates a commission task force, the Task Force on the Coordination of Children's Services. The purpose of the task force is to study collaboration and coordination among agencies that serve children and families with multiple service needs and to make recommendations to the commission, the Governor, and the General Assembly. The act sets out numerous duties relating to the task force's study and recommendations and requires the task force to report at least annually to the commission and on April 1 each year to specified legislative committees.

### **Other Studies**

S.L. 2007-156 (S 164) directs DHHS to study rules and regulations in North Carolina and other states relating to the appropriate care and housing of individuals with mental illness in the same "facility vicinity" as individuals without mental illness and to make recommendations relating to the housing of these individuals. The act also directs DHHS to study and make recommendations regarding the training of direct care workers in adult care homes who provide care to facility residents with mental illness. DHHS must present its findings and recommendations to the Study Commission on Aging and the Joint Legislative Oversight Committee on MH/DD/SA Services by March 1, 2008.

S.L. 2007-504 directs the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) to study the statutory rule-making authority of the Secretary of DHHS and the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services. The LOC must determine whether there is duplication, conflict, or lack of clarity with respect to the secretary's rule-making authority and that of the commission. The LOC may also consider whether rule making should be more clearly divided between the secretary and the commission and, if so, how and for what reasons. The LOC must report its findings and recommendations to the 2008 Regular Session of the 2007 General Assembly.

*Mark F. Botts*