

**Potential Items for Consideration
by the Joint Legislative Oversight Committee on Mental Health,
Developmental Disabilities, and Substance Abuse Services**

- 1. FUNDS FOR SUBSTANCE ABUSE PROGRAMS – START-UP AND SERVICES**
- 2. SERVICE DOLLARS FOR MENTAL HEALTH**
- 3. INFLATIONARY- AND POPULATION-BASED INCREASE**
- 4. DEVELOPMENTAL DISABILITIES PROPOSALS**
- 5. UNIFORM SLIDING FEE SCHEDULE**
- 6. CRISIS START-UP AND SERVICES/ADDITIONAL FUNDS/POLICY REVISIONS**
- 7. ADDITIONAL HOUSING ASSISTANCE**
- 8. IMPLEMENTATION OF NEW LME ADMINISTRATIVE COST MODEL AND ADDITIONAL FUNDING NEEDED**
- 9. CLARIFY SCREENING/TRIAGE/REFERRAL ROLES**
- 10. RESTRUCTURE THE MH/DD/SA TRUST FUND**
- 11. FIRST COMMITMENT PILOT PROGRAM**
- 12. MENTALLY ILL IN ADULT CARE HOMES**
- 13. WAIVERS/FUNDING FLEXIBILITY**
- 14. HOSPITAL BED DAY ALLOCATION**
- 15. COUNTY JAILS AND JUSTICE SYSTEM – MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**
- 16. TRANSPORTATION**
- 17. ASSISTANCE FOR AND OVERSIGHT OF DHHS AND DMH/DD/SA**

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RECOMMENDATIONS FOR THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MH/DD/SAS

1/16/07

FUNDS FOR SUBSTANCE ABUSE PROGRAMS – START-UP AND SERVICES

BACKGROUND:

1. Services Gap Study found North Carolina currently provides a low intensity of service for its population with substance abuse disorders.
2. Estimated range of persons with substance abuse disorders in North Carolina is between 400,000 and 800,000 individuals.
3. To achieve national average per capita funding in SFY 2007-08 for substance abuse services, the Division estimates it would require over \$35,000,000.
4. The Center for Substance Abuse Treatment emphasizes that by itself detox does not constitute complete substance abuse treatment.
5. Integrating substance abuse treatment and vocational services employment has been positively correlated with retention in treatment.
6. Additional funds for service dollars in the second fiscal year, assumes more programs or more persons will be served based on utilization of start up funds used to start-up programs.

PROPOSAL:

1. Appropriate **\$10,000,000** for SFY 2007-08 and **\$15,000,000 recurring** for SFY 2008-09 to DHHS for additional service dollars for substance abuse.
2. Appropriate **\$10,000,000 non-recurring** for SFY 2007-08 and **\$5,000,000 non-recurring** for SFY 2008-09 to the North Carolina Mental Health Trust Fund to provide start up funds to develop new and expand current substance abuse programs.

Total Recommended Substance Abuse Services:

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
DHHS	\$10,000,000		\$10,000,000	\$25,000,000		\$25,000,000
MHTF		\$10,000,000	\$10,000,000		\$15,000,000	\$15,000,000
Total	\$10,000,000	\$10,000,000	\$20,000,000	\$25,000,000	\$15,000,000	\$35,000,000

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SERVICE DOLLARS FOR MENTAL HEALTH

BACKGROUND

1. One of the recommendations from the Services Gaps Study was for increased funding for mental health services. North Carolina ranked 43rd in per capita funding for mental health services nationally in 2003 in “Grading the States – A Report on America’s Health Care System for Serious Mental Illness” (a study by the National Alliance for the Mentally Ill).
2. An additional \$30 million per year for mental health services would increase North Carolina’s per capita spending on state-funded mental health services from \$17.36 to \$20.43 per capita (not factoring in any other proposed appropriations).

PROPOSAL

Appropriate \$30,000,000 recurring for mental health services.

Total Recommended Funding:

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
Mental Health Services	\$30,000,000		\$30,000,000	\$30,000,000		\$30,000,000
Total	\$30,000,000		\$30,000,000	\$30,000,000		\$30,000,000

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INFLATIONARY- AND POPULATION –BASED INCREASES

BACKGROUND

One of the recommendations from the Services Gaps Study was for funding to keep pace with inflation and population growth. This would allow the State to, at a minimum, continue serving the same number of people with the same level of service from year to year.

PROPOSAL

Assuming 2% inflation each year and using population estimates from the State Demographer, following is a summary of how much funding would be needed by disability for funding to keep pace with inflation and population growth:

1. Mental Health:
 - a. \$5,556,826 recurring in SFY 2007-08
 - b. An additional \$5,633,469 recurring in SFY 2008-09 for a total of \$11,190,294.
2. Substance Abuse:
 - a. \$1,372,952 recurring in SFY 2007-08
 - b. An additional \$1,391,889 recurring in SFY 2008-09 for a total of \$2,764,841.
3. Developmental Disabilities:
 - a. \$5,852,574 recurring in SFY 2007-08
 - b. An additional \$5,933,296 recurring in SFY 2008-09 for a total of \$11,785,870.

Total Recommended Funding:

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
Mental Health Services Funding Increase	\$5,556,826		\$5,556,826	\$11,190,294		\$11,190,294
Substance Abuse Services Funding Increase	\$1,372,952		\$1,372,952	\$2,764,841		\$2,764,841
Developmental Disability Services Funding Increase	\$5,852,574		\$5,852,574	\$11,785,870		\$11,785,870
Total	\$12,782,351		\$12,782,351	\$25,741,005		\$25,741,005

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DEVELOPMENTAL DISABILITIES PROPOSALS

BACKGROUND:

1. One of the recommendations of the Services Gaps Study was that more individuals should be served with Evidence Based Practices.
2. The Committee has heard that Sheltered Workshops, which the State currently funds, are not an Evidence Based Practice, but that Supported Employment is.
3. The Committee has also made it a priority to serve individuals with developmental disabilities in the community rather than institutions.
4. In 2006, CMS refused to approve Developmental Therapies [a/k/a Community Based Services] as a Medicaid reimbursable service for the developmentally disabled. The State moved to place as many persons as possible on CAP waivers and find other appropriate services. The Division also recommended, and the General Assembly appropriated, \$26 million to be used to "replace services lost due to changes in federal policy and cuts in federal support." It is not clear whether these funds were meant to "hold harmless" individuals who had been receiving CBS or whether they are meant to create a new service available regardless of whether a person had been receiving CBS.

PROPOSALS:

1. Appropriate \$1,500,000 for start-up and ongoing support of Supported Employment services.
2. Appropriate funds for an additional 100 slots in the Community Alternatives Program for Mental Retardation/Developmental Disabilities (CAP MR/DD). The Division of MH/DD/SAS projects that each additional CAP MR/DD slot costs \$43,000 of which the State's share is approximately \$15,000. 100 additional slots are estimated to cost the state approximately \$1,330,000.
3. The funds appropriated in the 2006-07 Budget for developmental therapies will only be available for participants that were already receiving these services before the cuts in federal funding. These funds shall not be used to provide developmental therapy services for "new users". As participants no longer need developmental therapy services, any unused funds shall be used for CAP positions or Supported Employment.

Total Recommended Funding:

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
Supported Employment	\$1,500,000		\$1,500,000	\$1,500,000		\$1,500,000
CAP MR/DD slots	\$1,500,000		\$1,500,000	\$1,500,000		\$1,500,000
Total	\$3,000,000		\$3,000,000	\$3,000,000		\$3,000,000

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UNIFORM SLIDING FEE SCHEDULE

BACKGROUND:

1. G.S. 122C-146 requires LMEs and their contractual agencies to prepare fee schedules for services and make a reasonable effort to collect appropriate reimbursement for costs from individuals or entities based upon ability to pay or third-party payment. Funds collected from fees for LME operated services must be used for the fiscal operation or capital improvements of the LME's programs.
2. A survey of LMEs by the Division during the fall of 2006 showed that there is no uniformity across the State regarding these fee schedules. LMEs may or may not use the same fee schedule for all services. Some look at gross income, others do not. Some set an income floor below which no fee is charged, others do not. All LMEs that reported on their sliding fee scale had a maximum income above which no relief was provided. However, those maximum incomes ranged from \$7,200 to \$99,000 for a family of 1. A couple of LMEs charged for "no shows", but the vast majority did not. Only one LME had a maximum monthly liability limit.
3. A uniform fee schedule would ensure that consumers are treated consistently across the State. It would also allow providers to know what is expected of them, regardless of where they provide services. Revenues from the fees can be used to supplement State dollars and provide additional services.

PROPOSAL:

1. Direct the Department of Health and Human Services to adopt rules to set a sliding fee schedule. The fee schedule should take into account ability to pay, have a maximum liability limit, and charge a fee for "no shows". The fee schedule shall apply to all services paid for with either State or local funds. Private providers will be required to utilize the schedule. Amend G.S. 122C-146 accordingly.
2. Effective July 1, 2007 and until such time as the rules are adopted, the following shall become the state-wide uniform fee schedule:
 - o For persons at or below 100% of the Federal Poverty Level¹, fees paid cannot exceed fees paid by a Medicaid – eligible individual (at most \$3 per visit).
 - o For persons over 100% of Federal Poverty level, fees charged cannot exceed 5% of gross income per year.
3. Allow LMEs to retain all funds collected from fees to be used to purchase additional services. The Division estimates that 7% of funds spent on services could be collected from fees and third party payors.

¹ Federal poverty level is \$9,800 for 1 person and \$13,200 for two persons.

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CRISIS START-UP AND SERVICES/ADDITIONAL FUNDS/POLICY REVISIONS

BACKGROUND:

1. One of the recommendations from the Services Gaps Study was for increased funding for crisis services. The Study also noted that the State lacks data regarding emergency services for all crisis encounters, that there needs to be improved screening for substance abuse issues in emergency rooms, and that the State needs to utilize more mobile crisis services.
2. The LOC has heard repeatedly from sheriffs and other first responders that there is a lack of adequate crisis service providers, and that persons with mental illness and substance abuse disorders are disproportionately ending up in emergency rooms, county jails, and the State prison system.
3. In 2006, the North Carolina General Assembly made an investment in crisis services, appropriating \$7 million (recurring) for crisis services. These funds are currently available to LMEs. However, they have been allocated by the Division by age and disability groupings and may be spent only for identified services on a Unit Cost Reimbursement, or UCR, basis (fee for service). While UCR makes it easier to track how funds are spent, it reduces flexibility to use the funds to retain key personnel. LMEs have also expressed some concern that by allocating the funds by disability category and age, the usefulness of the new funding is diluted.
4. In 2006, the North Carolina General Assembly also invested \$5.25 million (non-recurring) for crisis services start-up funding. The start-up funds were to be allocated to regional groups of LMEs based upon crisis plans developed in conjunction with a consultant retained by DHHS. That consultant has been retained and the plans must be submitted no later than March 1, 2007.

PROPOSAL:

1. To continue increasing the crisis services available around the state, the LOC recommends recurring appropriations of \$10 million in SFY 2007-08 for crisis services and an additional \$5 million in SFY 2008-09 for a total of \$15 million.
2. Direct the Division of MH/DD/SA to allow crisis service funds to be used on either a UCR or non-UCR basis. If spent on a Non-UCR basis, the Division and the LME must develop a mechanism for tracking how the funds are spent and performance measures that are at least as specific as those used for UCR spending.
3. Require LMEs to make crisis services available to all age and disability groups, but direct the Division to cease allocating the funds according to those categories.

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4. Additionally, the LOC recommends appropriating \$10 million non-recurring to the Mental Health Trust Fund and \$5 million non-recurring in SFY 2008-09 set aside for building crisis services locally. These funds are to be spent in accordance with the crisis plans currently under development by the LMEs. Up to \$500,000 of this funding may be used to extend the contract with the crisis services consultant currently being used to develop these plans.
5. Explore ways to obtain better emergency service reporting on all crisis encounters, to provide better substance abuse screening in emergency departments, to increase the number of mobile crisis teams and their acceptance in emergency departments.

Total Recommended Funding:

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
Crisis Services	\$10,000,000		\$10,000,000	\$15,000,000		\$15,000,000
Crisis Services Start-Up Funding for the MHTF		\$10,000,000	\$10,000,000		\$5,000,000	\$5,000,000
Total	\$10,000,000	\$10,000,000	\$20,000,000	\$15,000,000	\$5,000,000	\$20,000,000

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ADDITIONAL HOUSING ASSISTANCE

BACKGROUND

In 2006, the Joint Legislative Oversight Committee on MH/DD/SAS recommended, and the General Assembly funded, the Housing 400 Initiative. This initiative appropriated \$1.2 million recurring for operating assistance of 400 independent- and supportive-living apartments and also appropriated \$10.94 million non-recurring for financing the apartments. The North Carolina Housing Finance Agency and the Department of Health and Human Services are jointly operating this initiative and the Committee heard a report on this topic during the November 13, 2006 meeting. This proposal would expand and continue this initiative.

PROPOSAL

1. Appropriate **\$5,250,000 recurring** to DHHS for additional operating cost subsidies for an estimated 1,000 independent- and supportive-living apartments for individuals with MH/DD/SA disabilities. Direct DHHS to maximize the number of subsidies that it can pay for with these funds by first giving priority to NCHFA-financed apartments, giving second priority to other publicly subsidized apartments, and finally to market-rate apartments. The apartments shall be made affordable to individuals with incomes at the SSI level. Up to \$250,000 can be used for administration of the subsidies.
2. Appropriate **\$10,000,000 non-recurring for SFY 2007-08** to the North Carolina Housing Trust Fund to finance independent- and supportive-living apartments for individuals with MH/DD/SA disabilities. These funds can be used to continue the current Housing 400 Initiative as currently operated.
3. Require an **evaluation** of the Housing 400 Initiative with a report to the LOC by March 1, 2008.
4. Require DHHS and NCHFA to work together to **plan** the most efficient and effective use of state resources in the financing and construction of additional independent- and supportive-living apartments for individuals with MH/DD/SA disabilities. This plan address gaps in the housing continuum identified by the study that DHHS will be conducting during SFY 2006-07 and SFY 2007-08.

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5. Appropriate **\$10,000,000 non-recurring for SFY 2008-09** to the North Carolina Housing Trust Fund to finance independent- and supportive-living apartments for individuals with MH/DD/SA disabilities according to the plan described above.

Total Recommended Housing Funding:

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
Operating Assistance (Rent Assistance)	\$5,250,000		\$5,250,000	\$5,250,000		\$5,250,000
Capital		\$10,000,000	\$2,000,000		\$10,000,000	\$10,000,000
Total	\$5,250,000	\$10,000,000	\$15,250,000	\$5,250,000	\$10,000,000	\$15,250,000

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IMPLEMENTATION OF NEW LME ADMINISTRATIVE COST MODEL AND ADDITIONAL FUNDING NEEDED

BACKGROUND:

1. S.L. 2006-66, Section 10.32 directed the Department of Health and Human Services to review and revise the LME systems management cost model and to recalculate local management entity (LME) systems management allocations for fiscal year 2006-07 to include funds for each LME to implement 24-hour, seven-days-a-week screening, triage, and referral, and to review, monitor, and comment on all person centered plans.
2. The Division of MH/DD/SAS presented a new LME Administrative Cost Model to the Joint Legislative Oversight Committee on MH/DD/SAS at the November 13, 2006 meeting. The new model is based on the old LME Administrative Cost Model with some adjustments in the cost categories. The total cost is similar to the LME administrative cost for SFY 2006-07, but will require additional state general funds to be fully funded. Below is a chart showing how the new model compares to SFY 2006-07 funding and how much additional state funds are required to fully fund the model.

	SFY 2007 (Old Model)		New Proposed Model		Difference	
	Dollars	% of Total	Dollars	% of Total	Dollars	Percentage Points
General Administration: Governance, Finance, HR, IT, Quality Assurance	\$ 54,152,954	42.30%	\$ 43,310,834	33.73%	\$(10,842,120)	(8.58%)
Claims Processing	\$ 7,464,589	5.83%	\$ 6,371,217	4.96%	\$ (1,093,372)	(0.87%)
Provider Relations	\$ 8,921,948	6.97%	\$ 17,507,929	13.63%	\$ 8,585,981	6.66%
Screening, Triage, and Referral	\$ 27,259,490	21.30%	\$ 27,739,107	21.60%	\$ 479,617	0.31%
Service Authorization	\$ 4,544,269	3.55%	\$ 8,374,232	6.52%	\$ 3,829,963	2.97%
Care Coordination & Community Collaboration	\$ 9,101,177	7.11%	\$ 18,111,065	14.10%	\$ 9,009,888	6.99%
Consumer Affairs	\$ 16,562,440	12.94%	\$ 7,004,208	5.45%	\$ (9,558,232)	(7.48%)
Total:	\$ 128,006,866		\$ 128,418,592		\$ 411,726	

Total Cost of New Model:	\$ 128,418,592
- Estimated Medicaid Funding Available:	\$ 55,917,117
- State Funding Currently Available:	\$ 55,234,089
Total Needed	\$ 17,267,386

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3. The State has failed to appropriate sufficient funds for LME administration for the past three years. The shortfall this year (SFY 2006-07) was approximately \$18 million. At the direction of the Secretary of DHHS, the Division cut reserves and some services to make up the difference.
4. LMEs are not currently required to report how local funds are spent, to collect income data on consumers, or how non-UCR funds are being used. The lack of this information makes it difficult to determine the extent of service gaps or the extent that some consumers might be able to supplement the cost of their services.

PROPOSAL:

1. Appropriate **\$17,300,000 recurring** to fully fund the LME cost model.
2. Require LMEs to report to the Division on all services provided (including services provided with county funds), income data of all consumers, and on non-UCR spending. The data shall be reported by service and by disability, and shall include information regarding any services to Medicaid eligible consumers that are being augmented with State funds. The Division and the LMEs shall develop a method of reporting on services delivered with non-UCR funding that allows the Division to measure outcomes achieved with the use of the funds and also allows more funding to be used on a non-UCR basis.
3. Appropriate **\$1,700,000 recurring** to be added to the cost model for these increased reporting requirements.
4. Restore funds cut in SFY 2006-07.

Total Recommended Funding:

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
LME Administrative Cost Model	\$17,300,000		\$17,300,000	\$17,300,000		\$17,300,000
Reporting Requirements	\$1,700,000		\$1,700,000	\$1,700,000		\$1,700,000
Total	\$19,000,000		\$19,000,000	\$19,000,000		\$19,000,000

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CLARIFY SCREENING/TRIAGE/REFERRAL ROLES

Background:

1. The purpose of STR is to gather basic demographic information about the consumer, determine whether the consumer is target or non-target population, make a very broad initial determination about the consumer's condition, and provide information regarding providers who can assist the consumer.
2. In the spring of 2006, the Division and LMEs negotiated a memorandum of agreement that outlined how STR should be handled. The MOA contemplated that only LMEs would implement STR for both Medicaid and non-Medicaid eligible consumers. The rationale for this position was that LMEs needed to know who was entering the system and this was the most efficient way for them to have that information. LMEs were also concerned about "self-referral" by the providers conducting STR.
3. During the summer of 2006, DHHS took the position that private providers should be able to do STR for Medicaid eligible consumers. DHHS argued that this implemented the "no wrong door" policy of the system and that when a consumer walks in the door of a private provider, that consumer has already exercised his/her choice.
4. LMEs objected to this position, arguing that there was no mechanism for LMEs to know when a Medicaid eligible consumer enters the system if the provider does STR. Eventually, DMH, DMA and the LMEs negotiated a system by which a provider must "register" a consumer with the LME within 5 days of the provider conducting STR. While some LMEs were satisfied with this solution, others have taken the position that the policy contradicts language adopted by the General Assembly in the 2006 session that lists STR as a "core function" of LMEs. Those LMEs also argue that the registration system is inefficient.
5. It should be noted that the State and Medicaid provide administrative funds for LMEs to conduct STR. However, STR is not a "service", therefore neither the State nor Medicaid will pay providers for conducting STR. It is possible that as more providers do STR, Medicaid will reduce its contribution to LME admin on the basis it is paying for a function that is not being provided.
6. The Secretary has been under a statutory obligation since 2001 to adopt rules implementing a "uniform portal process". This term refers to how consumers enter and exit the public system. Who is authorized to conduct STR is directly related to the uniform portal process.
7. The Secretary has not adopted a rule regarding this matter. However, implementing the policy outlined above effectively circumvents the rule making process. While DMH will be

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introducing a rule on this matter in January of 2007, the policy will remain in place during that time and conceivably during any protest period.

8. The cochairs sent a letter to the Secretary requesting that she suspend the policy until such time as rules could be adopted. The Secretary took the issue to the State Consumer and Family Advisory Council who supported the policy as being consumer friendly. The Secretary has responded to the rules issue with a letter that indicates that the General Assembly had tacitly given the Department the authority to adopt policies outside the rulemaking process.

PROPOSALS:

1. Adopt a statutory clarification regarding what entities are allowed to conduct STR.
2. Allow the rule making process to proceed "as is" with the policy in place.
3. Put a moratorium on the policy until a rule has been adopted.

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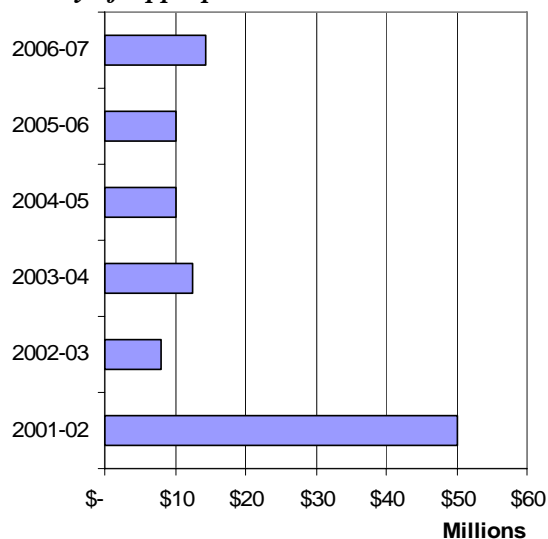
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RESTRUCTURE THE MH/DD/SA TRUST FUND

BACKGROUND:

1. G.S. 143-15.3D¹ creates the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs (MH/DD/SA Trust Fund). It is an interest-bearing, nonreverting special trust fund in the Office of State Budget and Management. Moneys in the Trust Fund are held in trust to be used solely to meet the mental health, developmental disabilities, and substance abuse services needs of the State. Any balance remaining in the Trust Fund at the end of any fiscal year is carried forward in the Trust Fund for the next succeeding fiscal year.
2. Below is a chart showing appropriations to the MH/DD/SA Trust Fund:

History of Appropriations to the Mental Health Trust Fund



Note: During FY 2001-2002, the Governor seized \$37.5 million from the Mental Health Trust Fund in response to the budget crisis.

3. The Trust Fund only can be used for specified purposes. These are:
 - o Provide start-up funds and operating support for programs and services that provide more appropriate and cost-effective community treatment alternatives for individuals currently residing in the State's institutions.
 - o Facilitate the State's compliance with the United States Supreme Court decision in *Olmstead v. L.C. and E.W.*
 - o Facilitate reform of the mental health, developmental disabilities, and substance abuse services system and expand and enhance treatment and prevention services in these program areas to remove waiting lists and provide appropriate and safe services for clients.

¹ Effective July 1, 2007, G.S. 143-15.3D is recodified as G.S. 143C-9-2.

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- Provide bridge funding to maintain appropriate client services during transitional periods as a result of facility closings, including departmental restructuring of services.
 - Construct, repair, and renovate State mental health, developmental disabilities, and substance abuse services facilities.
4. The State has never developed a strategic plan for how the funds should be spent. There is no specific process for applying for funds, or criteria (other than purpose) regarding how the funds may be spent.
 5. The General Assembly has, on occasion, enacted special provisions allowing the Trust Fund to be used for purposes other than those outlined above.²

PROPOSAL:

1. Repeal language in G.S. 143-15.3D that allows Trust Fund money to be used to construct, repair, and renovate State mental health, developmental disabilities, and substance abuse services facilities.
2. Replace the funds lost due to the 2001 Budget Crisis.
3. Have the LOC hire the consultant that is currently working on developing the State strategic plan and have that firm also develop a strategic plan for how the MH/DD/SA Trust Fund moneys should be allocated. The plan should provide that the funds should only be spent for implementation of evidence based practices. The plan should also include a specific process and procedure for reviewing requests for funding. There should be a mechanism at the State level to monitor the projects to ensure they have fidelity to the EBP model. All proposals would have to include funds to train local providers and personnel in the practice and implementation of the program. Allocation of funds appropriated to the Trust Fund would be contingent upon receipt and review by the LOC of the strategic plan.
4. Consider creating a recurring source of funds.

Total Recommended Funding:

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
MH/DD/SA Trust Fund		\$37,500,000	\$37,500,000	\$10,000,000	\$37,500,000	\$47,500,000
Funding for development of strategic plan		\$200,000	\$200,000			
Total		\$37,700,000	\$37,700,000	\$10,000,000	\$37,500,000	\$37,500,000

² See 2006-66; Sec. 10.33H.(b) allowing the Secretary to use Trust Funds to pay for up to 66 new positions at the Julian Keith Alcohol and Drug Abuse Treatment Center.

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FIRST COMMITMENT PILOT PROGRAM

Background:

1. Session Law 2003-178 (House Bill 883) authorized the Secretary of Health and Human Services to temporarily waive certain statutory requirements pertaining to initial (first-level) examinations conducted as part of the commitment process. Current law requires that first-level examinations be conducted by either a physician or eligible psychologist. The temporary waiver authorized by Session Law 2003-178 allowed the Secretary to approve LME requests to substitute appropriately trained licensed clinical social workers, masters level psychiatric nurses, or masters level certified clinical addictions specialists to conduct first-level examinations. Session Law 2003-178 authorized the Secretary to grant waivers to up to five LMEs for periods of time not to exceed three years and required that participating LMEs, "...assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary."
2. The Secretary approved the following five LMEs to participate in the pilot program: CenterPoint Human Services, Crossroads Behavioral Healthcare, Pathways MH/DD/SAS, Smoky Mountain Center, and Piedmont Behavioral Healthcare. As required by Session Law 2003-178, the Department delivered a report to the Joint Legislative Oversight Committee on MD/DD/SAS on the "effectiveness, quality, and efficiency" of services provided under the waiver.

PROPOSALS:

1. Reauthorize the pilot program in its current state (up to five LMEs may participate in pilot program for periods of up to 3 years). This would be accomplished by extending the sunset on the pilot program for whichever time period the legislators would like (original period was either three years or the period the LME requested in their business plan, whichever was shorter).
2. Reauthorize the pilot program, with an expansion to allow participation by more LMEs.
3. Make pilot program's temporary expansion of providers eligible to conduct initial (first-level) commitment examinations permanent. Introduce new legislation to codify changes to G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-181 through G.S. 122C-283, expanding the providers eligible to conduct initial (first-level) examinations to include licensed clinical social workers, masters level psychiatric nurses and masters level certified clinical addictions specialists (as provided on a temporary basis in the pilot program, by waiver by the Secretary).
4. Take no action and allow the program to expire on October 1, 2007.

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MENTALLY ILL IN ADULT CARE HOMES

BACKGROUND:

1. The Co-chairs of the Study Commission on Aging and The Joint Legislative Oversight Committee on MH/DD/SAS determined it would be beneficial to work in concert as a joint subcommittee to study issues relating to serving individuals who reside in long term care facilities and have a mental illness.
2. In 2005 the public mental health system served over 174,000 adults with mental illness, 1,149 of whom lived in licensed mental health homes and 5,000 lived in adult care homes.
3. Nationally, approximately 10% of adults with serious mental illness need specialized housing.
4. It was reported that over 40% of the adult care home population carries an active diagnosis of mental illness.
5. Currently there is no level of care between the hospital inpatient setting, the adult care home setting, and the independent living setting.

Proposals - The Subcommittee on Mentally Ill Residents in Adult Care Facilities recommends that the Commission on Aging and the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services recommend that the General Assembly:

1. Appropriate funds to the Department of Health and Human Services and the Housing Finance Agency to increase the stock of current housing options available to North Carolinians with mental illness (including independent living units, supported housing units and group homes).
2. Support Department of Health and Human Services and Housing Finance Agency efforts to develop new options for housing for North Carolinians with mental illness that are appropriate for and meet their needs.
3. Support the development of a "Transitional Residential Treatment Program" to provide 24-hour residential treatment and rehabilitation for adults who have a pattern of difficult behaviors, related to mental illness, which exceed the capabilities of traditional community residential settings.
4. Authorize the Commission on Aging and the Legislative Oversight Committee on MH/DD/SAS to explore the need for the General Assembly to enact statutes authorizing rules to regulate facilities that provide housing for adults with mental illness in the same location with adults without mental illness. Rules authorized shall address at least the following issues:

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housing of individuals with mental illness in the same bedroom or area of a facility with individuals without mental illness; and training of staff to provide care appropriate to each individual resident's needs with specific training addressing the needs of persons with mental illness.

5. Support ongoing efforts to develop a Uniform Screening Tool that would include the requirement that the Department of Health and Human Services notify Local Management Entities (LMEs) of the mental illness status of any individual admitted to any facility within the LME's catchment area. The Department of Health and Human Services shall specify which Division will be responsible for providing the notification and what resources will be required to accomplish the notification.
6. Appropriate funds to provide a total of 2,000 slots for use by adults through the State/County Special Assistance In-Home Program for Adults.

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WAIVERS/FUNDING FLEXIBILITY

BACKGROUND

1. Single Stream Funding - Smoky Mountain Center LME – When allocating state appropriations to the Smoky Mountain Center, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has implemented a single stream funding project which allows the Division to allocate state appropriations to the Smoky Mountain Center without dividing the funding into categories (ie. MH, DD, SAS, UCR, non-UCR). Instead, the Smoky Mountain Center LME is allowed to have the flexibility to utilize their funding to address community needs.
2. Medicaid Waiver - Piedmont Behavioral Healthcare LME – Piedmont Behavioral Healthcare has a Medicaid Waiver that allows them to independently manage their Medicaid services and resources. This waiver gives Piedmont Behavioral Healthcare the authority to perform such activities as manage their provider network, manage rates, authorize services, and pay provider claims. In addition, the Division of MH/DD/SAS also gives Piedmont the same flexibility with state funding that is given to the Smoky Mountain Center.

PROPOSAL

1. Require the Division of MH/DD/SAS to implement an application process that would allow up to four additional LMEs to be considered for the single stream funding process.
2. Require the Division of MH/DD/SAS to study the effectiveness of Piedmont Behavioral Healthcare's Medicaid Waiver and examine the possibility of another LME applying for the waiver.

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HOSPITAL BED DAY ALLOCATION

BACKGROUND

1. The current hospital bed day allocation plan distributes bed days to the LMEs based on their historical utilization. The current plan also built in a gradual change over a three year period that would allocate the bed days based on the LME's population; however, this transition never occurred. In addition, the current plan charged LMEs \$500 per additional bed day utilized over their initial bed day allocation. This practice was suspended after an LME sued the Division of MH/DD/SAS in 2002.
2. Currently, there is no incentive for LMEs to avoid over utilizing the state institutions. The Services Gap Study points-out there is a principal-agent conflict with the current system.
3. Currently, LMEs "authorize" State psychiatric Hospital usage, but have no authority to prohibit a person from being sent to the hospital. Subject to federal anti-dumping laws, community hospitals can send person in crisis to State hospitals directly. In addition, the decision whether to admit a consumer to a State hospital is made by staff at the State institution.
4. The Division's State Operated Section (SOS) is now in the process of developing a new plan to be completed by July 2007 and have provided the following update on their efforts on their bed day allocation planning.

Update from the Division:

State Operated Services (SOS) has been studying the overages in bed day allocations to determine practical ways to reduce bed day utilization. Following are current activities being conducted:

- A Bed Day Allocation Workgroup has been formed to determine incentives and penalties for reducing bed day utilization. Members of this workgroup include LME Directors, a State Psychiatric Hospital Director, an NC Council for Community Programs representative and SOS staff. The group met for the first time on December 7th and will be meeting again at a date to be determined in January with a desired outcome of developing definitive strategies that can be implemented as soon as possible.
- Plans of Enhancement from LMEs that over utilized bed days in FY05/06. The plans have been reviewed and joint conferences have been conducted with the DMH/DD/SAS LME Team to provide feedback and offer other strategies for LMEs to implement to further reduce bed day utilization.
- DMH/DD/SAS has approved a Charter for a workgroup to develop policy recommendations and possible outcomes to reduce admissions and facilitate discharge issues between the State Psychiatric Hospitals, LMEs and providers. An intent of this group is to provide additional input for reducing bed day utilization. The first meeting for this workgroup will be in January 2007. The Charter was approved in November 2006.

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- Research has been conducted by SOS staff to determine how many licensed and operational psychiatric beds are available at local hospitals. The information will be used by the workgroups mentioned above as recommended strategies are developed.
- SOS is represented on the DMH/DD/SAS Regional Crisis Workgroup to facilitate discussion around the crisis continuum and impact on bed day utilization.
- Bed day utilization data is reviewed continuously to monitor overages and to facilitate changes at the LME/provider levels.

Proposals:

1. Require the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to complete their new hospital bed day allocation plan by July 2007.
2. Direct the Division to identify 1-5 LMEs for a pilot program regarding usage of State psychiatric hospital usage. Each LME would be allocated the same amount of funds it "utilized" in the previous year for inpatient usage and the State facility would be "held harmless" during the life of the pilot.. The details of the pilot would be developed with input from key stakeholders. Components of the pilot might include shifting final authority for State hospital admissions to the LME, providing financial incentives to community hospitals to provide inpatient beds, and providing start-up for mobile crisis teams.

This recommendation will have a cost that has not yet been determined.

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
Total						

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COUNTY JAILS AND JUSTICE SYSTEM – MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

BACKGROUND:

1. The LOC has heard from sheriffs and other law enforcement officials that there are not sufficient mental health or substance abuse programs, and as a result, state and local law enforcement resources are being utilized by the mentally ill and persons suffering from substance abuse disorders.
2. The Services Gap Study found that there are not sufficient pre-booking, post sentence, and probation diversion programs for adults and juveniles to reduce costs to the corrections system.
3. At the request of the cochairs, the Division of MH/DD/SAS has provided information regarding the existing services to individuals with mental illness and substance abuse disorders involved in the criminal justice system.
 - DMH/DD/SAS currently funds 12 Jail Diversion programs that serve 17 counties at an average cost of \$60,000 annually. The Division is working with LMEs and other community partners (Police and Sheriff's Departments, CFACs, NAMI chapters, etc.) to expand the use of CITs (Crisis Intervention Teams).
 - DMH/DD/SAS administers the TASC Program (Treatment Accountability for Safer Communities) for individuals charged or convicted of crimes eligible for intermediate or community punishment.
 - In SFY 05-06, 498 Intermediate Punishment offenders exited prison in NC and the probation population consisted of 29,051. DMF/DD/SAS estimates of those individuals, or 6,791 are currently being served. The array of services needed for this population includes: Detoxification Services, Crisis Services, Intensive Outpatient Treatment, Comprehensive Outpatient Treatment, Residential Services, Community Support, and Halfway Houses.

PROPOSAL:

1. Appropriate \$3.6 million for 60 additional jail diversion programs, expanding jail diversion to all counties.
2. Appropriate \$100,000 for technical assistance and training of Crisis Intervention Teams.
3. Appropriate \$13.6 million for 272 additional care managers for the Treatment Accountability for Safer Communities (TASC) program to cover all known substance abuse offenders eligible for the program.

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- Appropriate \$54.1 million for mental health and substance abuse services to those individuals sentenced to intermediate punishments who are released from prison or on probation and in need of services.

Total Recommended Funding:

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
60 Additional Jail Diversion Programs (expand to all counties)	\$3,600,000		\$3,600,000	\$3,600,000		\$3,600,000
Technical Assistance and Training for CIT	\$100,000		\$100,000	\$100,000		\$100,000
272 Additional Care Managers for TASC to meet caseload	\$13,600,000		\$13,600,000	\$13,600,000		\$13,600,000
Providing MH and SA services to intermediate punishment offenders	\$54,071,556		\$54,071,556	\$54,071,556		\$54,071,556
Total	\$71,371,556		\$71,371,556	\$71,371,556		\$71,371,556

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TRANSPORTATION

BACKGROUND

1. North Carolina remains a predominately agrarian state with many areas with low population densities. Even in areas better suited for public transportation, many consumers have difficulty reaching services and treatments because they are unable to drive themselves or not well enough to take public transportation.
2. The LOC has also heard from sheriffs that they are also expending significant resources (in terms of officer time and cost of travel) to transport individuals to and from the State psychiatric hospitals.

PROPOSAL:

1. LOC staff is still working on possible options for this matter.

This recommendation will have a cost that has not yet been determined.

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
Total						

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ASSISTANCE FOR AND OVERSIGHT OF DHHS AND DMH/DD/SA

BACKGROUND :

1. The Division has stated that it does not have sufficient staff to implement reform. It was unable to provide timely reports as required by the General Assembly and used Mental Health Trust Fund moneys to hire an outside consultant to complete the task.
2. The Services Gap Study recommends that the State increase the Division's ability to monitor and oversee reform and to plan strategically.
3. The cochairs of the LOC have written to the Secretary of DHHS and requested that the Secretary provide the committee with information regarding the number and types of positions that are needed. The cochairs have not received a formal response from the Secretary.
4. There are no clear performance measures for DHHS or the Division to assist policy makers in determining whether reform is being implemented successfully or where resources need to be allocated to assist with implementation.
5. The Division and the Secretary have a large number of draft rules that will be taken before the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services for review and adoption over the next year.
6. LOC staff has not been able to obtain the consultant's methodology used to develop the models for the Services Gap Study and the Funding Allocation Study. Without that methodology, LOC staff is not able to determine what assumptions were used or calculations applied to develop the funding recommendations.

PROPOSAL:

1. Have the Secretary hire a technical assistance team to analyze the Division and make recommendations regarding any changes in staffing, resources and training that are needed to make the Division more effective in its role overseeing reform.
2. Have the LOC hire a consultant to analyze the Division and make recommendations regarding any changes in staffing, resources and training that are needed to make the Division more effective in its role overseeing reform.
3. Have the LOC hire a consultant to develop performance indicators for the Division.
4. Have the LOC hire a consultant to monitor the administrative rules that are being proposed to the MH/DD/SA Commission.

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5. Have the LOC hire a consultant to forensically construct the methodology used in the Services Gap and Funding Allocations models and to verify the validity of the models.

Total Recommended Funding:

	2007-08			2008-09		
	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total
Additional DMH Personnel to Implement Reform						
Secretary Consultant to Determine Staffing Needs of Division						
LOC Consultants to (1) Follow Rule Making Process, (2) Develop Performance Indicators for DHHS, and (3) Verify Models						
Total						