# MENTAL HEALTH LAW BULLETIN

Number 10 November 2006

## 2006 LEGISLATION AFFECTING MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

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This bulletin discusses acts of the General Assembly affecting mental health, developmental disabilities, and substance abuse 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 or units of local government called area mental health, developmental disabilities, and substance abuse authorities (area authorities) or county mental health, developmental disabilities, and substance abuse programs (county programs). These entities are also referred to as "local management entities," a term codified and defined in statute only this year, but a common reference among administrators since the 2001 mental health system reform act (S.L. 2001-437) shifted the primary function of area authorities and county programs away from service provision to the management and monitoring of services provided by others.

The 2006 legislative session of the General Assembly produced several significant pieces of legislation affecting publicly funded mental health, developmental disabilities, and substance abuse (MH/DD/SA) services. Most of this legislation was adopted upon the recommendation of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC). The LOC recommendations reflect, in part, the resolution of conflicting policy

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perspectives between the legislative and executive branches of state government regarding how local governments should carry out their responsibilities to administer and manage community-based services. The LOC recommendations also clarify aspects of the 2001 mental health system reform act, modify that law in light of unanticipated developments over the last five years, and attempt to strengthen some of the original principles underlying the reform law.

Significant legislative achievements for 2006 include a $60 million increase in funding for community-based MH/DD/SA services, increased funding and planning for crisis services, and statutory clarification of the functions to be carried out by local management entities. In addition, legislative enactments require the DHHS to develop indicators for measuring the performance of local management entities, standardize the processes related to local management entity (LME) functions—particularly in the area of business transactions between LMEs and the organizations that LMEs contract with to provide MH/DD/SA services—and provide to LMEs technical assistance with the implementation of LME functions. This bulletin discusses these laws and many others, including legislation codifying the existing requirement that every LME establish a consumer and family advisory committee.

# Appropriations

## General Fund Appropriations

In 2005 the General Assembly appropriated $602,556,655 from the General Fund to the DHHS Division of MH/DD/SA Services for the second year of the 2005–2007 biennium (S.L. 2005-276). This year, based largely on the recommendations of the LOC, the legislature added approximately $60 million to that appropriation, increasing the General Fund appropriation for 2006–07 to $662,795,012. Before this year, the highest appropriation for mental health services was the $630.4 million appropriation for 2000–01. Annual appropriations for the past five years were $603.3 million (2005–06), $574.4 million (2004–05), $577.3 million (2003–04), $573.3 million (2002–03), and $581.4 million (2001–02).

The Current Operations and Capital Improvements Appropriations Act of 2006, S.L. 2006-66 (S 1741) provides $26 million in new state funding to shore up losses in federal funding for developmental disabilities services. The appropriations act also provides $7.2 million for mental health services and $7.2 million for substance abuse services to be allocated to area authorities and county programs so that each entity receives a percentage of the total funding that is equal to its percentage of the state’s total population living below the federal poverty level. These three disability-specific appropriations are all recurring. Of the funds appropriated for substance abuse services, up to $300,000 must be allocated to the Treatment Accountability for Safer Communities program before allocations are made to the area authorities and county programs.

The appropriations act makes two major appropriations for crisis services to individuals with mental illness, developmental disabilities, and substance abuse addictions. The act makes a $5,250,000 nonrecurring appropriation to area authorities and county programs for operational start-up, capital, or other expenses related to the development and implementation of a “crisis plan” for local crisis services and regional crisis facilities. These funds are to be allocated on a per capita basis and funds not expended in 2006–07 will remain available for crisis plan implementation and not revert to the General Fund. In addition, the General Assembly makes a $7 million recurring appropriation to area authorities and county programs to pay for crisis services provided to non-Medicaid eligible adults and children who are indigent and have no other third-party payment source. This money is to be distributed to area authorities and county programs in an amount equal to each entity’s respective percentage of the state’s total population living below the federal poverty level.

The appropriations act makes a $10,937,500 nonrecurring appropriation to the North Carolina Housing Trust Fund to finance the construction of four hundred independent and supportive-living apartments for individuals with disabilities. The funds are to be used to finance that portion of the housing costs not able to be financed within the existing means of the North Carolina Housing Finance Agency. The apartments must be affordable to those with incomes at the Supplemental Security Income level. An additional $1.2 million in recurring funding is provided to subsidize the operating costs associated with the apartments. The appropriations act also makes a $635,000 recurring and a $330,000 nonrecurring appropriation to support twelve group home beds and eighty apartments financed through the United States Department of Housing and Urban Development.

Other expansion funding in the appropriations act for MH/DD/SA services includes $523,638 for area authorities and county programs to hire eighteen

care coordinators to work with child and family care teams, $3,969,719 for personnel and operating support associated with the expansion of the acute units of the Walter B. Jones and R.J. Blackley Alcohol and Drug Treatment Centers, and $3 million to the Division of Medical Assistance for additional slots for the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled.

Section 10.33H of S.L. 2006-66 amends G.S. 143-15D, effective July 1, 2007, to provide that DHHS is no longer required to use recurring savings realized from the closure of Dorothea Dix and John Umstead psychiatric hospitals to pay the debt service on the new psychiatric hospital being constructed at Butner. Instead these funds may be used for community-based services, with the debt service to be paid with funds from the General Fund.

Finally, in the area of capital improvements, Section 23 of S.L. 2006-66 authorizes the issuance or incurrence of special indebtedness to finance the capital facility costs of completing the central regional psychiatric hospital in Butner ($20 million), planning and constructing a 304-bed eastern regional psychiatric hospital to replace Cherry Hospital in Goldsboro ($145.5 million), and planning and constructing a 382-bed western regional psychiatric hospital to replace Broughton Hospital in Morganton ($162.8 million).

## 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 and must supplement, not supplant, existing state and local funding for these services. Specifically, the fund must be used only for the following:

1. To provide start-up and operating funding for community-based treatment alternatives for individuals residing in state-operated institutions
2. To facilitate compliance with the U. S. Supreme Court's Olmstead[1] decision
3. To expand services to reduce waiting lists
4. To provide bridge funding to maintain client services during transitional periods of facility closings and departmental restructuring
5. To construct, repair, and renovate state mental health, developmental disabilities, and substance abuse facilities

This year the General Assembly makes a nonrecurring appropriation of $14,390,000 to the trust fund. Section 10.33H of S.L. 2006-66 authorizes the Secretary of DHHS to use trust fund money for the 2006–07 fiscal year to support up to 66 new positions in the Julian F. Keith Alcohol and Drug Abuse Treatment Center. Allocations to the trust fund for previous fiscal years include $10 million in 2005–06, $10 million in 2004–05, and $12.5 million in 2003–04.

## Federal Block Grant Allocations

Section 5.1 of S.L. 2006-52 allocates federal block grant funds for fiscal year 2006–07. 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 $7,184,481 (up slightly from $6,983,202 in 2005–06) 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 2005–06) 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

1. Olmstead v. L.C., 527 U.S. 581, 119 S. Ct. 2176, 144 L. Ed. 2d 540 (1999). In *Olmstead*, the Court held that the unnecessary segregation of individuals with mental disabilities in institutions may constitute discrimination based on disability, in violation of the Americans with Disabilities Act. As a result of the ruling, states risk litigation if they do not develop a comprehensive plan for moving qualified persons with mental disabilities from institutions to less restrictive settings at a reasonable pace.

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 2005–06. The General Assembly allocated $20,537,390 for community-based alcohol and drug treatment services to adults and state-operated alcohol and drug abuse treatment centers. Other allocations include $4,940,500 for services for children and adolescents (for example, prevention, high-risk intervention, outpatient, and regional residential services), $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. 2006-52 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 DFS for mental health licensure purposes and $422,003 for the CTSP for Children. The SSBG allocations match the allocations made for 2005–06.

## 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 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 to conduct the first examination (S.L. 2003-178). Alternative professionals that may be used are a licensed clinical social worker, master's level psychiatric nurse, or master's level certified clinical addictions specialist. Intended as a pilot program, the Secretary's waiver would be in effect for no more than three years or for the duration of the area or county program's business plan for system reform. Section 10.27 of S.L. 2006-66 extends the sunset provision in the 2003 law from July 1, 2006, to October 1, 2007.

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## Crisis Services

As noted above, the General Assembly has appropriated $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. Of the $925,000 appropriated to the Division of MH/DD/SA Services for consultant services, Section 10.26 of the appropriations act directs DHHS to use $225,000 to hire one or more consultants to provide technical assistance to local management entities as they develop and implement their local crisis services and regional crisis facilities (their "crisis plan"). Like the other crisis plan funds, any portion of these funds not expended during fiscal year 2006–07 do not revert to the General Fund and remain available for crisis planning technical assistance.

With the assistance of the consultant, LMEs within a designated crisis region must work together to identify gaps in their ability to provide a continuum of crisis services for all consumers and use the funds allocated to them to develop and implement a plan to address those needs. At a minimum, the plan must address the development over time of the following components: 24-hour crisis telephone lines, walk-in crisis services, mobile crisis outreach, crisis respite/residential services, crisis stabilization units, 24-hour beds, facility-based crisis services, inpatient crisis services, and transportation. Options for voluntary admissions to a secured facility must include at least one service appropriate for adults and one service appropriate for children. Options for involuntary commitment to a secured facility must include at least one alternative to admission to a state facility.

The term "regional crisis facility" means a facility-based crisis unit that serves an area that may be larger than the catchment area of a single LME but that, with other regional crisis facilities, provides adequate facility access to all MH/DD/SA service consumers in the state. Section 10.26 of the appropriations act directs the Secretary of DHHS, in

consultation with the LMEs, to designate between fifteen and twenty regional groupings of LMEs for the development of regional crisis facilities. The groupings must take into consideration existing community facilities, prior LME groupings or partnerships, and geographical factors. If all LMEs in a crisis region determine that a facility-based crisis center is needed and sustainable on a long-term basis, the LMEs must first attempt to secure those services through a community hospital or other community facility. Further, if all the LMEs in a crisis region determine that the region's facility-based crisis needs are being met, then the LMEs may use their crisis funds to meet local crisis service needs.

Each LME must submit its crisis services plan to the Secretary for review no later than March 1, 2007. The plan must take into consideration and attempt to utilize all other sources of funds in addition to the funds appropriated for crisis services. The Secretary must review each plan to determine whether it meets all of the requirements of Section 10.26, and if the Secretary approves the plan, the LME must receive implementation funding.

Until July 1, 2008, LMEs must report monthly to DHHS and to the consultant regarding the use of funds, whether there has been a reduction in the use of state psychiatric hospitals for acute admission, and any remaining gaps in local and regional crisis services. The consultant and DHHS must report quarterly to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on MH/DD/SA Services regarding each LME's proposed and actual use of crisis funds.

# Secretary of the Department of Health and Human Services

## Powers and Duties

Upon the recommendation of the Joint Legislative Oversight Committee for MH/DD/SA Services, the General Assembly amended the statutory powers and duties of the Secretary to require the Secretary to standardize processes related to LME functions, develop and implement performance measures (also called "performance indicators") for evaluating how well LMEs perform their functions, and provide to LMEs ongoing and focused technical assistance with the implementation of LME functions. S.L. 2006-142 emphasizes that performance indicators must be used to hold LMEs "accountable" for managing MH/DD/SA services and be implemented by July 1, 2007. Other changes that are more technical or clarifying in nature emphasize that (1) the local business plan is an LME business plan; (2) the LME *manages*, rather than directly provides, MH/DD/SA services; and (3) when the Secretary monitors LMEs and providers for performance on outcome measures, the monitoring must examine adherence to best practices, assess consumer satisfaction, and include a review of client rights complaints.

When developing standard forms, quality measures, contracts, processes, and procedures to be used by all LMEs, the Secretary must consult with LMEs, LME Consumer and Family Advisory Committees, counties, and qualified providers. Any document, process, or procedure developed for the purpose of implementing standardization must also place on providers a duty to transmit to LMEs timely client information and outcome data. The Secretary must also adopt rules regarding what constitutes a clean claim for the purposes of billing. When implementing standardization, the Secretary must balance the LME's need to exercise discretion in the discharge of LME functions with the need of qualified providers for a uniform system of doing business with public entities.

## State Plan

In 2001 the General Assembly enacted legislation requiring DHHS to develop and implement a State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services that, among other things, sets out the vision and mission of the publicly-funded service system. Every year thereafter, DHHS issued a State Plan. As the years went by and each successive plan differed from earlier plans, it was unclear whether the plans were to be read cumulatively or whether the omission of subjects and provisions in subsequent plans signaled a shift in state policy away from earlier plans. This phenomena, combined with policymaking by DHHS in fiscal year 2005–06 that departed from policies enunciated in the State Plan, created uncertainty and a lack of continuity in local government planning and policymaking.

To address this issue, the LOC recommended and the General Assembly adopted Section 2 of S.L. 2006-142, which amends G.S. 122C-102 to clarify that the purpose of the State Plan is to provide a three-year, strategic template on how state and local resources are to be organized and used. The first plan, to be issued on July 1, 2007, must identify specific

goals to be achieved by DHHS, area authorities, and county programs over a three-year period of time, benchmarks for determining whether progress is being made toward those goals, and the data that will be used to measure that progress. To increase the ability of the state, area authorities, county programs, private providers, and consumers to successfully implement the goals of the State Plan, DHHS must not adopt or implement policies inconsistent with the State Plan without first consulting with the LOC.

The plan must include specific mechanisms for measuring increased performance in the following areas: access to services, consumer-focused outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter the Secretary must report to the General Assembly and the Joint Legislative Oversight Committee on MH/DD/SA services on the state's progress in these performance areas.

Until the 2007 State Plan is issued on July 1, 2007, DHHS must review all State Plans issued after July 1, 2001, and produce a single document that contains a cumulative statement of those provisions that are still applicable. This cumulative document will constitute the State Plan until July 1, 2007. DHHS must also identify those provisions in G.S. 122C-112.1, prior state plans, and directives or communications by the Division of MH/DD/SA Services that must be adopted as administrative rules to be enforceable and undertake to adopt those rules.

S.L. 2006-66 appropriates $700,000 for the hiring of consultants to conduct the following tasks related to the development of the State Plan:

1. Assist DHHS with the strategic planning necessary to develop the revised State Plan, which must be coordinated with the LME local and regional crisis service plans.
2. Study and make recommendations for increasing the capacity of DHHS to implement mental health system reform successfully and in a manner that maintains strong management functions for area authorities and county programs.
3. Help the Division of MH/DD/SA Services work with local management entities to (a) develop and implement, no later than July 1, 2007, five to ten performance indicators for the management of MH/DD/SA services by local management entities; (b) standardize the utilization management functions and functions related to person-centered plans; and (c) implement other uniform procedures for the management functions of local management entities.
4. Provide technical assistance and oversight to private sector providers and local management entities to ensure that best practices and new services are being delivered with fidelity to the state's service definition model.
5. In accordance with the Secretary's duty under new G.S. 122C-112.1(a)(9), provide ongoing and focused technical assistance and oversight to area authorities and county programs in the implementation of their administrative and management functions and the establishment and operation of community-based programs. The State Plan must include a mechanism for monitoring the Department's success in implementing this duty and the progress of area authorities and county programs in achieving these functions.
6. Assist the Division of MH/DD/SA Services with implementing standard forms, contracts, processes, and procedures (including standardized denial codes and a standard policy regarding the coordination of benefits) to be used by all local management entities when conducting business with other public and private service providers. The independent consultant must consult with area authorities and county programs regarding the development of these forms, contracts, processes, and procedures. Consultants also must balance the need for LMEs to exercise discretion in the discharge of their management responsibilities with the need of private service providers for a uniform system of doing business with public entities.

## Local Management Entities

For the first time since the term "local management entity" and its acronym, LME, entered the lexicon of mental health administrators in 2001, the General Assembly has codified both terms in G.S. 122C. An area authority, county program, and consolidated human services agency each perform the same basic functions, though each has a different governance structure and, therefore, a different relationship to the county governments of the counties they serve. S.L. 2006-142 adds new G.S. 122C-3(20b) to define "local management entity" and "LME" as terms that refer 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 local management entity functions.

Legislative enactments for 2006, addressed below, affect the service area, function, and contracting authority of local management entities, as well as the allocation and adequacy of state funding to management entities.

## Service Area

The geographic area served by an LME is called its "catchment area." The 2001 mental health system reform act directed the Secretary of DHHS to develop a catchment area consolidation plan that reduced the number of area authorities and county programs, at that time 39 in number, to "no more than a target of 20" by January 1, 2007. As of July 1, 2006, there were still 30 area authorities and county programs. 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. Section 10.32(c) of S.L. 2006-66 amends 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, effective July 1, 2007, DHHS must reduce by ten percent annually the state funding for LME functions to any LME that does not comply with these catchment area requirements.

## Functions

Section 4 of S.L. 2006-142 enacts new G.S. 122C-115.4, which states generally that local management entities are responsible for the management and oversight of the public system of MH/DD/SA services at the community level. To that end LMEs must plan, develop, implement, and monitor services within their catchment areas to ensure expected outcomes for consumers of services within available resources. To clarify some aspects of the 2001 mental health system reform act, to account for developments since 2001, and to resolve some of the conflicting policy perspectives between the LOC and the Secretary's Office over the proper role of local management entities, the LOC recommended and the General Assembly adopted G.S. 115.4(b), which directs LMEs to carry out the following primary functions:

1. Provide access to *core* services for all citizens. Core services are described at G.S. 122C-2 as (a) screening, triage, and referral (STR) services; (b) emergency services; (c) service coordination; and (d) consultation, prevention, and educational services. The new provision emphasizes that the STR service must be a 24-hour a day, seven-day a week service that includes a uniform portal of entry into care (a standardized process and procedure for ensuring access to public services in accordance with the State Plan).
2. Endorse, monitor, provide technical assistance to, develop the capacity of, and control the quality of services provided by, providers. Generally, this is a mandate to ensure available, qualified providers to deliver quality services in the LME's catchment area. Specifically, an LME must endorse a provider (determine that it is qualified under state rules to deliver services), before the provider may provide services to LME clients. The LME must monitor provider performance and service outcomes in accordance with state standards, provide technical assistance to providers, and develop the service capacity of the LME's provider network.
3. For consumers receiving state-funded services (not billed to Medicaid), conduct utilization management and review and determine the appropriate level and intensity of services for each consumer. This includes the review and approval of each consumer's person centered plan. For all consumers in the LME's catchment area who receive Medicaid services, review the consumer's person centered plan concurrent with the review performed by the state's fiscal agent hired to conduct utilization control activities for Medicaid services.
4. Authorize the utilization of state psychiatric hospitals and other state facilities by LME consumers, and determine eligibility requests for recipients who receive services under a Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD) waiver.
5. Coordinate care and manage quality. This function includes the direct monitoring of the effectiveness of person-centered plans, and the initiation of and participation in the

development of required modifications to the plans for high-risk and high-cost consumers in order to achieve better client outcomes or equivalent outcomes in a more cost-effective manner. Monitoring effectiveness includes reviewing client outcomes data supplied by the provider, making direct contact with consumers, and reviewing consumer charts.
6. Engage in community collaboration and consumer affairs, which includes a process to protect consumer rights, an appeals process, and the provision of support to an effective consumer and family advisory committee.
7. Engage in financial management and accountability for the use of state and local funds and information management for the delivery of publicly funded services.

*State authority to remove LME functions.* Except as otherwise authorized in G.S. 122C-142.1 and G.S. 122C-125, the Secretary may not remove from an LME any function enumerated in the previous paragraph unless all of the following apply:

- The LME fails for a three-month period to achieve a satisfactory outcome on any of the critical performance measures developed by the Secretary pursuant to S.L. 2006-142.
- The Secretary provides focused technical assistance to the LME in the implementation of the function for at least six months or until the LME achieves a satisfactory outcome on the performance measure, whichever occurs first.
- The LME fails, after receiving technical assistance from the Secretary for six months, to achieve or maintain a satisfactory outcome on the critical performance measure.

If the foregoing conditions apply, 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. Notwithstanding the foregoing conditions, in the case of serious financial mismanagement or serious regulatory noncompliance, the Secretary may temporarily remove an LME function after consultation with the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

*Rulemaking on LME functions.* To aid in the implementation of the LME functions and the Secretary's authority to remove such functions from an LME, the Commission for MH/DD/SA services is directed to adopt rules regarding:

- The definition of a high-risk consumer. Until such time as the commission adopts a rule under this subdivision, a high-risk consumer means a person who has been assessed as needing emergent crisis services three or more times in the previous twelve months.
- The definition of a high-cost consumer. Until such time as the commission adopts a rule under this subdivision, a high-cost consumer means a person whose treatment plan is expected to incur costs in the top 20 percent of expenditures for all consumers in a disability group.
- The notice and procedural requirements for removing one or more LME functions.

## Contracts

*Contracting out LME functions.* S.L. 2006-142 authorizes LMEs to contract with a public or private entity for the implementation of primary LME functions, which are set forth in new G.S. 122C-115.4(b). This appears to be a clarification, rather than a substantially new authorization, of a local management entity's authority to enter in to contracts for the performance of LME duties. The new provision also clarifies that such contracts are subject to all applicable state and federal laws and regulations, which means that any public or private entity contracting to perform LME functions will need to meet the same standards and obligations that the LME would have to meet if it were performing the functions itself.

*Standardized contracts for client services.* Section 1 of S.L. 2006-142 (H 2077) amends G.S. 122C-142 to require area authorities and county programs to use a standard contract, adopted by the Secretary of Health and Human Services, when contracting with MH/DD/SA service providers for the provision of MH/DD/SA services to area authority and county program clients. This provision was sought by providers of MH/DD/SA services, particularly those who contract with two or more local management entities, to reduce the variability in contract requirements among the local management entities. In addition, the standard contract developed by DHHS must require service providers who contract with a local management entity to give to the LME "timely data regarding the clients being served, the services provided, and the client outcomes."

While the new law requires general uniformity in contract language, the local management entity may amend the standard contract language as needed to

comply with any court-ordered duty or responsibility. An example of a court-ordered duty would be an involuntary commitment order designating an area authority or county program as the entity responsible for managing and supervising an individual's court-ordered outpatient treatment. Existing state law requires the area authority or county program to contract with other entities for the provision of these involuntary outpatient services. To the extent that the standard DHHS contract does not set forth all terms necessary to the effective execution and administration of contracts for court-ordered outpatient treatment, the area authority or county program is permitted to amend the standard contract language to address matters not addressed in the standard contract but necessary to the discharge of its court-ordered responsibilities.

Section 23 of S.L. 2006-259 (S 1523) amends G.S. 122C-142, as amended by S.L. 2006-142, to provide that an area authority or county program that is operating under a Medicaid waiver may amend the standard contract subject to the approval of the Secretary. Currently, Piedmont Behavioral Healthcare is the only LME operating under such a waiver.

*Contracting with county government service providers.* 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 may itself provide services directly to clients only if it seeks and obtains the approval of the Secretary of DHHS. G.S. 122C-141 authorizes area authorities and county programs to contract with any provider, public or private, that meets the qualifications as defined by rules adopted by the Secretary.

Most contracted providers of MH/DD/SA services are private incorporated organizations, but a few are public entities. For example, Rockingham County contracts with the Alamance-Caswell-Rockingham area authority to provide services to the area authority's clients. When the five counties served by the New River area authority began to consider forming a mulicounty provider agency through an interlocal agreement (G.S 160A, Article 20) that would contract with New River to provide MH/SS/SA services to the area authority's clients, the Division of MH/DD/SA Services and DHHS raised concerns over the appropriateness of such an arrangement. To address those concerns and to clarify the authority of counties to create a multicounty provider agency, the Joint Legislative Oversight Committee on MH/DD/SA Services recommended, and the General Assembly adopted, an amendment to the statutory provisions governing provider contracts. S.L. 2006-142 adds two new subsections to G.S. 122C-141 to provide that if two or more counties enter into an interlocal agreement under Article 20 of General Statutes Chapter 160A to be a public provider of MH/DD/SA services, before an LME may enter into a contract with the public provider

- the pubic provider must meet all provider qualifications as defined by rules adopted by the Secretary,
- the LME must adopt a conflict of interest policy that applies to all provider contracts, and
- the interlocal agreement must provide that any liabilities of the public provider must be paid from its unobligated surplus funds and that if those funds are not sufficient to satisfy the indebtedness, the remaining indebtedness must be apportioned to the participating counties.

A county that provides MH/DD/SA services through a consolidated human services agency may not be a provider of services under G.S. 122C-141. (Currently, Wake County is the only county operating a consolidated human services agency. Presumably, the new legislation prohibits a county participating in a consolidated human services agency from being a public provider of services, because the governing body for the county and for the LME is the same entity: the board of county commissioners. The contract between an LME and a provider is intended to be created at arms length, with the LME required to monitor and evaluate the provider's performance. This would be difficult to do where the two parties to the contract are one and the same, the board of county commissioners.)

Finally, the new statutory provisions require the Secretary to ensure that there is "fair competition" among providers, meaning that an LME must not unfairly favor public providers, particularly where a provider is also one of the counties it serves, over private providers when negotiating and monitoring contracts. DHHS must study the effect of the amendments to G.S. 122C-141 and report its findings and recommendations to the LOC by December 1, 2009.

### Allocation and Adequacy of State Funds

At the request of LMEs seeking greater flexibility in utilizing state funds, S.L. 2006-142 authorizes LMEs to transfer from one age or disability funding category to a different age or disability funding category up to 15 percent of the funds initially allocated to the age or disability category from which funds are being transferred. This authority is granted for a one-year trial period and is set to expire on July 1, 2007. Prior to the transfer, the Division of MH/DD/SA Services must verify that the transfer meets applicable federal requirements. LMEs utilizing this authority must publicly document that they have addressed the service needs of the category from which the funds are being transferred before any transfer may occur and submit the documentation to the Division of MH/DD/SA Services and to the Fiscal Research Division within fifteen days of making the transfer.

During fiscal year 2005–06 the Secretary of DHHS pursued a policy of removing certain LME functions from particular LMEs, giving those functions to other LMEs who would perform them on behalf of the LMEs from which the functions were removed. This policy included reallocating the state funding for these functions from the LMEs whose functions were removed to the LMEs who were to perform the functions on behalf of other LMEs. Section 4 of S.L. 2006-142 enacts new G.S. 122C-115.4(b) to clarify that certain LME functions are to remain with each LME. (See "Functions," above.) To restore to each LME the funding necessary to perform these functions, Section 10.32 of S.L. 2006-66 directs the Secretary of DHHS to recalculate LME systems management allocations for fiscal year 2006–07 to include funds for each LME to (1) implement 24-hour, seven-days-a-week screening, triage, and referral; and (2) review, monitor and comment on all person-centered plans.

In addition, the Secretary must review and revise the LME systems management cost model to provide adequate funds for LMEs to fully implement the functions outlined in new G.S. 122C-115.4(b). The Secretary must consult with the Joint Legislative Oversight Committee on MH/DD/SA Services prior to implementing the revised cost model. Any savings of state appropriations realized from the revised cost model must be reallocated to state-funded MH/DD/SA services. For the 2006–07 fiscal year and until the revised cost model is implemented, the Department must maintain the 2005–06 level of funding to LMEs for all LME functions, except that these levels may be reduced to $13,333,481 for utilization review and $12,156,042 for claims processing.

## Area Authorities and County Programs

### Area Authority Finance Reports

G.S. 122C-117(c) requires the area director and area authority finance officer to submit quarterly finance reports to each member of each board of county commissioners participating in the area authority. S.L. 2006-142 amends the requirement so that reports are to be submitted to the county finance officer for each participating county, who in turn submits the reports to the board of county commissioners at its next regularly scheduled meeting. In addition, if the report is not submitted within thirty days of each quarter of the fiscal year, the clerk of the board of county commissioners must notify the area director and area finance officer that the report has not been submitted as required. The law also enacts new G.S. 153A-453 to codify the same requirement in Chapter 153A of the General Statutes. G.S. 153-453 appears to make the requirements of amended G.S. 122C-117(c) applicable to county program directors and finance officers, although conforming changes were not made to G.S. 122C-115.1, which retains for county programs the same finance reporting requirements that applied to area authorities before the amendment to G.S. 122C-117(c).

### Area Authority Board and County Program Advisory Committee

S.L. 2006-142 amends G.S. 122C-118.1 to change the composition of the area board, the governing body for the area authority. Before the amendment, *at least* 50 percent of the members of the area board had to be comprised of specified clinical professionals, consumers of services, and family members of consumers, guaranteeing that at least half the board members would be appointed from these constituent groups. Now, *no more* than 50 percent of the board may be comprised of the following representatives:

- a physician who, when possible, is certified as having completed a residency in psychiatry;
- a clinical professional from the field of mental health, developmental disabilities, and substance abuse;

- a family member—or individual from a citizens' organization composed primarily of consumers or their family members—who represents the interests of persons with mental illness, developmental disabilities, or substance abuse; and
- an openly declared consumer who is mentally ill, developmentally disabled, or in recovery from addiction.

The effect of the amendment is that there appears to be no requirement, as there was previously, that board membership include the foregoing representatives, although the entity authorized to appoint board members (generally, boards of county commissioners or the commissioner members of the area board) must continue to "take into account" citizen participation and representation of the disability groups when making appointments.

The statute has also been amended to require at least two individuals with financial expertise; previously only one was required. The requirements to have a person with expertise in management or business and an individual representing the interests of children remain. The previous version of the statute permitted a board member to concurrently fill more than one required category of membership if the member had the qualifications or attributes of more than one category. This provision has been changed to limit concurrent representation to no more than two categories of membership. Now that the statute does not require clinical, consumer, or family member representation, the provision regarding the concurrent representation of two categories of membership appears to apply only to the categories of financial expertise, business or management expertise, and the representation of children's interests.

Board terms have been shortened from four years to three. (The area board terms of county commissioner members continue to be concurrent with their terms as county commissioners.) Before the enactment of S.L. 2006-142, G.S. 122C-118.1 provided that board members other than commissioner members must not be appointed for more than two consecutive terms. The new law makes the term limit applicable to all board members, including commissioner members. Further, language was added to say that board members serving as of July 1, 2006, may remain on the board for one additional term. The apparent effect of the added language is that a board member serving his or her second term as of July 1, 2006, could be appointed for an additional third term.

The new law codifies an earlier, uncodified enactment that permits a larger area board for the largest area authorities. Generally, an area board must be comprised of no fewer than eleven and no more than twenty-five members. However, a multicounty area authority consisting of eight or more counties and serving a catchment area with more than 500,000 people may have up to thirty board members. Finally, the statute that sets the compositional requirements for county program advisory committees—G.S. 122C-115.1—is amended to require these committees to adhere fully to the compositional requirements for area boards and to include two individuals with financial expertise, one with management or business expertise, and an individual representing the interests of children.

## Director and Finance Officer

S.L. 2006-142 amends provisions of G.S. 122C related to the role and qualifications of the director and finance officer for the area authority and county program. Amendments to G.S. 122C-111 provide that an area director or county program director must, among other things previously specified in that statute, manage the public MH/DD/SA system for the area authority or county program according to the local management entity's business plan adopted pursuant to G.S. 122C-115.2. Pursuant to G.S. 153A-77(e), this duty applies also to the human services director for a consolidated human services agency.

New G.S. 122C-120.1 requires the Office of State Personnel to develop a job classification for the area director and county program director that reflects the skills required of an individual operating a local management entity. The Office of State Personnel must also review the job classifications for area authority and county program finance officers to determine whether they reflect the skills necessary to manage the finances of a local management entity. The State Personnel Commission must adopt a job classification for director, and any new or revised job classification for finance officers, no later than December 31, 2006. These new classifications will apply to any person newly hired on or after January 1, 2007. It is unclear whether G.S. 122C-120.1 applies to the human services director for a consolidated human services agency.

Finally, the new law makes the previously existing statutory qualifications for area directors and multicounty program directors (masters degree, management and related experience) applicable to the program director for a single-county program.

# Consumer and Family Advisory Committee

## Local Committee

S.L. 2006-142 requires every area authority and county program to establish a Consumer and Family Advisory Committee (CFAC) to advise the area authority or county program on the planning and management of the local public MH/DD/SA service system. Specifically, the CFAC must do the following:

1. Review, comment on, and monitor the implementation of the local business plan
2. Identify service gaps and underserved populations
3. Make recommendations regarding the service array and monitor the development of additional services
4. Review and comment on the area authority or county program budget
5. Participate in all quality improvement measures and performance indicators
6. Submit to the State CFAC findings and recommendations regarding ways to improve the delivery of MH/DD/SA services

The director of the area authority or county program must provide sufficient support staff to assist the CFAC in implementing the foregoing duties, which must include data for the identification of service gaps and underserved populations, training to review and comment on business plans and budgets, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

The CFAC must be comprised exclusively of adult consumers of MH/DD/SA services and family members of consumers of services. Each of the three disability groups—people with mental illness, developmental disabilities, or substance abuse—must be represented on the CFAC, and the CFAC must represent as closely as possible the racial and ethnic composition of the catchment area. Member terms are for three years, and no member may serve more than two consecutive terms.

The CFAC must be a self-governing and self-directed organization. Each CFAC must adopt bylaws that govern the selection and appointment of its members, their terms of service, the number of members, and other procedural matters. At the request of either the CFAC or the governing board of the area authority or county program, the CFAC and governing board must execute an agreement that identifies the roles and responsibilities of each party, the channels of communication between the CFAC and local board, and a process for resolving disputes between the parties.

## State Committee

New G.S. 122C-171 establishes the State Consumer and Family Advisory Committee (State CFAC) to advise DHHS and the General Assembly on the planning and management of the state's public MH/DD/SA services system. Specifically, the State CFAC must do the following:

1. Review, comment on, and monitor the implementation of the State Plan for Mental Health, Developmental Disabilities, and Substance Abuse Services
2. Identify service gaps and underserved populations
3. Make recommendations regarding the service array and monitor the development of additional services
4. Review and comment on the state budget for mental health, developmental disabilities, and substance abuse services
5. Participate in all quality improvement measures and performance indicators
6. Receive the findings and recommendations by local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services
7. Provide technical assistance to local CFACs in implementing their duties

Like the local CFAC, the State CFAC must be a self-governing and self-directed organization. However, the Secretary must provide sufficient staff to assist the State CFAC in implementing its duties. The assistance must include data for the identification of service gaps and underserved populations, training to review and comment on the State Plan and departmental budget, procedures to allow participation in quality monitoring, and technical advice on rules of procedure and applicable laws.

Twenty-one members in size, the State CFAC must be composed exclusively of adult consumers of MH/DD/SA services and family members of consumers of services. Member terms are for three years, and no member may serve more than two consecutive terms. The members must be appointed as follows:

1. Nine by the Secretary. The Secretary's appointments must reflect each of the disability groups. The terms must be

staggered so that each year the terms of three of the appointees expire.
2. Three by the General Assembly upon the recommendations of the President Pro Tempore of the Senate, one from each region of the state's three regional designations for state-operated institutional facilities (Eastern Region, Central Region, and Western Region). The terms of the appointees shall be staggered so that the term of one appointee expires every year.
3. Three by the General Assembly upon the recommendations of the Speaker of the House of Representatives, one from each region of the state's three regional designations for state-operated institutional facilities. The terms of the appointees shall be staggered so that the term of one appointee expires every year.
4. Three by the North Carolina Council of Community Programs, one each of whom must come from the three state regions for institutional services. The terms of the appointees must be staggered so that the term of one appointee expires every year.
5. Three by the North Carolina Association of County Commissioners, one each of whom must come from the three state regions for institutional services. The terms of the appointees must be staggered so that the term of one appointee expires every year.

Vacancies will be filled by the appointing authority. State CFAC members are to receive the per diem and allowances prescribed by G.S. 138-5 for state boards and commissions.

## Confidentiality of MH/DD/SA Records

G.S. 7B-302 requires the department of social services to assess every abuse, neglect, and dependency report that falls within the scope of the Juvenile Code. The statute also authorizes the director of social services, or the director's representative, to make a written demand for any information or reports, whether or not confidential, that may in the director's opinion be relevant to the assessment of a report or to the provision of protective services. Upon such a demand, an agency is required to provide access to and copies of confidential information to the extent permitted by federal law. Pursuant to G.S. 122C-54(h), mental health and developmental disabilities service providers must provide access to client records. However, substance abuse programs are prohibited by federal law from providing access to substance abuse records under G.S. 7B-302.

Subsection (a) of G.S. 7B-302 provides that all information received by the department of social services pursuant to G.S. 7B-302 must be held in the strictest of confidence by the department. S.L. 2006-205 (S 1216) amends this provision to provide that the department of social services must disclose confidential information to any federal, state, or local governmental entity, or any agent of such entity, that needs confidential information to protect a juvenile from abuse and neglect. Any confidential information disclosed under this provision must remain confidential with the other governmental entity, or its agent, and may only be redisclosed for purposes directly connected with carrying out the governmental entity's or agent's mandated responsibilities.

S.L. 2006-205 also amends another provision affecting access to MH/DD/SA records when the department of social services is assessing a report of abuse, neglect, or dependency or providing protective services. G.S. 7B-3100 directs the Department of Juvenile Justice and Delinquency Prevention (DJJDP) to adopt rules designating local agencies that are required "to share with one another, upon request, information that is in their possession that is relevant to any case in which a petition is filed alleging that a juvenile is abused, neglected, dependent, or undisciplined." Like G.S. 7B-302, this statute, and regulations promulgated by DJJDP at 28 NCAC 01A .0300, require providers of mental health and developmental disabilities services, but not providers of substance abuse services, to disclose confidential client information when the conditions set forth in the statute are met. One of those conditions is that a petition must be filed alleging that a juvenile is abused, neglected, dependent, undisciplined, or delinquent.

S.L. 2006-205 amends G.S. 7B-3100 to extend the application of the statute to situations where a juvenile petition has not yet been filed but the department of social services is assessing a report or providing protective services. The amended statutes provides that agencies designated by the DJJDP must share with one another, upon request, and to the extent permitted by federal law and regulations, information in their possession that is relevant to

- any assessment of a report of child abuse, neglect, or dependency by the department of social services,

- the provision or arrangement of protective services in a child abuse, neglect, or dependency case by a local department of social services, or
- any case in which a petition is filed alleging that a juvenile is abused, neglected, dependent, undisciplined, or delinquent.

The requirement to share information under the foregoing circumstances continues until the protective services case is closed by the local department of social services, or if a petition is filed, until the juvenile is no longer subject to the jurisdiction of juvenile court.

## Joint Legislative Oversight Committee

S.L. 2006-32 (H 2120) amends Article 27 of Chapter 120 of the General Statutes to add new G.S. 120-244, which authorizes the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services (LOC) to obtain information and data from all state officers, agents, agencies, and departments, while in discharge of its duties, under G.S. 120-19, as if it were a committee of the General Assembly. The provisions of G.S. 120-19.1 through G.S. 120-19.4 will apply to the proceedings of the LOC as if it were a committee of the General Assembly. Any cost of providing information to the LOC not covered by G.S. 120-19.3 may be reimbursed by the LOC from funds appropriated to it for its continuing study. Article 23 of Chapter 120 of the General Statutes is repealed to abolish the legislative study commission on MH/DD/SA services.

S.L. 2006-32 authorizes the LOC to study the following issues and report its findings and recommendations to the 2007 Regular Session of the 2007 General Assembly:

1. Mechanisms to allow area authorities and county programs to purchase bed days from the state psychiatric hospitals. The LOC must consider options for holding area authorities and county programs accountable for their use of state psychiatric institutions and for ensuring that state institutions have sufficient funding to ensure quality care to patients and a stable and well-qualified workforce. In addition, the LOC must consider incentives for increasing community capacity as an alternative to using state psychiatric institutions.
2. Whether implementation of a Medicaid 1915(b) waiver on a statewide or expanded local basis would strengthen the ability of area authorities and county programs to manage the MH/DD/SA services system. As part of the study, the LOC must examine the current use of the waiver by one LME, Piedmont Behavioral Healthcare, and particularly the waiver's impact on Piedmont's ability to implement its LME management functions. If the LOC determines that a Medicaid 1915(b) waiver would improve the management capacity of area authorities and county programs, it must also examine whether it would be more appropriate to seek a statewide waiver or whether it would be both possible and advisable for additional area authorities and county programs to seek individual waivers.
3. Whether G.S. 122C-147.1 should be amended to modify or repeal the provisions that place funds appropriated by the General Assembly into broad age and disability categories.

A different act, S.L. 2006-248 (H 1723), authorizes the LOC to study issues related to mental health parity and, in consultation with the DHHS, conduct an analysis of funding for the administration of local management entities.

## Drug Treatment Court Study

Section 4 of S.L. 2006-32, as amended by S.L. 2006-187 (H 1848) and S.L. 2006-259 (S 1523) directs the Legislative Research Commission to study drug treatment courts in North Carolina. The study must include the following issues in relation to drug treatment courts: funding mechanisms, target populations, interagency collaboration at the state and local levels; and any other matter that the commission deems appropriate or necessary to provide proper information to the General Assembly on the subject of the study. The commission may report its findings and recommendations to the 2007 Regular Session of the 2007 General Assembly.

## Licensure of Substance Abuse Facilities

S.L. 2006-142 amends the definition of licensable facilities in G.S. 122C to remove outpatient substance services. Facilities that provide outpatient substance

abuse services will now be treated like facilities that provide outpatient mental health and developmental disabilities services, which are not required to be licensed under G.S. 122C. The change was sought to make it easier and more expedient for an LME to find or help develop a provider of outpatient substance abuse services when an existing provider ceases doing business with the LME

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Printed in the United States of America

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