

# 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 policies administered on the state level by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within the Department of Health and Human Services (DHHS), they are primarily delivered at the community level through a service network managed by local governments called “local management entities” or “LMEs.” Much of the legislation discussed in this chapter pertains, directly or indirectly, to LMEs.

The 2008 General Assembly, upon the recommendation of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC), enacted legislation to improve how LMEs receive and expend state funds, to reign in expenditures for the Medicaid community support program, to streamline the appeals process for Medicaid applicants and recipients whose services are denied or terminated, to address the backlog of cases brought by service providers challenging agency decisions requiring the payback of public funds, and to strengthen the LME role in authorizing services and monitoring providers. To address the continued high demand and unmet need for inpatient psychiatric care, the General Assembly also acted on LOC recommendations to increase the purchase of inpatient psychiatric beds in community hospitals and temporarily to expand state hospital beds. These and other legislative enactments are discussed below.

## Appropriations

### General Fund Appropriations

In 2007 the General Assembly appropriated \$721,639,723 from the General Fund to the DHHS Division of MH/DD/SA Services for the second year of

the 2007–09 biennium (S.L. 2007-323). The 2008 General Assembly, through a combination of cuts and expansion funding, provided a net increase of \$21 million, appropriating \$742,987,556 from the General Fund to the Division of MH/DD/SA Services for 2008–09. Annual appropriations for the past five years were \$713 million (2007–08), \$662.8 million (2006–07), \$603.3 million (2005–06), \$574.4 million (2004–05), and \$577.3 million (2003–04).

The Current Operations and Capital Improvements Appropriations Act of 2008, S.L. 2008-107 (H 2436), cuts \$4.3 million from the Division’s personnel and operating funds and \$15 million from MH/DD/SA services based on the expectation that this amount will be collected through increased patient receipts by implementing uniform co-payment collections. Expansion funding to the Division is described by general category below, as are appropriations to the DHHS Division of Medical Assistance (DMA) that affect MH/DD/SA services.

**Crisis services.** Crisis and inpatient services received particular attention in the appropriations act. In an effort to increase the availability of local inpatient psychiatric beds and reduce the need for state hospital beds, approximately \$8.1 million of the funds appropriated to MH/DD/SA services is allocated for the purchase of inpatient psychiatric care at community hospitals. These funds will be held in a statewide reserve rather than allocated to LMEs but will be used to pay for services authorized by LMEs and billed by hospitals through the LMEs. The money must be distributed across the state according to need as determined by DHHS and pursuant to contracts with LMEs and community hospitals that give LMEs control and management of the inpatient beds. In addition, LMEs will have the authority to determine which community or state-operated hospital an individual should be admitted to under an involuntary commitment order. If DHHS determines that (1) an LME is not effectively managing beds or bed days, as evidenced by beds or bed days in the local hospital not being

utilized while demand for services at the state psychiatric hospitals has not decreased, or (2) that the LME has failed to comply with payment provisions, then DHHS may pay the hospital directly.

Approximately \$1.9 million of the funding to MH/DD/SA services is allocated to LMEs to support six crisis services teams for persons with developmental disabilities based on the START (Systemic, Therapeutic, Assessment, Respite, and Treatment) model. Approximately \$6.1 million is appropriated for walk-in psychiatric services (crisis and immediate aftercare) to be allocated to LMEs to support thirty psychiatrists and related support staff. About \$1.6 million of this money is a nonrecurring appropriation for telepsychiatry equipment to be owned by the LMEs and distributed across the state according to need determined by DHHS. For mobile crisis services, the appropriation act provides approximately \$1.1 million in nonrecurring start-funds for eleven mobile crisis teams, increasing the total number of teams to thirty statewide, and \$4.6 million in operating subsidies for the thirty teams.

**Housing.** In the past two years the General Assembly has targeted the housing needs of individuals with disabilities by making a \$10.9 million appropriation in 2006 and a \$7.5 million appropriation in 2007, both nonrecurring, to the North Carolina Housing Trust Fund to finance the construction of independent and supportive-living apartments for individuals with disabilities. These apartments must be affordable to those with incomes at the Supplemental Security Income level. This year the General Assembly appropriated \$7 million in nonrecurring funds to the North Carolina Housing Trust Fund for additional independent and supportive-living apartments for persons with disabilities. An additional \$1 million in recurring funding was provided to subsidize the operating costs associated with the apartments. The appropriations act also makes a \$129,331 recurring and a \$155,000 nonrecurring appropriation to support six two-bedroom and nineteen one-bedroom apartments financed through the U.S. Department of Housing and Urban Development and \$200,000 in ongoing program service funding for two group homes under development by the Mental Health Association in North Carolina, Inc.

**State facilities.** Several publicized incidents of patient abuse at the state's psychiatric hospitals, which led to the suspension of federal funding, prompted the General Assembly to attempt to improve patient care through staff recruitment, training, and oversight. S.L. 2008-107 appropriates approximately \$7.3 million for 107 new positions at the hospitals and \$1.8 million to improve training and supervision of direct-care staff and create new monitoring, accounting, and pharmacy management positions. The appropriations act dedicates an additional \$1.3 million for recruitment and workforce development initiatives that include loan repayment and scholarship opportunities for psychiatrists and nurse practitioners.

To address the high rate of admissions to acute care unit beds in the state psychiatric hospitals, the appropriations act authorizes the Secretary of DHHS to maintain a sixty-bed unit at Dorothea Dix Hospital, which was slated to close upon the opening of the new Central Regional Hospital at Butner. The act appropriates \$5.2 million in 2008-09 for this purpose and expresses the legislative intent that funding will be provided for three years of operation. In addition to the state appropriation, the unit will be funded with approximately \$4.8 million in receipts from Wake County. S.L. 2008-107 appropriates \$472,785 to create a four-position pharmacy program at the Julian F. Keith Alcohol and Drug Abuse Treatment Center to serve the expanded acute care treatment beds. The Substance Abuse Prevention and Treatment Block grant includes \$70,000 in one-time, start-up funding for costs associated with the pharmacy.

**Division of Medical Assistance.** The appropriations act reduces state appropriations to the DHHS Division of Medical Assistance (DMA) by cutting \$86.4 million from the Community Support Services Medicaid program. Most of this reduction is achieved by tightening eligibility requirements for the program. Increases in funding to the DMA include an additional \$6,666,667 for the state's share of funding for the Community Alternatives Program Mental Retardation/Developmental Disability program (CAP-MR/DD) beginning November 1, 2008. This funding increase was made to create additional patient slots in the program, and the full-year cost of this recurring increase is anticipated to be \$10 million. The appropriations act also increases funding to the DMA to implement a mental health screening program for residents of adult care homes. A nonrecurring appropriation of \$1.9 million will permit 7,800 evaluations in 2008-09, and a recurring appropriation of \$198,846 is intended to provide approximately 850 evaluations per year in future years.

The appropriations act allocates \$70,934 in recurring and \$165,145 in nonrecurring funds to DMA for personnel positions in the Attorney General's Office to implement a new appeals process for providers of community support services. This appeals process is described further in the section below entitled "Community Support Services." Finally, S.L. 2008-107 appropriates to DMA \$217,021 in recurring and \$249,534 in nonrecurring funds for personnel to implement a new appeals process for consumers of Medicaid services who challenge the denial, reduction, or termination of their services. (See the "Medicaid Consumer Appeals" section in this chapter for more information.)

**Miscellaneous.** The appropriations act also

- Appropriates \$300,000 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.
- Reduces funding to the DMA for Medicaid-provider inflationary increases by \$35,324,306.
- Provides \$608,333 recurring and \$1 million nonrecurring for replacing resident furnishings at state mental health facilities.
- Appropriates about \$1.9 million for services for children with autism and \$30,000 for the development of a video for autism education for public officials, including judicial officials.
- Appropriates \$1 million for the provision of traumatic brain injury services.

### Federal Block Grant Allocations

Section 10.17 of S.L. 2008-107 allocates federal block grant funds for fiscal year 2008-09. 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 \$6,854,932 (up from \$5,654,932 in 2007-08) 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 whenever possible. From the same block grant the legislature appropriated \$3,921,991 (the same amount as in 2007-08) 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. The General Assembly allocated \$21,938,080 (up from \$20,287,390 in 2007-08) for alcohol and drug treatment services for adults. Other allocations include \$4,940,500 for services for children and adolescents, \$7,186,857 (up from \$5,835,701) for child substance abuse prevention, and \$8,069,524 for services for pregnant women and women with dependent children. The appropriations act also appropriates \$5,116,378 (up from \$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 \$70,000 for one-time expenses associated with the creation of a pharmacy program at the Julian F. Keith Alcohol and Drug Abuse Treatment Center.

From the Social Services Block Grant (SSBG), which funds several DHHS divisions, S.L. 2008-34 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 \$5 million is allocated to developmental disabilities services and \$422,003 to mental health services. From the same block grant the General Assembly allocated \$205,668 to the DHHS Division of Health Service Regulation for mental health licensure purposes. The dollar amounts of these SSBG allocations match the amounts allocated in 2007-08.

### State Psychiatric Hospitals

Section 10.15(g) of S.L. 2008-107 prohibits the Secretary of DHHS from transferring patients from John Umstead Hospital or Dorothea Dix Hospital to the new Central Regional Hospital until the Secretary submits a written report to the Governor stating that, on the day of its opening and thereafter, Central Regional Hospital will be operated in a manner that provides a safe and secure environment for its patients and staff. If this certification is made, the Secretary may transfer patients from John Umstead Hospital. Dorothea Dix patients may be transferred after John Umstead patients if the Secretary has determined that (1) Central Regional Hospital is in compliance with the standards for accreditation of the Joint Commission on the Accreditation of Healthcare Organizations and (2) that an inspection of Central Regional Hospital indicates that it complies with the conditions of participation set by the federal Centers for Medicare and Medicaid Services (CMS). In 2006 CMS suspended funding to Broughton Hospital for almost one year for failing to comply with CMS conditions for participation in Medicare and Medicaid. Cherry Hospital is currently facing similar sanctions.

### Local Management Entities

The 2008 legislative enactments discussed in this section affect LME mergers, functions, funding, and provider relations.

#### LME Mergers

S.L. 2008-107 prohibits the Secretary, until January 1, 2010, from taking any action that would result in the merger or consolidation of LMEs operating as of January 1, 2008, or that would establish consortia or regional arrangements for the same purpose. This provision does not prohibit

the Guilford Center, the Smoky Mountain Center, or the Mecklenburg Area Authority from pursuing their initiative, under way in the spring of 2008, to consolidate some of their functions under one administrative service organization. Any other plan for merging LMEs or consolidating LME functions that involves Secretary action must be developed with the consultation and input of the affected LMEs and presented to the General Assembly for review by March 1, 2009.

### Removal of LME Functions

In 2006 the General Assembly codified the primary functions of LMEs in G.S. 122C-115.4 and required the Secretary of DHHS to develop and implement critical performance indicators to hold LMEs accountable for managing the mental health, developmental disabilities, and substance abuse services system. Subdivision (d) of G.S. 122C-115.4 authorizes the Secretary of DHHS to remove an LME's authority to perform a function if (1) the LME fails for three months to meet the Secretary's performance standards related to the function and (2) continues to be unable to meet performance standards after six months of receiving related technical assistance from the Secretary. In this case, the Secretary must enter into a contract with another LME or agency to implement the function on behalf of the LME from which the function has been removed.

Section 10.15 of S.L. 2008-107 amends G.S. 122C-115.4(d) to reduce the technical assistance and corrective action period from six to three months. If the LME fails to meet relevant performance standards after three months of receiving technical assistance, the Secretary may remove the LME's authority to perform the function.

### Service Authorization

Among the functions of an LME is authorization of services to individual consumers. This includes authorizing initial eligibility and payment for state-funded services and the ongoing management and review of a consumer's services to determine continued eligibility and the appropriate level and intensity of services. DHHS has permitted LMEs to perform this function for non-Medicaid, state-funded services but has chosen to contract with an independent fiscal agent, a private firm called Value Options, to perform the service authorization function for Medicaid-funded services. For a couple of years now, the General Assembly's Legislative Oversight Committee on MH/DD/SA Services (LOC) has indicated an interest in moving service authorization for Medicaid-funded services, including the related functions of utilization review and utilization management, from Value Options back to the LMEs. As an indication of this intent, and perhaps a transition, the 2007 General Assembly amended G.S. 122C-115.4, the statute that enumerates and describes LME functions, to provide that an 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 to see that the consumer is receiving necessary services.

This year the appropriations act contains a special provision requiring DHHS to develop a plan by February 1, 2009, for returning the service authorization, utilization review, and utilization management functions for Medicaid-funded services to LMEs. By July 1, 2009, 30 percent of MH/DD/SA Medicaid services must be approved by LMEs. In addition, the act prohibits DHHS from contracting with a fiscal agent for the performance of service authorization, utilization management, and utilization review or from otherwise obligating funds for these purposes, beyond September 30, 2009. To be eligible to perform service authorization, utilization management, and utilization review, the LME must be nationally accredited (or demonstrate submission of an accepted application for national accreditation) by a national accrediting entity approved by the Secretary and demonstrate readiness to meet the requirements of the state's existing contract with Value Options.

The budget act also requires DHHS to develop a service authorization process that requires a comprehensive clinical assessment to be completed by a licensed clinician prior to service delivery, except where this requirement would impede access to crisis or other emergency services. DHHS must report on the development of this process by October 1, 2008, and may not implement the process until fifteen days after notifying the LOC and other specified legislative committees.

### 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 move toward "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. The 2007 General Assembly required DHHS to develop and implement clear standards for how an LME can qualify for single stream funding and to award single stream funding to any LME that meets these standards during the 2007-08 and 2008-09 fiscal years.

This year the appropriations act requires DHHS to encourage all LMEs to convert from non-single stream funding to single stream funding as soon as possible and to develop "prompt pay" guidelines as part of the requirements for receiving single stream funding. The department must develop standards for removing the single stream funding designation when an LME fails to comply with applicable requirements, but LMEs will have a six-month grace period for noncompliance with the standards during their first year of single stream funding designation.

### Other LME Funding Issues

To improve the utilization of state funding for MH/DD/SA services (non-Medicaid service funds), the legislature included several related provisions in the appropriations act. One provision attempts to deal with the cash flow problems that LMEs experience when the state does not pass the appropriations act until well after the beginning of the fiscal year, leaving LMEs without state funding for one or many months. Specifically, Section 10.15 of S.L. 2008-107 requires the Division of MH/DD/SA Services to allocate to each LME at the beginning of the fiscal year funds equal to one-twelfth of the LME's prior fiscal year funding. This provision applies only to LMEs that do not participate in single stream funding.

To encourage more providers of services to serve state-funded clients, S.L. 2008-107 requires DHHS to simplify the Integrated Payment and Reporting System used to bill for services provided to non-Medicaid, state-funded clients of MH/DD/SA services. This effort must include working with LMEs to develop billing codes for relevant services currently lacking such codes.

In an attempt to understand why some state funds have been unspent in the face of unmet service needs while other state dollars run out before the end of the fiscal year, the General Assembly directs DHHS to consult with LMEs and service providers to determine why there has been both underutilization and overutilization of state service dollars and to take actions necessary to address the problem. DHHS must report its actions to the General Assembly by January 1, 2009, and include in its report any recommended legislative action.

### Provider Endorsement

Before a provider of services may provide MH/DD/SA services to LME clients, the LME must determine that the provider is qualified to provide the services. The process used to make this determination is called provider "endorsement." Section 10.15A of S.L. 2008-107 requires DHHS to adopt rules governing the LME endorsement of providers of Medicaid- and state-funded services and guidelines for the periodic review of services by LMEs. The rules and guidelines must ensure that only qualified providers are endorsed and that LMEs hold providers accountable for the quality of the services they provide.

## Required Reporting of Confidential Information

### Driving Privilege of Person Adjudicated Incompetent

General Statutes 20-17.1 requires the commissioner of motor vehicles to determine whether a person is competent to operate a motor vehicle upon receiving notice from a clerk of court that the person has been adjudicated

incompetent or has been involuntarily committed for the treatment of alcoholism or drug addiction. Effective October 1, 2008, S.L. 2008-182 (H 2391) amends the statute to provide that, when the commissioner is inquiring about someone who has been adjudicated incompetent on or after October 1, 2008, the commissioner must consider the clerk of court's recommendation regarding whether the incompetent person should be allowed to retain his or her driving privilege.

### Trauma Injuries to Children

G.S. 90-21.20 requires physicians and hospitals to report to law enforcement agencies gunshot wounds, knife injuries, cases of illness caused by poisoning, and other wounds, injuries, or illnesses that appear to have resulted from a criminal act of violence. Effective December 1, 2008, S.L. 2008-179 (H 2338) amends the statute to require the reporting of any case involving recurrent illness or serious physical injury to any minor child if the illness or injury, in the judgment of the physician, appears to be the result of nonaccidental trauma. The report must be made as soon as practicable before, during, or after completion of treatment to municipal police authorities or, if the hospital or facility is outside the corporate limits of a city or town, to the sheriff of the county where the facility is located.

### Deaths in State Facilities

Effective July 18, 2008, S.L. 2008-131 (S 1770) amends G.S. 122C-31 to require state-operated MH/DD/SA facilities listed in G.S. 122C-181 to report the death of any patient, regardless of manner of death, to the medical examiner of the county where the deceased is found. The act amends G.S. 130A-383 to expand the medical examiners' jurisdiction to include deaths occurring in these facilities.

### Gun Privilege of Person Committed to Mental Health Treatment

Federal law makes it unlawful for a person to purchase or possess a firearm if the person has been (1) adjudicated by a court to be a danger to self or others as a result of mental illness or (2) committed by a court to treatment by a mental health facility. One of the questions that arose following the shooting of students at Virginia Tech by Cho Seng-Hui in 2007 is how Cho, who was disqualified on both grounds, managed to purchase a firearm. It turns out that the disqualifying information about Cho was not in the federal database that gun dealers use for background checks because Virginia law prohibited court officials involved in cases like Cho's from reporting the information. Similarly, North Carolina law makes proceedings for court-ordered mental health treatment confidential. North Carolina state legislators have created numerous public policy exceptions to the rules that generally prohibit the disclosure of confidential

information. For example, the clerk of court must report involuntary substance abuse commitments to the state's Division of Motor Vehicles so that the commissioner of motor vehicles can determine if the committed person is competent to operate a motor vehicle, and confidentiality is waived by law when necessary for reporting information to public officials charged with preventing child abuse and neglect, elder abuse, and the spread of communicable diseases. Yet, until the 2008 legislative session, state law did not permit court officials to report court-ordered mental health commitments to the National Instant Criminal Background Check System (NCIS).

Effective December 1, 2008, S.L. 2008-210 (S 2081) amends North Carolina's involuntary commitment statutes (Article 5 of G.S. Chapter 122C) to require the clerk of superior court to report to NCIS, as soon as practical, any person acquitted by reason of insanity, found mentally incompetent to proceed to trial, or committed for "inpatient or outpatient mental health treatment." The amendment to G.S. 122C-54 also provides that no involuntary commitment for outpatient treatment may be reported unless the individual is found to be "a danger to self or others." Because no finding of danger to self or others is required for outpatient commitment, and any finding of danger to self or others would necessarily lead to a court order for inpatient commitment, the new law appears, in spite of its introductory language to the contrary, to prohibit the reporting of any individual committed to an outpatient mental health facility. Accordingly, the new state law does not permit the reporting of all information that may disqualify an individual under federal law from purchasing or possessing a firearm.

The act also contains a restoration procedure for removing the bar to purchasing, possessing, or transferring firearms. At the expiration of any court-ordered commitment for mental health treatment, an adult may petition for removal of the bar to purchase or possess a firearm when he or she no longer suffers from the condition that led to the involuntary commitment and no longer poses a danger to self or others. The individual may petition the district court in the county where the commitment was ordered or the district court in the county of the petitioner's residence. Copies of the petition must be served on the director of the inpatient and outpatient treatment facility that treated the petitioner as well as on the district attorney for the county where the petitioner currently resides.

## Community Support Services

The General Assembly included special provisions in the appropriations act aimed at improving and strengthening the fiscal oversight of community support services, a category of Medicaid-funded MH/DD/SA services.

### Service Definitions

Section 10.15A of S.L. 2008-107 directs DHHS to submit to the federal government revised community support service definitions for Medicaid-billable services to adults and children. The revised definitions must focus on rehabilitative services and be designed to minimize over expenditures.

### Reimbursement Rates

The appropriations act requires DHHS to replace the current "blended rate" structure for community support services with a tiered rate structure that sets reimbursement rates according to the level of professional expertise necessary to perform a particular service. Services that are necessary but able to be performed without the skill, education, or knowledge of a professional who is "qualified" under the state's regulatory law may not be paid at the same rate as services provided by qualified skilled professionals. Once the tiered rate structure is implemented, at least 50 percent of community support services must be provided by qualified professionals.

### Provider Appeals

Section 10.15A of S.L. 2008-107 directs DHHS to create an expedited appeals process for providers of Medicaid community support services that temporarily substitutes for two existing appeals processes: the informal appeals process available through DHHS and the formal appeals process of the Office of Administrative Hearings (OAH). The act directs OAH to transfer all pending appeals of community support providers to DHHS for processing under the new procedure. The new appeals process applies to Medicaid community support services providers that are appealing:

- a DHHS decision to reduce, deny, recoup, or recover reimbursement for community support services,
- a DHHS decision to deny, suspend, or revoke a provider agreement for community support services, or
- an LME decision to withdraw or deny the endorsement that a provider must have to provide services to LME clients.

The act sets forth deadlines for filing petitions, issuing notice of hearings, and rendering decisions that are designed to provide prompt resolution of contested cases. The act applies to all petitions filed by a Medicaid community support services provider on or after July 1, 2008, and requires that the final decision in these cases be rendered within ninety days of the filing of the petition. The act also applies to all Medicaid community support services petitions that have been filed with OAH prior to July 1, 2008, but for which a hearing on the merits has not commenced.

by that day. The ninety-day decision deadline does not apply to petitions that were filed with OAH, or to requests for hearings made to DHHS under its informal settlement process, prior to July 1, 2008.

The act authorizes DHHS to suspend the endorsement or Medicaid participation of a provider of community support services pending a final agency decision. A provider whose endorsement, Medicaid participation, or services have been suspended is not entitled to payment during the period the appeal is pending.

The act also amends G.S. 122C-151.4 to clarify that providers who have had an application for endorsement denied by an LME may appeal to the State MH/DD/SA Appeals Panel after exhausting the appeals process at the LME level, unless the provider appeals directly to DHHS under the community support provider appeals process.

The new appeals process sunsets on July 1, 2010.

## Medicaid Consumer Appeals

S.L. 2008-107, as amended by Section 3.13 of S.L. 2008-118 (H 2438), establishes a temporary appeals process for Medicaid applicants and recipients who wish to appeal DHHS decisions to deny, terminate, suspend, or reduce benefits. Effective October 1, 2008, and until July 1, 2010, this process replaces the previous informal appeals process used by DHHS. All appeals pending under the old process on October 1, 2008, must be terminated, and the applicant or recipient must be offered an opportunity to appeal to OAH in accordance with the new appeals process.

Under the new process, at least thirty days before an adverse determination is effective, DHHS must give the applicant or recipient notice of the decision and the right to appeal. The applicant or recipient has thirty days from the mailing of the notice to file an appeal, which is a contested case under G.S. Chapter 150B. Prior to the hearing before an administrative law judge, the petitioner (the recipient or applicant) must be offered mediation as a means for resolving the dispute. If mediation is successful and the mediator informs the administrative law judge that a settlement has been achieved, the case will be dismissed. If mediation is unsuccessful, the administrative law judge must hear the case and make a decision.

To the extent possible, the case must be heard within forty-five days of submission of a request for appeal, and the administrative law judge has the authority to limit and simplify procedures to expedite the case. The petitioner has the burden of proof to show entitlement to a benefit that the agency has denied. The agency has the burden of proof when the appeal is from an agency decision to reduce, terminate, or suspend a benefit previously granted. Within twenty days of the conclusion of

the hearing the judge must send a written decision to DHHS, which has twenty days from receipt of the decision to make a final decision and promptly notify the petitioner of the decision and right to judicial review.

## Accreditation of Medicaid Service Providers

S.L. 2008-107 requires that providers of mental health, developmental disabilities, and substance abuse services be nationally accredited if they provide services designated by the Secretary as requiring accreditation. The Secretary must designate the kinds of services that require national accreditation either through the Medicaid State Plan, Medicaid waiver, or rulemaking process. Accreditation must be performed by an entity approved by the Secretary, and the failure to achieve specified progress toward, and ultimately obtain, accreditation according to the benchmarks and time frames set forth in the act, codified at G.S. 122C-81, will result in the termination of a provider's ability to provide services.

Providers of Medicaid services enrolled in the Medicaid program prior to July 1, 2008, and providing services requiring accreditation must successfully complete national accreditation requirements within three years of enrollment with the Medicaid program. Providers of Medicaid services enrolled in the Medicaid program on or after July 1, 2008, must be awarded national accreditation within one year of enrollment. Providers of state-funded services requiring national accreditation and contracting to provide state-funded services on or after July 1, 2008, must be awarded national accreditation within two years following their first contract to deliver a designated state-funded service.

## Education for Disabled Children in Psychiatric Facilities

S.L. 2008-174 (H 2306) requires the State Board of Education and the Department of Health and Human Services to meet jointly to determine which agency is responsible for providing special education and related services to children with disabilities who are placed in private psychiatric residential treatment facilities by an agency other than a local educational agency. By January 1, 2009, the two agencies must report their determination and any recommended legislation or policy changes to the Joint Legislative Education Oversight Committee and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

## Substance Abuse Professionals

S.L. 2008-130 (S 2117) amends the Substance Abuse Professional Practice Act, effective July 28, 2008, to eliminate the oral examination requirement for becoming a certified substance abuse counselor, certified substance abuse prevention consultant, or licensed clinical addictions specialist.

## Studies

### Involuntary Commitment Statutes

The Studies Act of 2008, S.L. 2008-181 (H 2431), authorizes the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services to study the involuntary commitment statutes in G.S. Chapter 122C to determine if an individual lawfully ordered to undergo an examination by a physician or psychologist is appropriately supervised to protect the health and safety of the individual and others during the period of the examination.

### Medicaid Waivers

The appropriations act directs DHHS to study the potential application of Medicaid waivers for all LMEs and, where a Medicaid waiver may not be appropriate for an LME, to identify and recommend strategies to increase LME flexibility to provide case management and assessment, limit provider networks, or develop other innovative approaches for managing care. By March 1, 2009, DHHS must report its findings and recommendations to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

## Developmental Disabilities

S.L. 2008-107 directs the Institute of Medicine to study and report on the transition of persons with developmental disabilities from one life setting to another. The study must examine barriers to transition and best practices in successful transitions and include the following topics: (1) the transition of adolescents leaving high school, including those in foster care and other settings; (2) the transition for persons who live with aging parents; and (3) the transition from developmental centers to other settings. The Institute must report its findings and recommendations by March 1, 2009, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

### Service Gap Analysis

The appropriations act directs DHHS to involve LMEs in an analysis of service gaps in the MH/DD/SA system and to report the results of the analysis by January 1, 2010, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

### Death Reporting

S.L. 2008-131 directs the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services to study current death reporting requirements and assess the need for any additional reporting requirements or modifications to existing rules. The commission must report its findings to the LOC by November 1, 2008.

*Mark F. Botts*