

Chapter 40

Mental Health Services

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In North Carolina, public mental health, developmental disabilities, and substance abuse services are a shared responsibility of state and local government in partnership with private enterprise. State and local government play very distinct roles. State government appropriates the vast majority of funds spent on public services from state and federal revenue and, consequently, is the primary policymaker, determining what kinds of services are to be provided and how they will be delivered. But, while the state operates some regionally based mental health, developmental disabilities, and substance abuse (MH/DD/SA) facilities, public services are delivered primarily on the community level through private service providers contracting with local government *area authorities* (the short term used for area mental health, developmental disabilities, and substance abuse authorities). Using the state and federal resources appropriated to them by state government, area authorities authorize, pay for, manage, and monitor services provided by their network of private contractors.

County governments also provide an important but relatively small amount of funding and play a role in establishing area authorities and appointing their governing boards. The area authority is the governance and administrative structure available to counties for carrying out their legal responsibility to provide publicly funded mental health, developmental disabilities, and substance abuse services to their citizens. This chapter discusses the functions of area authorities, their governing structure, and their relationship to county and state government. It also describes the populations served by area authorities and the primary sources of revenue used to pay for services.

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Historical Perspective

Development and Evolution of the Public Role

Only in the last half century has local government in North Carolina adopted a significant treatment role in mental health care. In the eighteenth and nineteenth centuries, county governments sometimes confined persons with mental disabilities in poorhouses or jails, but this was solely a custodial function undertaken to protect property or public safety from the dangers, real or perceived, posed by persons believed to be possessed by demons. Confinement for curative or treatment purposes did not begin until 1856, when the General Assembly, concerned about the abuse and neglect endured by persons indefinitely confined in local facilities and influenced by the emerging belief that mental disabilities could be cured if treated in the right environment, opened Dorothea Dix Hospital in Raleigh, the first “State Hospital for the Insane.” By 1914, North Carolina had opened two more state hospitals and a state facility for persons with “mental retardation.” Due to the limited capacity of state institutions, however, many people with mental disabilities languished in local poorhouses and jails.

During the first half of the twentieth century, state government continued to take primary responsibility for mental health services. Nevertheless, there was growing interest in the development of local mental health care facilities that could intervene with preventive treatment before confinement in a state institution was necessary. Charlotte and Winston-Salem, in the forefront of this movement, each established a local mental health clinic in the 1930s. But most counties did not have the financial resources or substantive expertise to develop mental health clinics. Federal funding spurred further development of community-based services when Congress passed the National Mental Health Act in 1946.¹ By 1959, North Carolina had utilized this funding to establish eleven community mental health clinics and psychiatric services in eight county departments of health.

Despite the federal incentives to develop community-based mental health care, North Carolina continued to focus on state-operated institutions, spending money to improve existing state facilities and adding a fourth mental hospital in 1947 and three more “mental retardation centers” between 1958 and 1963.² Ironically, this expansion occurred during a period of increasing dissatisfaction—both in North Carolina and in the rest of the nation—with the institutional model of care, which relied on prolonged or permanent confinement of persons with mental illness or developmental disability in huge, crowded institutions. Revelations of inhumane treatment at some state institutions, advocacy for community-based services by parents of children with developmental disabilities, and new drug therapies for mental illness contributed to a national movement to reduce the traditional emphasis on state institutions in favor of community-based services intended to fulfill the institutional functions of treatment, rehabilitation, medical care, nutrition, recreation, social contact, and social control, without excessive restrictions on personal liberty.

The watershed event in the movement to reform mental health care came in 1963, when President Kennedy proposed³ and Congress passed the Community Mental Health Centers Act (CMHCA),⁴ which authorized federal funding for the construction of community mental health clinics. The level of funding available provided a powerful incentive to states to implement federal mental health policy, a policy that emphasized the responsibility of communities and local governments. The North Carolina General Assembly responded immediately by authorizing local communities to establish and operate mental health clinics as a joint undertaking with state government in which the state would develop a plan for establishing community outpatient clinics, administer federal grants, set standards for clinic operations, and appropriate state funds for community services.⁵

1. Pub. L. No. 487, 60 Stat. 421 (1946).

2. Formerly called “mental retardation centers,” North Carolina’s three state-operated “developmental centers” serve people who have a diagnosis of intellectual or developmental disability.

3. John F. Kennedy, *President’s Messages: Mental Illness and Mental Retardation*, H.R. Doc. No. 58, at 1468 (1963). 109 Cong. Rec. 1744.

4. Title II of Pub. L. No. 88-164 (1963).

5. 1963 N.C. Sess. Laws ch. 1166; former Sections 122-35.1 through -35.12 of the North Carolina General Statutes (hereinafter G.S.).

Table 40.1 Number and Percentage of Persons Served by Community Mental Health Programs and State Institutions in North Carolina, Fiscal Years 1960–61 to 2012–13

Fiscal Year	Persons Receiving Institutional Care		Persons Receiving Community-Based Care		Total Persons Served
	Number	Percentage of total	Number	Percentage of total	Number
1960–61	23,327	74	8,196	26	31,523
1970–71	30,019	32	63,791	68	93,810
1980–81	25,658	13	171,712	87	197,370
1993–94	21,825	9	225,167	91	246,992
2004–05	24,840	7	330,083	93	354,923
2012–13	10,638	3	333,214	97	343,852

Note: The figures for state-operated institutions include psychiatric hospitals, developmental centers, alcohol and drug abuse centers, specialized nursing facilities, and residential programs for children. The 2004–05 figure for community-based care is an unduplicated headcount, whereas that year’s figure for institutional care is a “duplicated headcount,” meaning that it includes people who were counted more than once if they had more than one distinct admission event. The duplicated headcount for community services is 337,676 in 2004–05.

Sources: Data for fiscal years 1960–61, 1970–71, and 1980–81 derived from the *Strategic Plan 1983–1989*, Vol. I, Quality Assurance Section, N.C. Division of Mental Health, Mental Retardation, and Substance Abuse Services (Raleigh, N.C.: NCDMHMRSAS, 1981), 39. Fiscal year 1993–94 figures from Deborah Merrill, Data Support Branch, N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, memorandum to author, 8 December 1994. Data for fiscal year 2004–05 from *Transformation: A Commitment to Make a Difference*, Annual Report for the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Raleigh, N.C.: NCDMHDDSAS, 2005). Data for fiscal year 2012–13 from North Carolina Local Management Entity, Annual Statistics and Admission Report, Fiscal Year 2013, www.ncdhhs.gov/mhddsas/statspublications/Reports/Financialandstatisticalreports/Statisticalreports/areaprograms/2013lme-annualreport.pdf.

In the two decades that followed the passage of the CMHCA, Congress enacted a series of laws that expanded federal support to include funding for clinic staff and operations, ensuring that federal appropriations would continue to influence the development of mental health care at the state and local level. In North Carolina, as in other states, federal policy achieved the dual goal of reducing the proportion of mental health patients receiving treatment in state hospitals while expanding the number of persons receiving mental health services in the community. By 1980, 740 federally funded community mental health centers were serving areas comprising roughly one-half of the nation, and approximately 3 million persons received services annually. The number of inpatients in state mental hospitals across the nation, which had peaked at 560,000 in 1955, decreased to 160,000 in 1977 and to about 120,000 in 1986, a decline of almost 80 percent since 1955.⁶

North Carolina’s experience matched the national trend, as the percentage of public-sector MH/DD/SA clients served by state institutions declined dramatically between 1961 and 1981, from 74 to 13 percent of the total persons served. By fiscal year 2004–05, state-operated psychiatric hospitals, developmental centers, alcohol and drug treatment centers, and other institutions accounted for only 7 percent of admissions to the public-sector system, with the remainder of admissions, 93 percent, occurring at community-based facilities (see Table 40.1). During this period, the relative decline in institutional care, however, appears related more to the dramatic increase in the number of persons served by community programs—from 8,196 in 1961 to 330,083 in 2005—than to any decrease in the actual number of persons served at state institutions, as state institutional admissions held steady with 24,840 persons served in 2005 compared to 23,327 in 1961. The greatest legacy of the development of community-based services, therefore, is not so

6. Rebecca T. Craig and Barbara Wright, *Mental Health Financing and Programming* (National Conference of State Legislatures, 1988); 7. Other factors contributing to the deinstitutionalization included legal decisions restricting the involuntary commitment of persons to psychiatric hospitals and federal funding policies that motivated the transfer of some patients to Medicaid-supported nursing homes.

much the deinstitutionalization of disabled individuals as it is the expansion of services to populations not previously served.

Since 2005, however, there has been an actual decline in the number of persons served by all of the state-operated institutions combined, from 24,840 persons served in 2005 to 10,638 persons receiving institutional care in 2013.⁷ This decrease in institutional care is largely due to a deliberate policy decision of state government to decrease inpatient psychiatric services at the three state-operated hospitals since 2004. As a consequence, the total number of persons served at the state-operated psychiatric hospitals decreased 77 percent, from 16,987 in fiscal year 2004 to 3,964 in fiscal year 2013. Because the number of people receiving community-based care increased only slightly during this period, from 330,083 to 333,214, the more significant decrease in institutional care meant a drop in the total number of persons receiving care, from 354,923 to 343,852.

Although the federal government repealed the CMHCA in 1981,⁸ the current structure of North Carolina's public MH/DD/SA service system—local governmental entities created specifically for the purpose of ensuring the coordination and delivery of community-based services pursuant to state policy, oversight, and financial support—is founded upon a vision of the community as the locus of care, the original goal of the CMHCA and its legislative progeny. One feature of the system—the central role of local government—remains unaltered since the 1977 General Assembly required counties to establish, either singly or jointly with other counties, local government agencies (area authorities) responsible for managing community-based services and accountable to a locally appointed governing board.⁹

Mental Health Reform

Although area authorities continue to be responsible for the delivery of publicly funded, community-based services, the functions of these governments changed significantly with the 2001 Act to Phase In Implementation of Mental Health System Reform at the State and Local Level.¹⁰ Before this legislative enactment, area authorities were permitted to provide services directly to clients using their own staff, or they could contract with other persons, organizations, or agencies to provide services to clients. Every area authority utilized both means of service provision, and most area authorities employed a large number of personnel with either clinical or case management skills who were devoted to providing services directly to clients. The 2001 mental health system reform act barred area authorities from directly providing services to those in need and, instead, required area authorities to use contracted providers. Services were privatized, and the area authority became responsible for assessing the needs of its geographic *catchment area* (the geographic area served), developing a provider network that could meet those needs through the provision of an array of services, creating a system for clients to access those services, authorizing and paying for services, and monitoring service quality and effectiveness.

To mark this change in function and organizational identity—from a service provider in direct contact with clients to a manager, monitor, and, sometimes, payer of services provided by others—most people affiliated with the public system at the time, including policy makers and administrators, began to use *local management entity* (LME) to refer to an area authority. This term, and the functions it denotes, remained uncodified until the 2006 General Assembly enacted S.L. 2006-142 (H 2077),¹¹ which defined “local management entity”¹² and described the local management

7. The use of the term “institutional care” when discussing these figures includes only those receiving services in state-operated institutions. For example, many public MH/DD/SA clients receive inpatient psychiatric care from other public and private hospitals. Those admissions are not included in these figures and, therefore, these figures do not include that institutional care.

8. The Omnibus Budget and Reconciliation Act of 1981, Pub. L. No. 97-35, Title IX § 901, 42 U.S.C. § 300x.

9. 1977 N.C. Sess. Laws ch. 568; former G.S. 122-35.35 through -35.57.

10. S.L. 2001-437.

11. This same legislation directed the North Carolina Department of Health and Human Services to develop performance measures for LME functions related to service access, consumer outcomes, individualized service planning, promotion of best practices, system efficiency and effectiveness, quality management, and prevention and early intervention. In some ways, these performance measures foreshadowed today's more extensive data collection and reporting requirements under the state's Medicaid managed care waiver.

12. G.S. 122C-3(20b).

entity functions that area authorities must perform.¹³ These functions are a feature of today's service system and are discussed in more detail below in the section entitled "Today's Area Authority."

The 2001 mental health system reform act also did a number of other things. It required the consolidation of the thirty-nine existing area authorities into twenty authorities by January 1, 2007. In an attempt to solicit greater involvement of county government in area authority affairs, the law required the counties served by an area authority to jointly develop, review, and approve an "LME business plan" for the management and delivery of mental health, developmental disabilities, and substance abuse services.¹⁴ The 2001 mental health system reform act also expanded the kinds of administrative units or structures that counties could create to carry out local government functions related to MH/DD/SA services, granting counties the authority to create units of local government that were alternatives to the area authority. Finally, with policy initiated in tandem with mental health reform but not codified until 2006, the state required area authorities to involve consumers and family members of consumers in the governance and management of the public system by establishing consumer and family advisory committees (CFACs) to advise the area authority boards.¹⁵

Some of the reforms discussed above have gone by the wayside, and some continue to trend forward beyond their original goals. Today, the area authority functions associated with managing care have grown to include substantial new responsibilities; the consolidation of area authorities into fewer entities covering larger geographic areas continues (see Figure 40.1); many of the legislative mechanisms that provided for greater county involvement have been deleted from the statutory law; the organizational alternatives to area authorities have all been eliminated; and consumer and family involvement has grown beyond CFACs to include representation by consumers and family members on the governing body. Most of these recent developments can be attributed to another major step in the evolution, or ongoing reform, of North Carolina's MH/DD/SA service system—one that embraces the concept of "managed care."

It should be noted for purposes of understanding the movement to managed care that area authorities initially did not have the authority to implement all LME functions with respect to most services. Under mental health reform, area authorities were required to perform these functions with respect to services paid for with state appropriations from state revenue sources (non-Medicaid state appropriations), but they did not have the authority to fully perform these functions with respect to Medicaid-funded services because Medicaid funds did not pass through the LME. While LMEs were required to contract with providers for Medicaid-paid MH/DD/SA services, those providers dealt directly with the Department of Health and Human Services' Division of Medical Assistance, or its contracted vendor, to obtain authorization to provide services, submit claims for reimbursement, and receive payment for the services provided. Because state government was the fiscal agent for Medicaid funds and LMEs did not have the authority to approve or deny the expenditure of Medicaid money for those services, LMEs could not adequately exercise the LME functions of utilization management and review,¹⁶ care coordination,¹⁷ and financial management and accountability.¹⁸ The movement to managed care, described below, involves moving responsibility for managing the quality and cost of care for all services, including those paid for with Medicaid funds, from state government to the area authorities.

13. G.S. 122C-115.4.

14. See G.S. 122C-115.2. The 2001 legislation and some of the factors precipitating its adoption are described in greater detail in Mark F. Botts, "2001 Legislation Affecting Mental Health, Developmental Disabilities, and Substance Abuse Services," *Mental Health Law Bulletin* No. 7 (March 2002).

15. The terms "consumer" and "client" are used interchangeably throughout this chapter, as they are in the General Statutes, to refer to a person receiving services through an area authority.

16. Utilization management and review involves approving a service plan and periodically reviewing it to determine that the level and intensity of services is appropriate to meet the need.

17. Care coordination involves monitoring the effectiveness of services to determine that neither too little nor too much service is being provided to achieve the desired results.

18. Financial management and accountability involves controlling costs by limiting the expenditure of public funds to those services that the provider has demonstrated, through the LME's utilization management and care coordination, to have a sound clinical basis.

Figure 40.1 Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities in North Carolina (Local Management Entities/Managed Care Organizations)

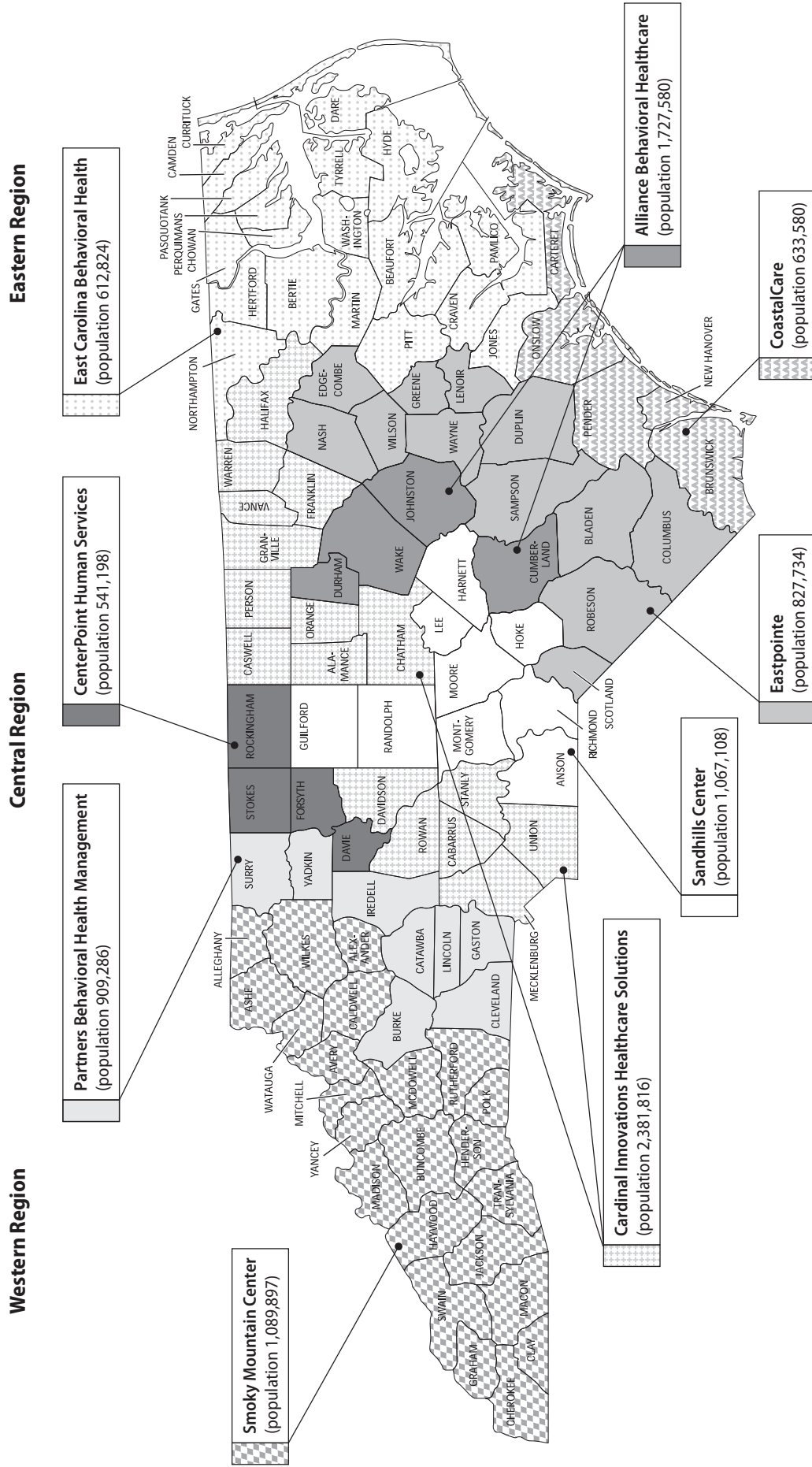
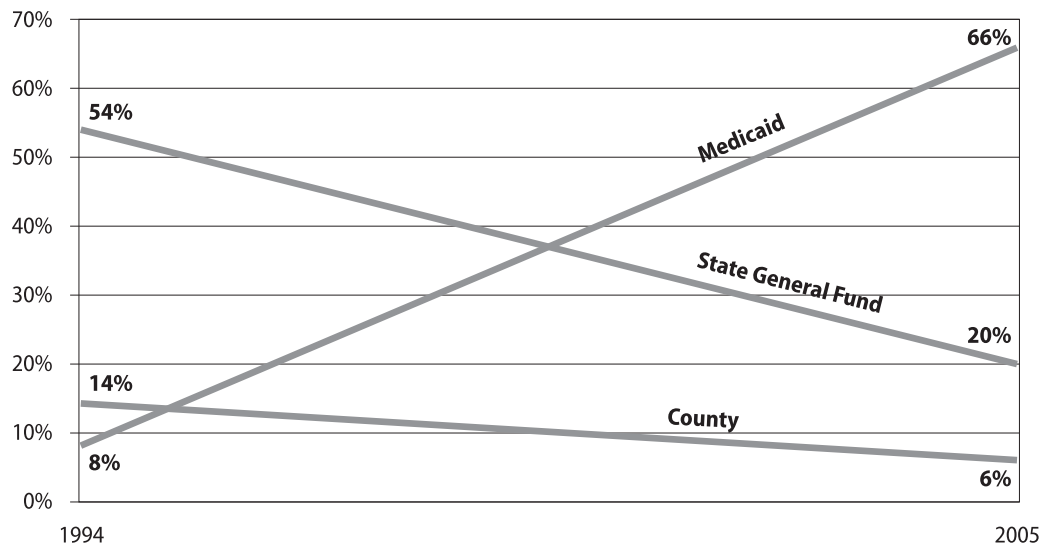


Figure 40.2 LME Revenue Trends

Medicaid Managed Care

The movement to managed care for MH/DD/SA services was precipitated by the confluence of at least three factors. One was the mental health reform act of 2001, which charged area authorities with service management functions that were, in essence, a nascent form of managed care for services funded by non-Medicaid state appropriations.

A second factor has been the rising cost of Medicaid programs nationally and a desire by state legislatures, including the North Carolina General Assembly, to control escalating costs.¹⁹ In 1986, Medicaid ranked lower nationally than state and local governments, private insurance, and patients as payers for mental health care. Today, Medicaid is the largest payer of mental health care, more than any other private or public source of funding. In North Carolina, Medicaid, which was the smallest source of area authority revenue twenty years ago, is now the largest (see Figure 40.2). Because Medicaid is the largest single source of revenue for community-based MH/DD/SA services, policymakers who seek to deal with the rising cost of care look to Medicaid policy.

States have a variety of tools at their disposal to control Medicaid costs, including reducing provider reimbursement rates, changing the eligibility criteria for Medicaid services, and limiting the services paid for by Medicaid. Another tool is managed care, which is really a set of processes and techniques used by an entity responsible for care to control or influence the quality, accessibility, utilization, costs, or outcomes of services provided to a defined enrollee population.

A third factor is a North Carolina demonstration project in managed care that the state was able to look to for a possible statewide model for controlling the quality and costs of care. In 2005, the federal Centers for Medicaid and Medicare Services (CMS) granted the Piedmont Behavioral Healthcare (PBH) area authority, through the state's Department of Health and Human Services (DHHS), the authority to administer and manage a "1915 (b)/(c) Medicaid Waiver"²⁰ as a pilot project for the delivery of publicly funded MH/DD/SA services. At the time, PBH, now Cardinal Innovations, served Cabarrus, Davidson, Rowan, Stanly, and Union counties, and the demonstration project applied to those five counties.

19. A major driver of increasing Medicaid expenditures is long-term care for the elderly in nursing homes. For more information on the escalating cost of Medicaid nationally and in North Carolina, see Christine Kushner, "Medicaid and North Carolina's Aging Population," *North Carolina Insight* 23, no. 2 (N.C. Center for Public Policy Research, Raleigh, N.C., January, 2010).

20. The term "1915 (b)/(c) Medicaid Waiver" refers to two sections of the Social Security Act that allow states to apply for waivers from certain federal Medicaid regulations. The "(b) Waiver" allows Medicaid beneficiaries to enroll in managed care plans and allows the state to limit the provider network based upon the needs of recipients. The "(c) Waiver" permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries in continuing to live in the community and avoid-ing institutionalization.

The term “waiver” refers to the federal government waiving, at the state’s request, certain federal rules that normally apply to Medicaid so that the state can implement a Medicaid system with certain features that would not be allowed under the regular Medicaid rules. For example, under the PBH demonstration project, all Medicaid-eligible beneficiaries who sought MH/DD/SA services had to use PBH-contracted providers and did not have the freedom to choose providers outside of the PBH network. This was permissible only because the normal patient freedom of choice rule was waived.

In addition, in order for PBH to control the quality and cost of care—in order to fully perform the *managed care* functions of service authorization, utilization management and review, care coordination, and financial management and accountability—all Medicaid funds for MH/DD/SA services in the PBH catchment area were appropriated directly to PBH. Providers looked to PBH, not the state, for service approval and payment, and PBH was required to manage care and funding so that the allocated funds would be sufficient to meet the needs of its catchment area. PBH had the authority to review applications for care and determine whether it would authorize the expenditure of Medicaid funds for the services sought, and if services were authorized, PBH would review the appropriateness and effectiveness of services over time to ensure that Medicaid money was being expended for services that were effective at achieving identified client outcomes. This contrasted with the fee-for-service system that other area authorities were operating under, where providers of services to area authority clients would seek service authorization from, and submit claims for reimbursement directly to, the state’s Division of Medical Assistance (DMA).

The waiver of Medicaid rules for the PBH area authority allowed the state to test whether an area authority, if it controlled the funding for care and was permitted a certain level of control over provider behavior and patient choice through managed care techniques, could control both the quality and cost of care. Within a few years, PBH had begun to do so. In 2010 and 2011, it served a greater proportion of those in need, exceeding the state average for percentage of persons served, and it did so in every age and disability category.²¹ And beginning in 2008, there was a substantial difference in the average expenditures for care, with expenditures remaining relatively stable at PBH while expenditures soared across the rest of the state.²²

Based on the success of the PBH program at holding down Medicaid costs compared to other area authorities, in 2009, DHHS recommended that its Division of Medical Assistance and its Division of Mental Health, Developmental Disabilities, and Substance Abuse Services develop a 1915 (b)/(c) Medicaid Waiver application, similar to PBH’s, for submission to CMS that would permit North Carolina to expand the PBH model to other parts of the state.²³ The state’s proposed model would allow for managed care contracts between DMA and each area authority that would place responsibility for containing costs and improving quality and efficiency on the area authorities, which would be financially at risk if they failed to adequately achieve contract performance goals through the application of a host of managed care functions.

North Carolina was granted authority to expand its Medicaid Waiver in 2010, and at first, the state permitted area authorities to voluntarily choose to apply for DHHS approval to operate under the waiver. That changed in 2011, when the General Assembly enacted a law requiring all area authorities to implement the “1915(b)/(c) Managed Care Waiver” by July 1, 2013.²⁴ The 2011 law seeks to establish a system that is capable of managing all public resources available

21. See N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services, *The PBH Managed Care Experience: A Comparison to Non-Managed Care Local Managed Entities* (December 1, 2011), www.ncdhhs.gov/mhddsas/statspublications/Reports/DivisionInitiativeReports/LME-MCOPerfReports/PBHExperience2011-12.pdf.

22. The rise of expenses in the rest of the state was due primarily to expenses associated with Community Support Services. PBH reports that it was able to manage and limit these services using managed care tools that other LMEs did not have because they were not operating under the Medicaid managed care waiver.

23. This Waiver Amendment was submitted to CMS on December 16, 2009.

24. S.L. 2011-264. North Carolina’s managed care waiver, authorized by § 1915(b) of the Social Security Act, is called the North Carolina Mental Health, Intellectual and Developmental Disabilities and Substance Abuse Services Health Plan. North Carolina’s Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in § 1915(c) of the Social Security Act. This program is called North Carolina Innovations, or the Innovations waiver. The North Carolina Innovations waiver targets individuals who meet the ICF-IID eligibility criteria as defined in the State Medicaid Agency’s Clinical Coverage Policy, which is located on the DHHS Division of Medical Assistance website at www.ncdhhs.gov/dma/.

for mental health, intellectual and other developmental disabilities, and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice, and all other public funding sources. Through the 2011 law and succeeding legislation, the General Assembly has required North Carolina's area authorities to operate as *managed care organizations* for publicly funded, community-based MH/DD/SA services under the direction and supervision of DHHS.

The State's Role in Community Services

The primary state government actors in the mental health, developmental disabilities, and substance abuse (MH/DD/SA) services arena are the North Carolina Department of Health and Human Services (DHHS); the North Carolina General Assembly; and the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, a rulemaking body of DHHS. In general, the General Assembly makes policy by enacting legislation, and the executive branch of state government—in this case, DHHS—implements and administers the legislative policy. But DHHS and the commission also make policy by adopting rules that have the force and effect of law. The General Assembly has authorized the secretary of DHHS and the commission to adopt rules governing numerous matters relating to the delivery of MH/DD/SA services²⁵ and has charged the secretary with enforcing the rules and legislation governing community-based, publicly funded mental health, developmental disabilities, and substance abuse services.

Policymaking

In 2011, the North Carolina General Assembly directed DHHS to expand the PBH Medicaid Waiver demonstration program to all area authorities by July 1, 2013.²⁶ Among other things, the General Assembly directed DHHS to establish a system for managing all public funds for MH/DD/SA services that used managed care strategies, such as care coordination and utilization review, to reduce the trend of escalating costs in the state Medicaid program and to ensure easy access to medically necessary care provided at a level of intensity appropriate to a client's assessed need. Significantly, the General Assembly directed DHHS to vest these responsibilities in the state's area authorities—public entities that were uniquely positioned, if not adequately prepared, to carry out these functions. (The local management entity (LME) functions that area authorities were already performing were similar to, if not as complex as, Medicaid managed care functions.) Accordingly, the General Assembly directed DHHS to require all LMEs to operate a 1915(b)/(c) Medicaid Waiver or merge with an LME that was approved by DHHS to operate the Medicaid Waiver.

The kinds of bodies utilized by the General Assembly to develop MH/DD/SA policy have varied over the years. In 2000, the General Assembly created the Joint Legislative Oversight Committee (LOC) on Mental Health, Developmental Disabilities, and Substance Abuse Services and charged it with developing a plan to reorganize the public system of mental health, developmental disabilities, and substance abuse services based on recommendations of the state auditor.²⁷ After much study and deliberation by its subcommittees, the LOC on MH/DD/SA services introduced a mental health reform bill that addressed, among other things, such issues as the governance of the local service systems, the quality of services, and consumer and family involvement in oversight of the system. The bill ultimately adopted by the General Assembly is known as the mental health system reform act of 2001.²⁸ In 2006, the LOC recommended and the General Assembly adopted legislation modifying the 2001 act, including changes to clarify the respective powers and duties of state and local government with regard to public services.

In 2011, the General Assembly restructured legislative committees and consolidated the duties of the Joint LOC on MH/DD/SA Services, the North Carolina Study Commission on Aging, the Joint Legislative Health Care Oversight Committee, and the Public Health Study Commission into one body, the Joint Legislative Oversight Committee on

25. G.S. 122C-112.1; G.S. 143B-147 through -150; G.S. 122C-114.

26. S.L. 2011-264.

27. S.L. 2000-83.

28. S.L. 2001-437.

Health and Human Services.²⁹ This body, composed of eleven members appointed by the Senate and eleven by the House of Representatives, is charged with examining on a continuing basis statewide issues affecting the development, budgeting, financing, administration, and delivery of health and human services. In 2012, the General Assembly directed this body to appoint a Subcommittee on Mental Health to examine the state's delivery of mental health, developmental disabilities, and substance abuse services.³⁰ This is the current legislative body where most policy review and development related to MH/DD/SA services is initiated, and it is this body, through the Joint Legislative Oversight Committee on Health and Human Services, that makes legislative recommendations to the General Assembly.

Administration

The Department of Health and Human Services, through its Division of MH/DD/SA Services and its Division of Medical Assistance (DMA), is the state agency responsible for administering and enforcing state statutes and regulations governing the funding and operation of area authorities.³¹ DHHS allocates federal and state funds appropriated by the General Assembly for community services, enforces requirements for federal aid, and adopts and enforces rules governing the expenditure of area authority funds.

DHHS administers state and federal funding for community services through the application of two contracts that incorporate statutory and regulatory law and add other requirements. One, a contract between each area authority and the Division of MH/DD/SA Services (the DMHDDSAS contract), governs the expenditure of non-Medicaid state appropriations from the state general fund and federal block grants. Another, a contract between each area authority and DMA (the DMA contract), governs the expenditure of state Medicaid funds and is the primary means used by DHHS to restructure area authority "management responsibilities" through "the 1915(b)/(c) Medicaid Waiver."³² Each of these contracts addresses numerous and specific "management functions"³³ that area authorities must perform to receive funding. These functions include the collecting and reporting of data relating to the functions themselves so that the area authority and the state can determine whether the area authority is meeting the state's "performance expectations."³⁴

Pursuant to the DMA and DMHDDSAS contracts, area authorities are required to collect and report to DHHS specified data intended to measure the effectiveness of care, access to and availability of services, patient and provider satisfaction, use of services, treatment prevalence (the percentage of persons estimated to be in need of services who actually receive services), timely initiation and continued engagement in services, the extent of follow-up care after patient discharge from inpatient facilities, and the utilization of crisis and inpatient services.³⁵ Some of this data, both in the aggregate for a statewide view and separated by area authority for purposes of assessing each area authority's individual performance, is published and available to the public.³⁶ Pursuant to the area authority's contracts with DHHS, the state must use the foregoing data to evaluate the performance of each of the area authority's management functions. (These functions are discussed under "Agency Functions" in the section of this chapter entitled "Today's Area Authority.")

In 2013, the General Assembly enhanced the DHHS secretary's enforcement authority by requiring the secretary to certify, every six months, that each area authority has met certain contract performance expectations.³⁷ If the secretary

29. S.L. 2011-191.

30. S.L. 2012-142, sec. 10.11, as amended by S.L. 2012-145, sec. 3.4.

31. G.S. Ch. 143B; G.S. 122C-111 and -112.1.

32. S.L. 2011-264.

33. Generally, the DMHDDSAS contract governs local management entity functions and the DMA contract governs managed care organization functions.

34. See DMA and DMHDDSAS contracts and G.S. 122C-124.2.

35. These reporting requirements are set forth in the *North Carolina LME/MCO Performance Measurement and Reporting Guide*, DMA and DMHDDSAS, September 17, 2013.

36. See *MH/DD/SAS Community Systems Progress Report*, prepared quarterly by the Quality Management Team, Community Policy Section, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, available on the DMHDDSAS website at www.ncdhhs.gov/mhddsas/statpublications/Reports/DivisionInitiativeReports/communitysystems/index.htm.

37. S.L. 2013-85.

does not certify that an area authority has made (1) adequate provision against the risk of insolvency with respect to funding for Medicaid enrollees,³⁸ (2) timely provider payments,³⁹ and (3) an adequate exchange of information (billing, payment, and other transaction data) with DHHS and the area authority's contracted providers, then DHHS must reassign the area authority's DMA contract responsibilities to another area authority and move to dissolve the noncompliant area authority. If at any time an area authority is not in compliance with other DHHS contract requirements, then the secretary must notify the area authority in writing, allow the area authority thirty days to demonstrate compliance, and reconsider its initial determination. If the area authority remains out of compliance, the secretary must allow the area authority thirty days to negotiate a merger with another area authority and, if such negotiations are not successful, the secretary must assign the area authority's contract responsibilities, and oversee the transfer of its operations, to another area authority.

Finally, for some inpatient and residential services, area authorities rely upon regionally based facilities operated by the DHHS Division of State Operated Healthcare Facilities. The division operates three alcohol and drug treatment centers, three psychiatric hospitals, three developmental centers for persons with intellectual and developmental disabilities, two residential programs for children with serious emotional and behavioral disorders, and three neuro-medical centers for people with mental illness or developmental disabilities who have significant or long-term medical conditions.

Rulemaking

The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services is a state body authorized to adopt, amend, and repeal rules governing the delivery of mental health, developmental disabilities, and substance abuse services.⁴⁰ Appointed by the governor and the General Assembly, the thirty-two-member commission is made up of persons with knowledge and expertise in these services, including professionals in the field and consumers or immediate family members of consumers of services. Commission rules govern the operation of area authorities and their contract agencies, the admission of individuals to state-operated facilities, and the licensing of public and private facilities that provide mental health, developmental disabilities, and substance abuse services. The commission has the authority to adopt rules establishing a process for non-Medicaid eligible clients to appeal area authority decisions affecting their care and to generally advise the secretary of DHHS on mental health, developmental disabilities, and substance abuse services. Finally, statutory law specifically requires the commission to adopt rules governing the development of a process for screening, triage, and referral of clients to LME providers; the LME monitoring of providers of services; the LME provision of technical assistance to providers; and the requirements of "qualified public or private providers" as those terms are used in Section 122C-141 of the North Carolina General Statutes (hereinafter G.S.).

Financing Community Services

Revenue to support community services comes from a variety of sources, including the state general fund, federal block grants, special purpose grants from the federal government and private foundations, county appropriations, client fees,

38. "Adequate provision" includes submitting financial records and reports to DHHS as required by the DMA contract; having no consecutive three-month periods during which the LME/MCO's ratio of current assets to current liabilities is less than 1.0, based on a monthly review of the LME/MCO's balance sheets for each month of the three-month period; and having an intradepartmental monitoring team designated by the secretary determine that the LME/MCO has made adequate provisions against the risk of insolvency based on a quarterly review of the financial reports submitted to DHHS. G.S. 122C-124.2.

39. The secretary must certify that an LME/MCO is making timely provider payments if there are no consecutive three-month periods during which the LME/MCO paid less than 90 percent of "clean claims" for covered services within the thirty-day period following the LME/MCO's receipt of these claims during that three-month period. A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. The term includes a claim with errors originating in the LME/MCO's claims system. The term does not include a claim from a provider who is under investigation by a governmental agency for fraud or abuse or a claim under review for medical necessity. G.S. 122C-124.2.

40. G.S. 143B-147 through -150; G.S. 122C-114.

and federal Medicaid funding. When looking at the sources of revenue for community services, two things become clear. First, the system serves primarily, though not exclusively, individuals who are eligible for Medicaid, as Medicaid funding is the largest single source of revenue for community-based services. Thus, it should come as no surprise that Medicaid policy, both state and federal, drives North Carolina policy governing public mental health, developmental disabilities, and substance abuse (MH/DD/SA) services. Second, the largest source of revenue for providing services to individuals who are not eligible for Medicaid and who have no third-party insurance coverage is the state general fund.

A couple of sample area authority budgets illustrate the funding picture. The Cardinal Innovations area authority, covering fifteen counties in 2013, reported \$356 million in budgeted revenues for fiscal year 2012–13, 80 percent of which came from Medicaid (see Figures 40.3 and 40.4).⁴¹ CenterPoint Human Services, an area authority serving four counties, reported that 62 percent of its budgeted revenue came from Medicaid.⁴²

Medicaid pays for medically necessary, covered services for eligible people. In other words, to receive services paid for with Medicaid funds, an individual, due to disability or membership in a low-income family, must be eligible for and enrolled in the Medicaid program, must be applying for a service covered by the State Medicaid Plan, and must have a condition that makes the service medically necessary as determined by a clinician conducting an assessment under state clinical guidelines.

Under North Carolina's Medicaid managed care waiver, the state pays area authorities Medicaid funds on a per member/per month capitated model. This means that, based on a calculation of the historical Medicaid spending on MH/DD/SA services in the area authority's catchment area under the former fee-for-service model, the state determines the total annual Medicaid funding that should be needed to meet the MH/DD/SA service needs in the pending fiscal year and disburses that money to the area authority in twelve monthly installments. The funding is "capitated," meaning that the area authority receives the funds up front and is expected to meet the MH/DD/SA service needs of all Medicaid enrollees in its catchment area without any additional funding. This differs from the former fee-for-service model where, from the state's perspective, Medicaid costs were unpredictable: the more services providers provided and billed for in a given year, the greater the amount of Medicaid money spent. Under the capitated funding model, state government shifts the financial risk to the area authority, which accepts full risk for the cost of care and attempts to manage both the cost and quality of care using the managed care techniques described more fully below in "Agency Functions" under the section of this chapter entitled "Today's Area Authority." To enhance the area authority's ability to manage the financial risk, all Medicaid-eligible individuals seeking or receiving MH/DD/SA services must enroll with an area authority so that the area authority can manage their care. And, all providers of these services must enroll in the area authority's provider network—which the area authority can limit—where they are subject to the area authority's performance expectations related to the cost and quality of care.

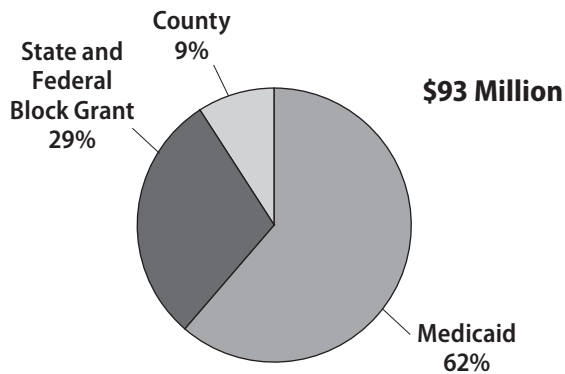
Non-Medicaid state appropriations—appropriations from the state general fund and federal block grants—represented 29 percent of CenterPoint Human Services' revenues and 18 percent of Cardinal Innovations' revenues in fiscal year 2012–13 (see Figures 40.3 and 40.4). This funding is used by area authorities to provide services to indigent and disabled clients who are not eligible for Medicaid services because their impairment is not severe enough or their income not low enough for them to qualify. To receive services paid for with this state funding, an individual must meet "target population criteria," which are eligibility criteria set by the state to target funds to those with the most serious or severe unmet needs.⁴³ Area authorities also sometimes use state funding to pay for licensed professional services not covered by Medicaid.

41. In 2014, Mecklenburg County joined Cardinal Innovations, bringing the catchment area to sixteen counties and increasing the size of Cardinal's budget.

42. Medicaid is funded jointly by the state and federal governments, with the federal government contributing about 65 percent and about 35 percent coming from the state. Until the county share was phased out on July 1, 2009, counties contributed 2.7 percent.

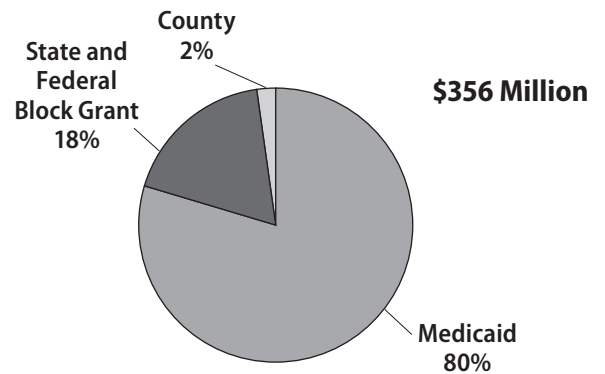
43. This source of revenue is commonly referred to as Integrated Payment and Reimbursement System (IPRS) funding. For more about the state's target populations, see "The Populations and Disabilities Served."

**Figure 40.3 Who Pays for Services?
(CenterPoint Human Services)**



CenterPoint Human Services
FY 2012–13 Budgeted Revenues by Source

**Figure 40.4 Who Pays for Services?
(Cardinal Innovations)**



Cardinal Innovations
FY 2012–13 Budgeted Revenues by Source

Counties must, and cities may, appropriate funds to support the LME serving their catchment area.⁴⁴ In addition, G.S. 122C-2 provides that the furnishing of services through a public system centered in area authorities “requires the cooperation and financial assistance of counties, the State, and the federal government.” Nevertheless, county appropriations comprise a very small percentage of total revenues. County appropriations funded through property tax proceeds or other local revenues comprised 9 percent of the total revenue available to CenterPoint Human Services and 2 percent of the revenue available to Cardinal Innovations in 2012–13

Because area authorities do not have the power to levy taxes, their ability to generate revenue is limited. Client co-payments may provide some revenue, but this is limited, as most area authority clients are indigent and uninsured, and no person may be refused services because of an inability to pay.⁴⁵ Any revenue generated by an area authority or its providers through the collection of client co-payments must be used to provide services to individuals who meet the state’s target population criteria; it may not be used as a justification for reducing or replacing the budgeted commitment of county tax revenue.⁴⁶

The Populations and Disabilities Served

Area authorities arrange and monitor care and treatment for mental illness, intellectual and developmental disabilities, and substance abuse. As noted earlier, individuals who meet specific *target population* criteria or who are *Medicaid eligible* may qualify for publicly funded mental health, developmental disabilities, and substance abuse (MH/DD/SA) services.

In North Carolina, there are 1.37 million people in need of mental health, developmental disabilities, and substance abuse services—almost 14 percent of the state population.⁴⁷ Of these, the state estimates that 609,087 people need

44. G.S. 122C-115(b).

45. G.S. 122C-146. An indigent person can, however, be denied services for not meeting Medicaid or state target population criteria.

46. G.S. 122C-146.

47. Aisander Duda and Mebane Rash, “Mental Health, Developmental Disabilities, and Substance Abuse Service in North Carolina: A Look at the System and Who It Serves,” *North Carolina Insight* 23, no. 4/24, no. 1 (N.C. Center for Public Policy Research,

mental health services, 122,813 need developmental disability services, and 639,512 need substance abuse services. Within these figures, children comprise 313,910 of those who need services.⁴⁸

*Mental illness*⁴⁹ covers a group of illnesses, including both emotional and cognitive disorders, characterized by alterations in thinking, mood, or behavior associated with stress or impaired functioning, or both. Examples include major depression, a mood disturbance that interferes with the ability to work, eat, sleep, study, and enjoy life, and attention deficit hyperactivity disorder, manifested by difficulty controlling behavior, staying focused, and paying attention. Other examples include bipolar disorder, characterized by mood swings between mania and depression, and post-traumatic stress disorder, a type of anxiety disorder that may occur as a result of seeing or experiencing a threat of injury or death.

Evidence of mental illness may include perceptual difficulties, delusions, visual and auditory hallucinations, and impairments in personal, social, and occupational functioning. Schizophrenia and related illnesses, affecting a small percentage of the population, are considered the most debilitating of the mental illnesses and the most difficult and expensive to treat. Depression, on the other hand, is more common; a major cause of suicide, it frequently goes unrecognized and untreated, particularly in elderly populations.

Developmental disability is a severe, chronic disability attributable to mental or physical impairment (or a combination of mental and physical impairments) that appears before age twenty-two (unless caused by traumatic head injury), is likely to continue for life, and produces substantial functional limitations in three or more of the following major areas of life activities: self-care, learning, mobility, language, capacity for independent living, self-direction, and economic self-sufficiency.⁵⁰ These impairments reflect the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are lifelong or extended in duration and individually planned and coordinated. Depending on severity, the term "developmental disability" includes intellectual disabilities, epilepsy, autism, and cerebral palsy. The term also includes delayed cognitive, physical, or communication and social-emotional development in children.

Intellectual disability is described by the American Association on Intellectual and Developmental Disabilities as one of several developmental disabilities that can occur in an individual's developmental period before the age of eighteen.⁵¹ It is a disability characterized by significant limitations in both intellectual functioning and adaptive behavior. Intellectual functioning—also called intelligence—refers to general mental capacity, such as learning, reasoning, and problem solving, and is sometimes measured by an IQ test. A score of 75 or below can indicate a limitation in intellectual functioning. Adaptive behavior refers to a collection of conceptual, social, and practical skills performed by people in their everyday lives. Conceptual skills include language, literacy, and an understanding of money, time, and numbers. Social skills refer to interpersonal skills, social responsibility, self-esteem, gullibility, naïveté, social problem solving, and the ability to follow rules, obey laws, and avoid being victimized. Practical skills involve activities of daily living such as personal care, occupational skills, health care, transportation, routines, safety, and the use of money and the telephone.

Substance abuse is the use of drugs or alcohol in a dangerous, self-defeating, or destructive way and to a degree that produces impaired personal, social, or occupational functioning. An individual who engages in substance abuse has difficulty controlling his or her use, even though the use may be sporadic. Persons engaging in substance abuse who might receive community-based services include injecting drug users, substance abusing women with children, those convicted of driving while impaired, persons involved in the criminal justice and juvenile justice systems, those under

Raleigh, N.C., December 2012): 29, citing N.C. Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "Semi-Annual Report to the Joint Legislative Oversight Committee on Health and Human Services," Statewide System Performance Report, SFY 2011–12, Spring Report, Raleigh, N.C. (April 1, 2012): Tables 1.1.a and 1.1.b.

48. *Id.*

49. Historically, the common term for children is "emotional disturbance."

50. 42 U.S.C. § 15002(8); G.S. 122C-3(12a).

51. The term for the condition we know today as *intellectual disability* has changed over time and most recently was known as *mental retardation*. See the American Association on Intellectual and Developmental Disabilities website, <http://aaid.org/intellectual-disability/definition>.

investigation or supervision by child protective services, and those whose substance abuse involves recurring episodes of habitual use requiring assisted detoxification.

Simply suffering from mental illness, substance abuse, or a developmental disability does not qualify an individual for receiving publicly funded, community-based MH/DD/SA services. Due to limited public resources, the primary focus of the publicly funded system, particularly since the redesign that began in 2001, is to provide services to individuals with the most severe disabilities. The goal is to use public resources to allow people with the most severe disabilities to function and receive services in their community and to reduce as much as possible the public system's reliance on expensive institutional care.⁵² To meet this goal, the Department of Health and Human Services has established target populations defined by specific diagnostic and functional criteria along with unique individual circumstances. These include several specific sets of criteria for each of the major age and disability categories: children with mental illness, adults with mental illness, adults suffering from addictive disorders, substance abusing youth or those at risk of engaging in substance abuse, and adults and children with developmental disabilities.

Generally, to receive community-based services paid for by appropriations from the state general fund, an individual must fall within the target population for his or her age and disability category. For example, while many children may suffer from mild mental illness, the state's target population criteria generally focus on children with *serious emotional disturbance* (SED).⁵³ Children with SED—which may include anxiety disorders, disruptive behavior disorders, depression, substance abuse, or eating disorders—are seriously affected in their ability to develop and function normally at school, at home, or with peers, and they typically require mental health and other services during childhood and in many cases throughout their lives.⁵⁴ Often these children require placement out of the home or are at risk of out-of-home placement, and without treatment and support, children with SED are more likely to be expelled from school, drop out of school, become pregnant during adolescence, commit suicide, or be convicted of a crime.⁵⁵

Those individuals eligible for Medicaid and with a condition that meets “medical necessity” for a particular service as defined by the federal Centers for Medicare and Medicaid Services are entitled to receive services whether or not they meet the state's target population criteria for receiving state-funded services. Since the majority of funding to support publicly funded, community based MH/DD/SA services comes from the state Medicaid program (see Figures 40.3 and 40.4, above), the state's federally approved service definitions for Medicaid-reimbursable MH/DD/SA services largely determine who receives services and the kinds of services they receive. In comparison, the limited state funding available to address the needs of individuals who are not Medicaid eligible and who have no third-party insurance coverage leads to a state policy that targets state funds to the most severely disabled.

52. Legal developments also contributed to renewed emphasis on this goal. The most recent example is *Olmstead v. L.C.*, 527 U.S. 581 (1999), where the U.S. Supreme Court held that the unnecessary segregation of individuals with mental disabilities in institutions could constitute discrimination based on disability, in violation of the Americans with Disabilities Act. After the ruling, states believed they risked litigation if they did not develop a comprehensive plan for moving qualified persons from psychiatric hospitals to less restrictive settings at a reasonable pace. North Carolina developed its *Olmstead Plan* for individuals institutionalized for sixty or more days in state psychiatric institutions, developmental disabilities centers, and community-based intermediate care facilities for persons with mental retardation. The plan includes a process for assessing individuals to determine the services and support needed to return them to the community and discharging them from institutional care where appropriate.

53. National estimates indicate that 20 to 28 percent of children in the United States suffer from a mild mental health disorder, and 5 to 6 percent suffer from a serious emotional disturbance. *Child Mental Health Plan*, North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (updated March 2004).

54. *Children's Mental Health: Strategies for Providing High Quality and Cost-Effective Care*, North Carolina Family Impact Seminar (Center for Child and Family Policy, Duke University, Durham, N.C., May 17, 2006): 10.

55. *Id.*

Today's Area Authority

Every county must provide mental health, developmental disabilities, and substance abuse (MH/DD/SA) services through an area authority.⁵⁶ A board of county commissioners for a single county or the boards of county commissioners for two or more counties must establish an area authority with the approval of the secretary of the Department of Health and Human Services (DHHS).⁵⁷ Thus, an area authority may serve either a single county or multiple counties, with the size of the catchment area (geographic area served) determined by how many counties join together to establish an area authority.

Historically, there has been no requirement relating to the size of an area authority or the number of counties it serves. Beginning on July 1, 2013, however, the catchment area served by an area authority had to meet a 500,000 population threshold to ensure that the area authority has a sufficiently large number of Medicaid enrollees to achieve the administrative efficiencies deemed necessary to effectively implement the Medicaid managed care waiver described above.⁵⁸ Thus, the single-county area authority is all but theoretical, and the population requirement led several area authorities to consolidate with each other, resulting in fewer authorities covering larger geographic areas. Today, North Carolina is served by nine multi-county area authorities (see Figure 40.1, above).⁵⁹

As noted earlier, the evolution in area authority functions—through the 2001 law assigning local management entity functions and the 2011 law assigning managed care functions with respect to Medicaid and other public funding—has led area authorities to be called *local management entities* or LMEs and *managed care organizations* or MCOs. As a result of a 2013 legislative enactment, area authorities are also called “LME/MCOs.”⁶⁰ For the purposes of this chapter, these terms are used interchangeably to refer to the same entity unless otherwise indicated.

Agency Functions

Area authorities are responsible for the management and oversight of the public system of MH/DD/SA services at the community level. As LME/MCOs, area authorities must plan, develop, implement, and monitor services within their catchment area to ensure expected outcomes for consumers of services within available resources.⁶¹ This broad management and oversight responsibility includes many functions, some specified by statute⁶² and some set forth in the area authority's Division of Medical Assistance (DMA) and Division of MH/DD/SA Services (DMHDDSAS) contracts.⁶³

56. G.S. 122C-115(a).

57. G.S. 122C-115(c).

58. S.L. 2011-264, sec. 2 (amending G.S. 122C-115).

59. The 2014 appropriations act cuts funding for LME/MCO administration based on the assumption that the nine LME/MCOs will consolidate to seven or fewer LME/MCOs by June 30, 2015. S.L. 2014-100 (S 744) and Joint Conference Committee Report on the Continuation, Expansion, and Capital Budgets, July 30, 2014.

60. The General Assembly amended G.S. 122C-3 to say that a “local management entity/managed care organization” or “LME/MCO” means a local management entity (area authority) that is under contract with DHHS to operate the combined Medicaid Waiver program authorized under Sections 1915(b) and 1915(c) of the Social Security Act. S.L. 2013-85.

61. G.S. 122C-115.4.

62. G.S. 122C-115.2 and -115.4.

63. The multiple and inconsistent ways that area authority functions are categorized and described across multiple sources of law, including legal obligations not codified in statute or rule, make it challenging to consistently and coherently identify and describe agency functions while maintaining fidelity to the law. The General Statutes enumerate “local management entity functions” (G.S. 122C-115.4) and “core administrative functions” (G.S. 122C-115.2). These are essentially the same functions, although the two lists depart slightly from each other. “Managed care organization functions” are not treated in any comprehensive fashion by the General Statutes, and the state chooses to identify and require these functions primarily through the DMA contract that every area authority must enter into to receive and manage Medicaid funds.

In spite of the complexity of the relevant statutory law and contractual obligations that area authorities must carry out, three themes emerge from a review of agency functions: (1) many LME functions are the same as many MCO functions, although they may vary in application because they arise from different contracts that govern two different sources of revenue, each with its own rules on what services and activities are reimbursable; (2) the advent of MCO functions has required area authorities to meet more rigorous financial accountability standards and more intensive information management, analysis, and reporting demands; and (3) some LME functions, such as community collaboration, involve interagency planning and coordination with other public agencies

The primary functions include the following:

1. *Planning.* The area authority must determine the service needs of consumers in its catchment area, assess the quality and availability of services, identify service gaps and methods for filling those gaps, and ensure the availability of an array of services based on consumer needs. Local service planning must address the equitable delivery of services among member counties and the most efficient and effective use of funds. Local planning must be an open process involving key stakeholders. The area authority must annually assess its progress toward implementing its service plans and achieving its goals and outcomes, and it must develop and submit to the secretary of DHHS a business plan that addresses how the area authority will carry out most of the functions described below.⁶⁴
2. *Access.* The LME/MCO must implement a system for citizens to access services and, in particular, for the LME/MCO to respond to the need for emergency or crisis services. This system must include a telephonic access and customer call center that provides a screening, triage, and referral (STR) process available twenty-four hours a day, seven days a week. STR serves as a portal of entry to community services for individuals who are eligible for Medicaid or who meet the state's target population criteria for non-Medicaid state funding. Individuals experiencing an emergency must receive face-to-face service within two hours. Urgent situations, defined as involving a moderate risk or incapacity, require a response within forty-eight hours, and routine situations, those involving mild risk or incapacity, require a referral to a provider capable of delivering face-to-face services within fourteen calendar days.⁶⁵
3. *Provider development and management.* For citizens to access services, providers of services must be available. In light of the assessed service need for its catchment area, the LME/MCO must assess the availability of providers to meet those needs and the qualifications and competencies of available providers. It must contract with qualified⁶⁶ public or private agencies or institutions for the provision of services, maintain a stable and high quality network of providers, and provide technical assistance to providers. The area authority must monitor provider performance and service outcomes in accordance with state standards and, to enable the authority to carry out this responsibility, the standard provider contract⁶⁷ requires service providers to make timely reports regarding the clients served, the services provided, and the resulting outcomes.⁶⁸
4. *Service management.* This function is designed, in part, to ensure that public dollars are spent on eligible individuals and for services that are at an appropriate level and intensity given the severity of an individual's illness or disability. The LME/MCO must approve specific services to individual consumers (service authorization); evaluate the medical necessity, clinical appropriateness, and effectiveness of services using established guidelines and criteria (utilization management); and monitor individual care decisions at critical treatment junctures to assure effective care is received when needed (care coordination).⁶⁹

(e.g., social services, juvenile justice, schools, and health) that go well beyond the functions of a typical managed care organization and that evince a public role absent in a system where Medicaid funds are managed by private MCOs. For the foregoing reasons, the newer LME/MCO designation for area authorities may more appropriately denote the full scope of area authority functions and more fully recognize the unique role of a public managed care organization.

64. G.S. 122C-117; G.S. 122C-115.2.

65. G.S. 122C-117; G.S. 122C-115.4; G.S. 122C-115.2.

66. A provider is qualified to contract with an area authority if it meets the provider qualifications set forth in rules adopted by the secretary. S.L. 2007-504 amended subsections (d) and (e) of G.S. 122C-141 to replace references to the secretary with references to the Commission for MH/DD/SA Services as the rulemaking entity responsible for promulgating rules defining provider qualifications. S.L. 2007-504 also amended G.S. 122C-114 to add to the powers and duties of the rulemaking commission the duty to adopt rules establishing the qualifications necessary to be a qualified provider. Nevertheless, S.L. 2007-504 left intact the language in G.S. 122C-141(a) that says provider qualifications are defined by the secretary.

67. A standard contract, adopted by the secretary of DHHS, must be used when contracting with qualified providers for the provision of MH/DD/SA services.

68. G.S. 122C-115.2; G.S. 122C-115.4; G.S. 122C-141; G.S. 122C-142.

69. G.S. 122C-115.4; G.S. 122C-115.2.

- *Utilization management.* The area authority's utilization management program must comply with federal Medicaid regulations and include a written utilization management plan that addresses the procedures used to review and approve requests for services, identifies the clinical criteria used to evaluate the medical necessity of the service being requested, and describes the mechanism used to detect underutilization or overutilization of services.⁷⁰ Even after services are authorized and paid for, the LME/MCO must conduct post-payment reviews to ensure that authorized services were clinically appropriate and provided in accordance with state standards. The LME also must authorize the utilization of state psychiatric hospitals and other state facilities and prioritize the needs of individuals waiting to participate in the NC Innovations Waiver.
 - *Care coordination.* The LME is responsible for individual care decisions at critical treatment junctures (discharge from inpatient facilities, admission to hospital emergency departments, court order to outpatient treatment, transfer from one service to another, movement from a state developmental center to community placement) to assure that client care is coordinated, received when needed, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. Care coordination must be provided by clinically trained professionals with the authority and skills necessary to determine appropriate diagnosis and treatment, approve treatment and service plans, link clients to higher levels of care when necessary, resolve disagreements between providers and clinicians, and consult with clinicians, providers, case managers, and utilization reviewers. Specific care coordination activities are required for high-risk/high-cost consumers and consumers of services with unstable medical and MH/DD/SA diagnoses.⁷¹
5. *Quality management.* The area authority must develop procedures for monitoring and evaluating the quality of services.⁷² Consistent with this requirement, the DMHDDSAS contract requires the area authority to establish a quality management (QM) committee to identify and address opportunities to improve LME/MCO operations and the local service system, with input from providers, consumers of services, family members of consumers, and other stakeholders. The LME/MCO must implement a process for the timely identification, response, reporting, and follow-up to consumer incidents and stakeholder complaints about service access or quality. This and other data are available for the QM committee's review, as the LME/MCO must also produce reports that summarize and analyze patterns and trends related to consumers (outcomes, services used, and critical incidents); providers (quality, access by population group, underserved populations, service capacity, barriers to care, system performance); and LME/MCO operations (volume and costs of services, STR processes, management of funds, complaint response). Pursuant to federal regulations, the DMA contract requires the area authority to submit to an annual external quality review by an independent quality review organization hired by DMA.⁷³
 6. *Community collaboration.* The LME/MCO must collaborate with other local service systems and other area authorities and state facilities to ensure access to and coordination of services at the local level.⁷⁴ This includes establishing and maintaining effective collaborative working relationships with departments of social services, local health departments, community hospitals, housing and homeless services agencies, vocational rehabilitation and employment agencies, domestic violence agencies, jails, detention centers, training schools, prisons, public schools, colleges, universities, law enforcement agencies, courts, corrections agencies, juvenile court counselors, Community Care Networks, and other public agencies and health care providers. In addition, the LME/MCO must engage in local service planning to ensure the efficient and effec-

70. 42 C.F.R. § 456 and 42 C.F.R. § 438, Subpart D; DMA Contract, Section 7.4.

71. G.S. 122C-115.4. *See also* DMA Contract, Section 6.13.

72. G.S. 122C-191; G.S. 122C-115.2(b)(1)f.

73. 42 C.F.R. §§ 438.310 through 438.370; DMA Contract, Section 7.

74. G.S. 122C-115.2.

tive use of all funds for targeted services, a planning process that must be open to key stakeholders.⁷⁵ Specifically, the area authority is charged with coordinating with Treatment Accountability for Safer Communities the provision of services to criminal justice clients and coordinating and providing services to juveniles in the custody of the Division of Adult Corrections and Juvenile Justice of the Department of Public Safety.⁷⁶

7. *Consumer affairs.* The LME/MCO must establish a client rights committee for protecting consumer rights and a consumer complaint and appeals process.⁷⁷ The area authority must adopt and implement grievance and appeals procedures for Medicaid enrollees that meet federal and state requirements⁷⁸ and are approved in writing by DMA.⁷⁹ These procedures permit Medicaid enrollees to appeal the denial or reduction of services. The LME/MCO must establish and support an effective consumer and family advisory committee (advisory to the governing board) and conduct community outreach and education.⁸⁰ For more on the consumer and family advisory committee, see the section entitled “The Role of Consumers and Families.”
8. *Financial management and accountability.* The LME/MCO must carry out business functions in an efficient and effective manner and manage resources dedicated to public services—and information related to the delivery of services—in a manner that is accountable to state and local government funding sources.⁸¹ The area authority must review provider reimbursement claims for proper documentation and pay claims promptly according to state requirements. (This *claims processing* function is listed separately from *financial management* in the DMHDDSAS contract.) To minimize the risk associated with operating under an at-risk, capitated Medicaid funding model, the area authority must maintain a restricted reserve account equal to 15 percent of the annualized cost of the DMA contract so that it may meet any cost overruns related to program services covered by the DMA contract. Every six months, the area authority must demonstrate to DHHS that it has made (1) adequate provision against the risk of insolvency with respect to funding for Medicaid enrollees,⁸² (2) timely provider payments,⁸³ and (3) an adequate exchange of information (billing, payment, and other transaction data). For information on the local government finance laws applicable to area authorities, see “Area Board Powers and Duties” in the section entitled “The Governing Board.”
9. *Information management analysis and reporting.* The LME/MCO is required to collect and manage information relating to the delivery of publicly funded services.⁸⁴ The DMHDDSAS contract requires the area authority to maintain an information technology (IT) infrastructure that complies with federal laws governing the privacy and security of electronic health records and that includes accurate and up-to-date consumer information and eligibility records. The LME/MCO must submit to DHHS, and ensure that providers submit to the LME/MCO, timely consumer information, including information regarding screening, admission, discharge, and eligibility determinations. In addition, the area authority must maintain a website that includes current and accurate information on how consumers and families may access services. The DMA contract also imposes numerous data requirements concerning the collection and reporting of provider claims and clinical information as well as requirements governing the capabilities of the area authority’s IT infrastructure.

75. G.S. 122C-115.2; G.S. 122C-115.4.

76. G.S. 122C-117.

77. G.S. 122C-64; G.S. 122C-115.4.

78. 42 C.F.R. § 438, Subpart F; G.S. Ch. 108D.

79. G.S. Ch. 108D.

80. G.S. 122C-115.4; G.S. 122C-64; G.S. 122C-170.

81. G.S. 122C-115.2; G.S. 122C-115.4; G.S. 122C-124.2.

82. G.S. 122C-124.2. See note 38.

83. G.S. 122C-124.2. See note 39.

84. G.S. 122C-115.4.

The Governing Board

The area authority is governed by an area board whose members are appointed by the board or boards of county commissioners for the county or counties participating in the area authority.⁸⁵ Each board of county commissioners within an area authority must adopt an area authority business plan that, among other things, describes the area board composition, selection and appointment process, and procedure for notifying each board of county commissioners of all appointments made to the area authority board.⁸⁶

Area Board Appointment and Composition

An area board must have no fewer than eleven and no more than twenty-one voting members, plus two nonvoting members. The board of county commissioners for a county served by a single-county area authority appoints the members of the area board. The boards of county commissioners for the counties participating in a multi-county area authority have the authority to appoint the members of the multi-county area board. The statute is silent on the manner of appointment other than to say that the process for appointing multi-county area board members must ensure participation from each of the constituent counties of the area authority, leaving counties that participate in a multi-county area authority the discretion to devise and agree to a selection and appointment process.⁸⁷

The boards of county commissioners within a multi-county area authority with a population of at least 1,250,000 have the option to appoint members of the area board “in a manner and with a composition other than as required” by G.S. 122C-118.1. To exercise this option, each county participating in the area authority must adopt a resolution to that effect, and the secretary of DHHS must grant approval in writing. Unless such a waiver of the statutory requirements is granted, the area board must include the following:

1. At least one member who is a current county commissioner.
2. The chair of the area authority’s Consumer and Family Advisory Committee (CFAC) or the chair’s designee.
3. At least one family member of the CFAC, as recommended by the CFAC, representing the interests of individuals with mental illness, individuals with intellectual or other developmental disabilities, and individuals in recovery from addiction.
4. At least one openly declared consumer member of the CFAC, as recommended by the CFAC, representing the interests of individuals with mental illness, individuals with intellectual or other developmental disabilities, and individuals in recovery from addiction. (Categories 2 through 4 must be used to appoint one member who represents individuals with mental illness, one who represents individuals with intellectual or other developmental disabilities, and one who represents individuals in recovery from addiction.)
5. An individual with health care expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.
6. An individual with health care administration expertise consistent with the scale and nature of the managed care organization.
7. An individual with financial expertise consistent with the scale and nature of the managed care organization.
8. An individual with insurance expertise consistent with the scale and nature of the managed care organization.
9. An individual with social services expertise and experience in the fields of mental health, intellectual or other developmental disabilities, or substance abuse services.
10. An attorney with health care expertise.
11. A member appointed by the secretary of Health and Human Services who represents the general public and who is not employed by or affiliated with the Department of Health and Human Services.

85. G.S. 122C-118.1.

86. G.S. 122C-115.2(b)(2) and -117(a)(8).

87. G.S. 122C-118.1.

12. The president of the area authority's Provider Council or the president's designee to serve as a nonvoting member and who shall participate only in meetings open to the public.
13. An administrator of a hospital providing mental health, developmental disabilities, and substance abuse emergency services to serve as a nonvoting member and who shall participate only in meetings open to the public.

While the board must include representation from all of the categories identified above, county commissioners may elect to appoint a member of the area board to fill concurrently two categories of membership if the member has the qualifications and attributes of the two categories of membership.⁸⁸ If the boards of county commissioners responsible for board appointments do not comply with the compositional requirements, or have not utilized the waiver that may be granted for catchment areas containing 1.25 million or more people, the secretary of Health and Human Services must appoint the unrepresented categories.

Except for the two nonvoting members, an individual who contracts with the area authority to provide mental health, developmental disabilities, and substance abuse services may not serve on the area board for the period during which the contract for services is in effect. No person registered as a lobbyist under Chapter 120C of the General Statutes may be appointed to serve on an area board.

Area Board Terms, Officers, and Meetings

Commissioner members on the area board serve in an ex officio capacity at the pleasure of the initial appointing authority for a term not to exceed three years or the member's service as a county commissioner, whichever is earlier. County manager members on the area board serve at the pleasure of the initial appointing authority for a term not to exceed three years or the member's employment as a county manager, whichever is earlier. Other area board members serve three-year terms, except that upon initial formation of an area board to bring it into compliance with the 2012 legislation⁸⁹ that set forth the compositional requirements discussed above, one-third of the board members must be appointed for one year, one-third for two years, and all remaining members for three years. No member may serve more than three consecutive terms.

Area board members may be removed with or without cause by the person or group authorized to initially appoint the member. The area board may declare vacant the office of an appointed member who fails to attend three consecutive scheduled meetings without justifiable excuse. If a vacancy occurs on the area board before the end of the term, the person or group who initially filled the seat must choose a replacement before the end of the term of the vacated seat or within ninety days of the vacancy, whichever occurs first, and the appointment must be for the remainder of the unexpired term.

Area board members elect the area board chair, who may be a commissioner member of the area board, to serve a one-year term.⁹⁰ The area board must meet at least six times per year. Meetings are called either by the board chair or by three or more members who have given written notice to the chair.

Area Board Finance Committee

The area board must establish a finance committee that meets at least six times per year to review the financial strength of the area authority.⁹¹ This committee must have at least three members, two of whom have expertise in budgeting and fiscal control. The area board member who is the individual with financial expertise, or any county finance officer serving on the board, must serve on the finance committee as an ex officio member. All other finance officers of the counties participating in a multi-county area authority may serve on the finance committee as ex officio members. If the area board so chooses, the entire area board may function as the finance committee, but its meetings as a finance committee must be distinct from its meetings as an area board.

88. G.S. 122C-118.1(c).

89. S.L. 2012-151.

90. G.S. 122C-119.

91. *Id.*

Area Board Training

All area board members must receive initial orientation on area board member responsibilities and annual training provided by DHHS that includes training on fiscal management, budget development, and fiscal accountability.⁹² A member's refusal to be trained is grounds for removal. The DMHDDSAS contract also requires that the LME/MCO provide annual training, information, or support to ensure that the board actively reviews regular reports on finances, system performance, unmet service needs, provider capacity, and provider compliance with service requirements, and trends in service utilization, consumer health and safety, customer service, and complaints and appeals.

Area Board Powers and Duties

The area board exercises specific powers and duties set forth in the North Carolina General Statutes and the North Carolina Administrative Code. In addition, the DMA and DMHDDSAS contracts that the area authority enters into with DHHS for Medicaid and non-Medicaid funding have additional, often more detailed, requirements related to the implementation of these duties.

Some statutory duties, expressed in broad general terms, can be viewed as encompassing many of the more discrete duties listed below. For example, the board is legally responsible for ensuring, within available resources, the provision of mental health, developmental disabilities, and substance abuse services to citizens in the area authority's catchment area.⁹³ So that the board may carry out this broad charge, statutory law also requires the board to assess community needs, contract for services, and evaluate service quality.

In another broadly stated charge, statutory law requires the area board to "[e]ngage in comprehensive planning, budgeting, implementing, and monitoring of community-based" services.⁹⁴ One particular responsibility related to this general charge is the duty to adopt an annual budget. Another is the duty to develop an *LME business plan* for the management, delivery, and oversight of community services.⁹⁵ This plan must be in effect for at least three years and must address how the area authority will carry out the management functions described above under "Agency Functions." The LME business plan must be submitted for approval to the board or boards of county commissioners participating in the area authority before being submitted to the secretary of DHHS for approval.

Because the area board is composed of individuals volunteering their time and expertise at board meetings that may occur at the statutory-minimum frequency of six times per year, the board must rely on the area director and staff to carry out many of the tasks associated with these legal responsibilities; thus, the level of direct board involvement in the operation of the area authority is limited. Nevertheless, some legal responsibilities listed below, including the adoption of certain policies mandated by law, require direct action by the board. For example, the area board must appoint and annually evaluate the area director, develop an LME business plan, adopt an annual budget, and establish a finance committee.

Services. The board's statutory responsibilities related to service provision include the power and duty to do the following:

- Determine the needs of the area authority's clients and annually assess the area authority's ability to meet those needs.⁹⁶
- Enter into contracts for the provision of services.⁹⁷
- Assure that services meet state standards and comply with federal requirements as a condition of receipt of federal grants.⁹⁸

92. G.S. 122C-119.1.

93. G.S. 122C-2; G.S. 122C-117; G.S. 122C-115.4.

94. G.S. 122C-117; G.S. 122C-115.4.

95. G.S. 122C-117; G.S. 122C-115.2.

96. G.S. 122C-117.

97. G.S. 122C-141.

98. G.S. 122C-117.

- Develop procedures for monitoring and evaluating the quality of services and assure that services provided are of the highest possible quality within available resources.⁹⁹
- Perform public relations and community advocacy functions.¹⁰⁰
- Submit to DHHS and the boards of county commissioners quarterly service delivery reports that assess the quality and availability of services within the area authority's catchment area and an annual report that assesses progress toward implementing service plans and achieving service goals and outcomes.¹⁰¹
- Recommend to the board of county commissioners the creation of local program services.¹⁰²

In addition, the General Statutes point the board's attention to specific service areas by requiring a crisis response service that includes triage and referral of clients within one hour of notification to appropriate face-to-face crisis providers, coordination with the Treatment Accountability for Safer Communities program, provision of services to criminal justice clients, and coordination and provision of services to juveniles in the custody of the Division of Adult Corrections and Juvenile Justice of the Department of Public Safety.¹⁰³

Client rights and consumer affairs. The area board has the power and duty to do the following:

- Establish a local consumer and family advisory committee to advise the area authority on its planning and management of community services.¹⁰⁴
- Establish a client rights committee that monitors services for compliance with client rights, reports annually to the area board, and establishes review procedures for client grievances.¹⁰⁵
- Adopt and implement for Medicaid enrollees grievance and appeals procedures that meet federal and state requirements¹⁰⁶ and are approved in writing by DMA.¹⁰⁷

Budget and finance. In the area of budget and fiscal control, the area board must do the following:

- Establish a finance committee that meets at least six times a year to review the financial strength of the area authority.¹⁰⁸
- Develop and maintain an annual budget as required by the Local Government Budget and Fiscal Control Act.¹⁰⁹
- Submit the area authority budget to the participating boards of county commissioners and county managers for informational purposes.¹¹⁰
- Submit quarterly reports on the financial status of the area authority 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.¹¹¹
- Prepare annual financial statements that set out the financial position of the area authority as of the end of the fiscal year and the financial results of operations during the course of the year.¹¹²
- Appoint a budget officer to serve at the pleasure of the area board.¹¹³

99. G.S. 122C-191.

100. G.S. 122C-117.

101. *Id.*

102. *Id.*

103. *Id.*

104. G.S. 122C-170.

105. G.S. 122C-64.

106. 42 C.F.R. § 438, Subpart F; G.S. Ch. 108D.

107. G.S. Ch. 108D.

108. G.S. 122C-119.

109. G.S. 122C-117; G.S. 122C-144.1.

110. G.S. 122C-117.

111. *Id.*

112. G.S. 159-34.

113. G.S. 159-9. G.S. 122C-121 charges the area director with developing the area authority budget for review by the area board. Because this is a budget officer responsibility under G.S. 159-11, one might conclude that the area director, by virtue of holding

- Appoint a finance officer unless the area director appoints the finance officer. The finance officer may be appointed by either the area board or the area director to serve at the pleasure of the appointing board or director.¹¹⁴
- Hire an independent certified public accountant to complete an annual audit for submission to the Local Government Commission in conformance with the Local Government Budget and Fiscal Control Act.¹¹⁵
- Submit to each board of county commissioners of participating counties a copy of the area authority's annual audit.¹¹⁶
- Enter into a memorandum of agreement (DMHDDSAS contract) with the secretary of DHHS for the purpose of ensuring that state funds are used in accordance with priorities expressed in the area authority's business plan.¹¹⁷
- Maintain a restricted risk reserve account equal to 15 percent of the annualized cost of the DMA contract to meet any outstanding obligations, such as cost overruns, related to services covered by the contract.
- Implement for the area authority and its contract providers the family income co-payment schedule adopted by the secretary of DHHS under G.S. 122C-112.1(a)(34). An LME and its contract provider agencies must make every reasonable effort to collect appropriate reimbursement for the costs of services from individuals or entities able to pay, including insurance and third parties who cover the cost of care.¹¹⁸

Human Resources. Statutory duties related to human resources require the area board to do the following:

- Appoint an area director to serve at the pleasure of the area board.¹¹⁹
- Evaluate annually the area director for performance based on criteria established by the area board and the secretary of DHHS.¹²⁰
- Establish a salary plan that sets the salaries for area authority employees in conformance with the State Human Resources Act.¹²¹
- Adopt and enforce a professional reimbursement policy that (1) requires fees for services provided directly by the area authority be paid to the area authority (not to its employees), (2) prohibits area employees from providing on a private basis services that require the use of area program resources and facilities, and (3) allows area employees to accept dual compensation and dual employment only if they first obtain the written permission of the area authority.¹²²

In addition to the powers and duties listed above, the area authority may add one or more additional counties to its catchment area upon the adoption of a resolution to that effect by a majority of the members of the area board and with the approval of the secretary of DHHS.¹²³

that position, is the budget officer for the area authority and the area board need not appoint a budget officer. It is not entirely clear, however, that the area director's budget duty expressed in G.S. 122C-121, by itself, relieves the multi-county area board of the duty, set forth in G.S. 159-9, to appoint a budget officer. Of course, the multi-county area board could choose to impose the duties of budget officer on the area director.

114. G.S. 159-24.

115. G.S. 122C-144.1.

116. G.S. 122C-117.

117. G.S. 122C-115.2(d).

118. G.S. 122C-146.

119. G.S. 122C-117; G.S. 122C-121.

120. G.S. 122C-121.

121. G.S. 122C-156. Approval of the plan by the board or boards of county commissioners is not required unless the salary plan for a single-county area authority exceeds the county's salary plan, or the salary plan for a multi-county area authority exceeds the highest paying salary plan for any county within the area authority's catchment area.

122. G.S. 122C-157.

123. G.S. 122C-115(c1).

The area board has the power to lease and purchase real property¹²⁴ and, with the approval of the Local Government Commission, the power to borrow money.¹²⁵ The area board also has the power to contract for the purchase, lease, or lease-purchase of personal property, including equipment necessary for the operation of the area authority. The area board may purchase life insurance, health insurance, or both for the benefit of all or any class of area authority officers or employees as part of their compensation.¹²⁶ In addition, the area board may enter into a contract to insure the area authority, board members, and employees against civil liability for damages caused by the actions of agents, board members, or employees of the area authority when acting within the course of their duties or employment.¹²⁷

The board also has implicit authority to enter into other contracts necessary to carry out its duty to provide services. Examples of contracts necessary to the performance of area authority functions are contracts for the construction and repair of facilities and contracts for professional or other services not directly related to client services.

Finally, the area board is required to establish informal dispute resolution procedures for (1) persons who claim that the area authority's failure to comply with state laws adversely affected their ability to participate in planning or budgeting processes, (2) clients or contractors who claim that the area authority acted arbitrarily and capriciously in reducing funding for services, (3) contractors who claim that the area authority did not act within applicable law when imposing a particular requirement, and (4) contractors who claim that the area authority imposed a requirement that substantially compromises their ability to fulfill the contract.¹²⁸

Area Board Role

As the governing body for the area authority, the area board bears ultimate responsibility for the execution of all powers and duties conferred by law on the area authority. But, as noted in the introduction to board powers and duties above, the board cannot directly carry out all powers and duties, nor can it perform the many agency functions associated with these duties. What, then, is the board's role beyond discharging those duties that require direct board action, such as adopting a budget or establishing a consumer and family advisory committee? The answer is that the board's role is not to *carry out* all agency responsibilities but to *be accountable* for all responsibilities—in other words, to make sure that the LME/MCO performs as required.

One significant phenomenon associated with area board responsibilities is that many of the subjects warranting board oversight emanate not from statute or published rules but from the area authority's two voluminous contracts with DHHS, which together currently amount to at least two hundred pages of reading. While this might be challenging to officials who need to understand and govern the agency, these contracts also provide the tools for board accountability. These contracts focus not only on LME/MCO functions and the many requirements related to the administration of these functions but also on the collection and reporting of data that the state uses to measure the performance of these functions. Accordingly, the contracts point to some of the operations and activities that area boards should pay attention to as well as the data that may be used to monitor these operations and activities.

In carrying out its responsibilities, the board should look to the statutory and contractual requirements relating to LME/MCO functions described above under "Agency Functions" in the section of this chapter entitled "Today's Area Authority." The board can utilize the performance data that the state requires the area authority to collect and report relating to these management functions, and it should work with staff to determine how this data can be reported to the board in a meaningful way that permits the board to measure the quality and effectiveness of the local service system. (Remember, the *LME Business Plan* is supposed to address how the area authority will carry out its management functions, including how it will ensure the quality of services and measure their effectiveness. Thus, the *LME Business Plan* could include a description of the board's role in evaluating the quality and effectiveness of services.)

124. G.S. 122C-147.

125. G.S. 122C-117.

126. G.S. 122C-156.

127. G.S. 122C-152; G.S.122C-153; G.S. 122C-142.

128. G.S. 122C-151.3; G.S. 122C-151.4.

When monitoring the LME/MCO's service-related functions, the area board, as well as county boards of commissioners and other interested persons, could utilize the following related performance data:¹²⁹

- *Access.* The area authority is required to report to the board, its consumer and family advisory committee, and DHHS access patterns and trends (number of persons requesting services; number determined to need emergency, urgent, and routine care; and number for which access is provided within the time periods defined in state performance standards). This data is helpful in evaluating the LME/MCO's *access* function.
- *Provider management.* The general duty to ensure the provision of services includes the duty to ensure the availability of qualified providers to deliver services, a matter that falls within the scope of the LME/MCO's *provider management* function. The area authority's service delivery reports submitted quarterly to counties include data on types of services delivered, number of persons served, and services requested but not delivered. This data speaks to the question of whether the area authority has adequately developed the capacity of its provider network. In addition, DMA may use the LME/MCO-DMA contract as a means for requiring the submission of other information related to an area authority's provider network. For example, DMA has used contract language to require the area authority to submit to DMA written reports of findings of the area authority's own provider network analyses and, whenever network gaps are identified, to submit to DMA a network development plan within a time frame specified by DMA. This kind of information would be central to any board's performance evaluation of the LME/MCO's provider management function.
- *Service management.* Data that pertains to the LME/MCO *service management* function includes the quarterly reports on service utilization patterns and trends that must be submitted to the area board and reports to DHHS on (1) utilization of services by service type (for example, inpatient, intensive outpatient, emergency department), (2) treated prevalence by age-disability category (number of persons who received treatment for a particular condition compared to number estimated to have that condition) and, (3) percentage of provider service authorization requests processed in the state-required time frame.
- *Quality management.* The area authority's *quality management* committee must review and quarterly report to the area board and CFAC on consumer trends (client outcomes, use of emergency services and state hospitals, perceptions of care), provider trends and performance (service capacity, provider quality), and LME operations (trends in volume and cost of services per consumer, access system data, management of state funds). The LME/MCO contract with DMA requires the area authority to submit data to DMA annually on quality of care measures as well as information on the area authority's performance improvement projects.

The Area Director

The area director, who is the administrative head of the area authority, is appointed by and serves at the pleasure of the area board. The area director appoints and supervises area authority employees, implements area board programs and policies, administers area authority services in compliance with state law, acts as a liaison between the area authority and DHHS, and provides information and advice to boards of county commissioners through the county manager.¹³⁰ In addition, the area director must develop the budget for the area authority for review by the area board.

Unless one of these qualifications is specifically waived by the secretary of DHHS, an area director must have a master's degree, management experience, and other related experience. Any area director hired after January 1, 2007, must meet the job classifications adopted for area directors by the Office of State Human Resources.¹³¹

129. This list is intended to be illustrative only, not exhaustive, as other data exists that the board may want to receive as monitoring reports. In addition, dumping huge quantities of data on the board and in a form that is not meaningful or helpful to the board's monitoring responsibilities can be overwhelming and counterproductive. Monitoring reports should present data in a way that is clearly tied to relevant goals and performance expectations. Monitoring is more than simply receiving lots of data. If an entity doesn't know what it is measuring and why, the data is not meaningful or useful.

130. G.S. 122C-121.

131. G.S. 122C-120.1.

The area board must annually evaluate the area director for performance based on criteria established by the area board and the secretary of DHHS. The secretary requires that the director be evaluated for performance in each of the following areas: (1) maintaining an effective relationship with the area board and the CFAC; (2) developing and maintaining effective relationships with the community served and with state and local officials; (3) encouraging consumer and family involvement in system management activities, including program development, quality management, and community development; (4) recruiting, monitoring, and maintaining effective relationships with qualified providers of services; (5) managing human resources; (6) managing fiscal resources; and (7) demonstrating leadership skills.¹³² In conducting the evaluation, the area board must consider comments from boards of county commissioners.¹³³

The area board must establish the area director's salary in accordance with the State Human Resources Act.¹³⁴ An area director may be paid a salary that is in excess of the salary ranges established by the State Human Resources Commission with prior approval of the director of the Office of State Human Resources. Any proposed salary that is higher than the maximum of the applicable salary range must be supported by documentation of comparable salaries in comparable operations within the region and must also include the specific amount the board proposes to pay the director.

The area board is not permitted to provide the director with any benefits that are not also provided by the area board to all permanent employees of the area authority, except that the area board may offer severance benefits, relocation expenses, or both to an applicant for the position of director as an incentive for the applicant to accept an offer of employment. Otherwise, the director may be reimbursed only for allowable employment-related expenses at the same rate and in the same manner as other employees of the area program.¹³⁵

Human Resources Administration

Human resources administration for area authority employees must be conducted in accordance with the State Human Resources Act and the rules and policies of the North Carolina State Human Resources Commission.¹³⁶ These rules and policies govern position classification, qualifications, recruitment, promotion, dismissal, compensation, personnel records, and nepotism (employment of relatives). For example, area authorities must use a competitive recruitment process that selects employees based on a relative consideration of the applicants' skills, knowledge, and abilities. Employees who have satisfactorily completed a probationary and/or trainee appointment may not be demoted, suspended, or dismissed except for "just cause" or reduction in force.¹³⁷ Under the just cause standard defined by the State Human Resources Commission, area employees may not be discharged, suspended, or demoted for disciplinary reasons without adequate procedural due process and a demonstration that just cause for the disciplinary action—unacceptable job performance or personal conduct—exists.

The area board is authorized, but not required, to purchase life insurance and health insurance for the benefit of all or any class of area authority officers or employees as part of their compensation. Other fringe benefits for officers and employees may also be provided.¹³⁸

132. The criteria are published in the North Carolina Administrative Code at title 10A, subchapter 27G, section .0507. That regulation also says that area boards may use the area director evaluation as an opportunity to create an annual plan for the area director that includes both policy and programmatic considerations.

133. G.S. 122C-121(b).

134. G.S. 122C-121(a1).

135. G.S. 122C-121(a2).

136. G.S. 122C-154.

137. These and other rules applicable to area authority employees are found in the North Carolina Administrative Code at title 25, subchapter 1I, section .1700.

138. G.S. 122C-156.

Budget and Fiscal Control

Like all other local governments and public authorities, the area authority's budgeting and fiscal management must be administered according to the Local Government Budget and Fiscal Control Act,¹³⁹ which prescribes a general system for adopting and administering a budget. Independent of the county governments that are involved in the establishment of the area authority, the area authority is responsible for its own budgeting, disbursing, accounting, and financial management under the direction of a budget officer appointed by the area board and a finance officer appointed by the area director or board.¹⁴⁰

All area authorities must operate under a balanced annual budget ordinance adopted by the area board. Except for funds used for certain purposes, all moneys received or expended by the area authority—whether federal, state, local, or private in origin—must be spent in accordance with the budget ordinance.

Each area authority also must complete and submit an annual independent audit to the Local Government Commission. Under the audit requirement, an independent certified public accountant examines the area authority's accounting records and other evidence supporting its financial statements to provide independent verification that the financial statements are credible and can be relied upon. This is called a *financial audit*. The accountant also conducts a *compliance audit* to determine whether the area authority has complied with requirements for receiving federal or state financial assistance.

The Role of Consumers and Families

In addition to requiring at least three representatives of consumers of services and their family members to serve on the governing body for the area authority, North Carolina law requires consumers and family members to serve in an advisory capacity on both the state and local levels of government.

Local Consumer and Family Advisory Committee

Every area authority must establish a Consumer and Family Advisory Committee (CFAC) to advise the local management entity on its planning and management of the local mental health, developmental disabilities, and substance abuse (MH/DD/SA) service system.¹⁴¹ Specifically, the CFAC must

1. review, comment on, and monitor the implementation of the LME 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 budget;
5. participate in all quality improvement measures and performance indicators; and
6. submit to the state CFAC findings and recommendations regarding ways to improve the delivery of services.

139. G.S. Ch. 159.

140. The *multi-county* area authority—because it is considered a *public authority* for purposes of the Local Government Budget and Fiscal Control Act—is responsible for its own budgeting and financial management. Before 2012, a single-county area authority was considered a department of the county in which it was located for purposes of budget and fiscal control (G.S. 122C-116), which meant that the single-county area authority had to present its budget for approval by the county commissioners in the manner requested by the county budget officer, and its financial operations had to follow the budget set by the county commissioners in the county's budget ordinance. In 2012, the General Assembly amended G.S. 122C-116 to delete the language stating that a single-county area authority was a department of the county for purposes of budget and fiscal control. S.L. 2012-151, sec. 2.(a). While it is not clear that this brought the single-county area authority within the scope of the term "public authority" as defined in G.S. Chapter 159, it did signal the legislature's intent that the single-county area authority no longer be a part of the budgeting and accounting system of any county but be independent of county government and under the sole governance of the single-county area board.

141. G.S. 122C-170.

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

The CFAC is composed exclusively of adult consumers of MH/DD/SA services and family members of consumers of services. People in each of the three disability groups—mental illness, developmental disabilities, and substance abuse—must be represented on the CFAC, and membership 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 three consecutive terms.

The law requires the CFAC to be self-governing and self-directed, indicating the legislative intent that the CFAC act independently of the LME staff and board, albeit with staff support, much like LME staff might support the LME board by providing needed information and logistical support. Each CFAC must adopt bylaws that govern the selection and appointment of its members, their number and terms of service, 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

The law also establishes the State Consumer and Family Advisory Committee (State CFAC) to advise the Department of Health and Human Services (DHHS) and the General Assembly on the planning and management of the state's public MH/DD/SA services system.¹⁴² This twenty-one-member body, composed exclusively of adult consumers of MH/DD/SA services and family members of consumers of services, must

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 of local CFACs regarding ways to improve the delivery of mental health, developmental disabilities, and substance abuse services; and
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, and the secretary of DHHS 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.

The Role of County Government

After increasing the role of county government in area authority affairs in 2001, the General Assembly has moved in the opposite direction since 2011. The 2001 Act to Phase In Implementation of Mental Health System Reform at the State and Local Level¹⁴³ enhanced the role of county government by involving county boards of commissioners in the

142. G.S. 122C-171.

143. S.L. 2001-437.

hiring of the area director, the monitoring of the area authority's fiscal health and service capacity, and the development and approval of the area authority business plan. Counties were given additional administrative options for carrying out their duty to provide mental health, developmental disabilities, and substance abuse (MH/DD/SA) services; they retained exclusive authority to appoint members of the governing board; and every county was represented on the area board by a county commissioner or county manager. Counties had the authority to dissolve an area authority and join with other counties to create a new one. The authority to acquire and hold title to real property used by an area authority was vested in the participating counties.

Since the advent of managed care, and starting with legislation enacted in 2011,¹⁴⁴ the role of county government has receded as much of the authority granted by the 2001 legislation has been eliminated—in some cases directly through statutory amendments, and in some cases indirectly through policy changes implemented by the executive branch of state government. Nevertheless, the law still provides for county responsibility and involvement in certain area authority matters.

Establishing and Dissolving the Area Authority

Counties are required to provide MH/DD/SA services through an area authority.¹⁴⁵ With the approval of the secretary of the Department of Health and Human Services (DHHS), a county, or two or more counties jointly, must establish an area authority to provide mental health, developmental disabilities, and substance abuse services.¹⁴⁶ Because statutory law has recently been amended to require each area authority to serve a catchment area population of at least 500,000 people, most single-county area authorities have had to join other area authorities to meet the population threshold, and the idea of establishing a single-county area authority is a remote consideration for most counties.

Until recently, counties could withdraw from, or jointly dissolve, an area authority if the board or boards of county commissioners determined that the authority was not operating in the best interests of its citizens and the change would not adversely affect the continuity of services. Now, the counties participating in a multi-county area authority no longer have the authority to jointly dissolve the area authority.¹⁴⁷ Only the secretary of DHHS may dissolve an area authority, and he or she is required to do so when an area authority fails to meet particular performance expectations for operating a managed care organization.¹⁴⁸ Individual counties retain the authority to withdraw or “disengage” from an area authority and “realign” with another one, but only pursuant to rules adopted by the secretary that address a number of matters specified by statute.¹⁴⁹ The authority to accept a new county into an existing area authority, once the province of the boards of county commissioners of the counties participating in the area authority, now belongs to the governing body for the area authority itself. Thus, while a board of county commissioners needs to act to disengage from an area authority and to join a new area authority, the counties participating in the area authority receiving that county no longer must act in concert to approve the addition of the new county.¹⁵⁰ A new county can be added by a majority of area board members adopting a resolution to that effect.¹⁵¹

144. S.L. 2011-264 required each LME to begin operating a 1915(b)/(c) Medicaid Waiver with approval of the secretary by January 1, 2013, and if an LME could not apply for and obtain secretary approval, to merge with an LME that had obtained approval to operate the waiver.

145. G.S. 122C-115(a).

146. G.S. 122C-115.

147. S.L. 2013-85, sec. 5(a).

148. G.S. 122C-124.2.

149. G.S. 122C-115(a3).

150. A contrary interpretation of the applicable law is possible. Statutory law still says that counties must establish an area authority (G.S. 122C-115). Arguably, when a county joins an existing area authority, a new area authority is being established, as the resulting change in the catchment area necessitates a new business plan, a new area board, and a new contract for managed care between the state and the area authority. Thus, it is possible that adding a county to an existing area authority catchment area requires *both* a joint resolution of the boards of commissioners for all of the counties in the new catchment area *and* a resolution adopted by the area board.

151. G.S. 122C-115(c1).

Appointing and Serving on the Area Board

Until 2013, many area boards were appointed by and composed primarily of county commissioners, and the membership of most multi-county area boards included a county commissioner from every county served by the area authority. This was due in part to a desire by each county to be represented by an elected official and also in part to the process used by commissioners for appointing area board members. The board appointment statute provided that each county in a multi-county catchment area would appoint a county commissioner to the area board. This group of commissioner members would then appoint the remaining members of the board, and the requirements for any particular categories of representation were few. As a result, the majority of most area board members were county commissioners, with one commissioner from each county served by the area authority. For example, East Carolina Behavioral Health, a nineteen-county area authority, had nineteen county commissioners on its area board. The Smoky Mountain Center had fifteen county commissioners, one from each of the fifteen counties participating in the area authority.

Changes in the compositional requirements for area boards no longer permit county commissioner representation from every county. Ten of the twenty-one voting members of the area board must be individuals with particular professional expertise or consumers of services or their family members. That leaves eleven board seats for other categories of representation—not enough to accommodate the appointment of a county commissioner from every county in a nineteen- or fifteen-county area authority. Some area authorities, like the eight-county Partners Behavioral Health Management or Sandhills Center area authorities can still accommodate a commissioner from every county. But the traditional practice of having each county represented by a county commissioner on the area board is no longer possible for a majority of counties.

For more on the composition and appointment of the area board, see the section of this chapter entitled “The Governing Board.”

County Commissioner Advisory Board

In 2013, the General Assembly established a county commissioner advisory board for each area authority to advise the authority and director on matters pertaining to the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders.¹⁵² Each board of county commissioners within the catchment area must designate one of its commissioner members to serve on the advisory board, and each board of commissioners may determine the manner of designation, the term of service, and the conditions of service for its designee. The advisory board must meet on a regular basis.

Local Management Entity Business Plan

Each county, through its area authority, must develop, review, and approve a business plan for the management and delivery of services and submit the plan for the approval of the North Carolina Secretary of Health and Human Services.¹⁵³ The business plan must remain in effect for at least three years and must address implementation of local management entity (LME) functions and other topics specified by statute. For example, the plan must address the area board composition and appointment process, the method for calculating county cash and in-kind contributions to the area authority, resources available and needed within the local area to prevent out-of-community placements, collaboration with other local service systems to ensure access to and coordination of services, and planning for services that identifies gaps in services and methods for filling those gaps. The statute also requires that local service planning related to development of the business plan involve key stakeholders and that the identification of resources available and needed to prevent out-of-community placements include input from other public agencies in the community.

While the business planning requirement is a clearly expressed statutory mandate, it has not been consistently and faithfully pursued by counties and area authorities since the last LME business plans were developed in 2006 and implemented for the three-year cycle beginning July 1, 2007. This is likely due, in part, to the fact that many view the

152. G.S. 122C-118.2.

153. G.S. 122C-115.2.

business planning process as an anachronistic requirement that was developed during mental health reform before the system moved to managed care and therefore as having less relevance now. As well, some may feel that, given the fast pace of change in the system since the implementation of managed care, the expenditure of resources to engage in a time-consuming community planning process among multiple local governments is not appropriate or even possible, and any resulting plan might be out-of-date by the time it is completed. The General Assembly seemed to acknowledge some of these factors when, in 2012, it granted the secretary the authority to waive any requirements of the business planning statute that are inconsistent or incompatible with contracts entered into between DHHS and the area authority for carrying out the 1915(b)/(c) Medicaid Waiver.¹⁵⁴ At the date of this publication, the secretary had not expressly exercised this authority.

For county government, even though its role under the Medicaid Managed Care Waiver is diminished relative to the role granted by the 2001 mental health reform legislation, the development and periodic renewal of the business plan provide opportunities to influence the area authority's planning for such things as service provision and collaboration with other local government service systems. Because county government has no direct control over the governance and management of area authorities, the business planning process provides one of the few vehicles for county input. Moreover, required elements of the business plan not only relate directly to such LME functions as collaboration with other local service systems and planning to close gaps in services but also are intended to address county appointments to the area board and county funding to the area authority, all matters of concern to county commissioners and many of the citizens they serve.

Funding

Counties must appropriate funds to the area authority serving their catchment area without regard to whether any area authority programs are physically located within the county.¹⁵⁵ Cities may appropriate funds to support the area authority. Counties and cities may appropriate funds from revenues not restricted by law, and counties may fund appropriations by levy of property taxes pursuant to G.S. 153A-149(c)(22).

Counties may not reduce county appropriations and expenditures for current operations and ongoing services of area authorities because of revenues available to the area authority from state-allocated funds, client fees, capitation amounts, or fund balance.¹⁵⁶ Counties may reduce county appropriations from the amount previously appropriated for one-time or nonrecurring special needs of the area authority. This "non-supplant" restriction on reductions in county appropriations for ongoing services limits the authority of counties to reduce appropriations to area authorities in response to the availability of funding from other sources.

Oversight

To facilitate county oversight of the community-based service system, area authorities must make regular reports to their participating board or boards of county commissioners regarding the area authority's financial health and service capacity. These reports include quarterly financial reports,¹⁵⁷ quarterly service delivery reports that assess the quality and availability of services within the area authority's catchment area, and an annual progress report assessing the

154. S.L. 2012-151, sec. 9.(b), amending G.S. 122C-115.2. "The Secretary may waive any requirements of this section that are inconsistent with or incompatible with contracts entered into between the Department and the area authority for the management responsibilities for the delivery of services for individuals with mental illness, intellectual or other developmental disabilities, and substance abuse disorders under a 1915(b)/(c) Medicaid Waiver."

155. G.S. 122C-115(b).

156. G.S. 122C-115(d).

157. 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. 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 county finance officer that the report has not been submitted as required. At the request of the board of county commissioners, the report may be presented in person by the area director or the director's designee.

area authority's ability to meet the service needs of its catchment area.¹⁵⁸ As a practical matter, these area authority duties serve informational purposes and, while the board or boards of county commissioners can comment on this information, the county boards have no governing authority with respect to the matters reported. However, the subjects of these reports do relate to elements of the LME business plan, discussed above, which must be developed with the participation of the county board of commissioners for each county participating in the area authority.

Property

Until 2012, the authority to purchase and hold title to real property used by an area authority was vested in the county where the property was located. This authority could be delegated to the area authority, but it required a resolution of the boards of county commissioners of all the counties within the area authority's catchment area. These provisions were deleted in 2012, and now an area authority has the authority to acquire and hold title to real property without needing the approval of county government.¹⁵⁹

Budget and Fiscal Control

Until 2012, a single-county area authority was considered a department of the county for purposes of the Local Government Budget and Fiscal Control Act.¹⁶⁰ Thus, its administration was linked to county administration in ways not characteristic of the more independent multi-county authorities. The single-county area authority presented its budget for approval of the county commissioners in the manner requested by the county budget officer, and its financial operations had to follow the budget set by the county commissioners in the county's budget ordinance. The ability of the board of county commissioners to approve the budget of the single-county area authority gave the commissioners a substantial role in determining the budget, the scope of services available to county residents, and the number of personnel positions within the area authority. In addition, the county had responsibility for fiscal management and could require that all disbursements, receipts, and financial management of the area authority be handled by the county's finance officer.

In 2012, the General Assembly deleted statutory language that referred to the single-county area authority as a department of the county for purposes of budget and finance, and that statute now refers to all area authorities as local political subdivisions of the state.¹⁶¹ As a consequence, a single-county area authority appears to have the same status as a multi-county area authority, which is not a part of the budgeting and accounting system of any county but is responsible for its own budgeting, disbursing, accounting, and financial management under the direction of a budget officer and finance officer appointed by the area authority.

Because all counties must appropriate funds to the area authority serving them, boards of commissioners, depending on the size of their appropriations, have the potential to shape or influence the area authority budget and services—particularly services for indigent citizens who would not qualify for services funded by Medicaid or other state appropriations, the two primary sources of revenue for area authority services. To keep counties apprised of the area authority's budget policy and financial status, a multi-county area authority must submit its approved budget and annual audit to the participating boards of county commissioners for informational purposes.¹⁶²

Human Resources

Before 2012, the area board's appointment of the area director was subject to the approval of the boards of county commissioners for the counties within the area authority's catchment area. In addition, a county manager and at least one county commissioner had to sit on the area board search committee involved in selecting the new area director. While

158. G.S. 153A-453; G.S.122C-117.

159. G.S. 122C-147.

160. G.S. Ch. 159. For more about the Local Government Budget and Fiscal Control Act, see Chapter 20, "Budgeting for Operating and Capital Expenditures."

161. S.L. 2012-151, sec. 2.(a).

162. G.S. 122C-117.

these statutory provisions have been deleted,¹⁶³ the law still retains a role for county commissioners in the director's annual performance evaluation. The relevant statute does not express any formal mechanism for obtaining county commissioner input on the performance evaluation, but it directs the area board to "consider comments from the board of county commissioners."¹⁶⁴ County commissioner comment seems particularly appropriate when considering that the same statute lists among the area director's duties the obligation to provide information and advice to the county commissioners through the county manager, and the DHHS secretary criteria for evaluating director performance includes the director's performance in developing and maintaining effective relationships with local officials.

Employees under the direct supervision of the area authority are area employees, not county employees. Nonetheless, county personnel policies may apply to area employees in certain circumstances, and counties may pursue statutory options to bring the personnel administration of a single-county authority within the county personnel system. The degree to which county personnel policies may regulate area employees depends in part on whether the area authority is a single-county or multi-county authority and in part on whether a county affirmatively acts to exert authority over area employees.

In the case of a single-county area authority, the board of county commissioners may prescribe for area employees rules governing annual leave, sick leave, hours of work, holidays, and the administration of the pay plan, if these rules are adopted for county employees generally.¹⁶⁵ The State Human Resources Act also appears to grant the same authority to counties that comprise the catchment area of a *multi-county* authority, but the respective boards of county commissioners would have to jointly exercise this authority and apply the rules to their respective county employees, an unlikely course of action given the large number of counties participating in most area authorities. The county rules must be filed with the director of the Office of State Human Resources in order to supersede any rules adopted by the State Human Resources Commission.

The county served by a single-county area authority has the option of bringing area employees within the county system of personnel administration. If the board of county commissioners establishes and maintains a personnel system for all county employees and that system is approved by the State Human Resources Commission as being substantially equivalent to the state's personnel system for area authority employees, then the county personnel system will cover employees of the area authority.¹⁶⁶ In this case, employees covered by the county system would be exempt from the State Human Resources Act, but the provisions on equal opportunity for employment and compensation would continue to apply. In order for the county personnel system to be deemed substantially equivalent, it would have to meet the State Human Resources Commission's basic requirements for recruitment, selection, advancement, classification, compensation, suspension, dismissal, and affirmative action.

As for multi-county area authorities, county governments have no independent authority to substitute a substantially equivalent personnel system for the state rules of human resources administration.

Looking Ahead

While preliminary assessments of North Carolina's Medicaid managed care program for MH/DD/SA services indicate that cost savings are being achieved,¹⁶⁷ and while LMEs are still developing and perfecting the multiple and complex changes required to implement the newly minted managed care program, the future of North Carolina's public system of community MH/DD/SA services remains as uncertain as ever. As has been the case since 2001, the only constant on

163. S.L. 2012-151, sec. 9.(a).

164. G.S. 122C-121.

165. G.S. 126-9(a); G.S. 153A-94.

166. G.S. 126-11.

167. For example, based on the first three LMEs to implement managed care, DHHS reports that the per member (Medicaid enrollee) per month cost for services decreased on average by 10 percent and the state-funded cost of LME administration decreased by 9 percent. North Carolina Department of Health and Human Services, Proposal to Reform North Carolina's Medicaid Program, Report to North Carolina General Assembly (March 17, 2014), p. 28.

the horizon is the prospect for further change. While some proposed changes might be considered a natural or logical extension of prior changes—in a sense, the further evolution of managed care as ever more sophisticated techniques and measures are developed—other proposals involve more fundamental questions about the function, structure, and public nature of North Carolina’s managed care organizations, as well as the size of the geographic areas they serve.

The 2014 General Assembly cut administrative funding to LME/MCOs based on the assumption that the nine LME/MCOs will consolidate into seven or fewer entities by June 30, 2015.¹⁶⁸ This action follows the presentation of a Medicaid reform plan by DHHS to the General Assembly on March 17, 2014, that recommends consolidating area authorities into four LME/MCOs, increasing DHHS review and oversight of LME/MCO operations, requiring LME/MCOs to implement more objective outcome and performance measures, and engaging organized groups of health care providers (accountable care organizations) to coordinate and manage physical health services for Medicaid beneficiaries.¹⁶⁹ Under the plan, LME/MCOs and accountable care organizations would collaborate to integrate physical and behavioral health care.

On two fundamental matters—whether to proceed with LME/MCOs as managed care organizations for MH/DD/SA services and whether to create a new department responsible for Medicaid services—the two houses of the 2014 General Assembly could not agree. During the regular legislative session, the House passed a Medicaid reform bill generally aligned with the DHHS Medicaid reform plan.¹⁷⁰ The Senate passed and sent to the House a committee substitute that, among other things, would eliminate the DHHS Division of Medical Assistance and move Medicaid responsibility to a new Department of Medical Benefits run by a board of business, health care, and health insurance leaders. The Senate committee substitute would also, it appears, end LME/MCO responsibility for managing MH/DD/SA services under the state’s current federally approved Medicaid waiver and instead require that these services be managed together with other Medicaid health care services by private managed care companies.¹⁷¹ On July 30, 2014, the House failed to concur with the Senate plan, and the General Assembly adjourned its 2014 Regular Session on August 20, 2014.¹⁷² It is not clear whether these policy issues will arise again in the next legislative session.

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