HOUSE BILL 916

Short Title:	Statewide Expansion of 1915(b)/(c) Waiver.	(Public)
Sponsors:	Representatives Barnhart, Dollar, Burr, and Insko (Primary Sponsors). For a complete list of Sponsors, see Bill Information on the NCGA Web Site.	
Referred to:	Health and Human Services, if favorable, Finance.	

May 5, 2011

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH REQUIREMENTS FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND LOCAL MANAGEMENT ENTITIES WITH RESPECT TO STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services (Department) shall proceed with statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through expansion of the 1915(b)/(c) Medicaid Waiver. It is the intent of the General Assembly that expansion of the 1915(b)/(c) Medicaid Waiver will be completed by July 1, 2013, and will result in the establishment of a system that is capable of managing all public resources that may become available for mental health, intellectual and developmental disabilities, and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice, and all other public funding sources. In implementing the restructuring and expansion authorized in this section, the Department shall do all of the following:

(1) Establish accountability for the development and management of a local system that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for consumers in need of mental health, intellectual and developmental disabilities, and substance abuse services.

(2) Maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model, a proven system for the operation of all public resources for mental health, developmental disabilities, and substance abuse services.

(3) Designate a single entity to assume responsibility for all aspects of Waiver management. The following operational models are acceptable options for Local Management Entity (LME) applicants:

a. Merger model: A single larger LME is formed from the merger of two or more LMEs.

b. Interlocal agreement among LMEs: A single LME is identified as the leader for all Waiver operations, financial management, and accountability for performance measures.

(4) Use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid

program while ensuring medically necessary care and deploy a system for the allocation of resources based on the reliable assessment of intensity of need. The Department shall design these strategies to efficiently direct consumers to appropriate services and to ensure that consumers receive no more and no less than the amount of services determined to be medically necessary and at the appropriate funding level.

(5) As the 1915(b)/(c) Medicaid Waiver expands statewide, phase out the current CAP-MR/DD Waiver as well as the utilization management functions currently performed by public and private contractors.

(6) Design the Innovations Waiver in such a way as to serve the maximum number of individuals with intellectual and developmental disabilities within aggregate funding.

(7) Require LMEs approved to operate a 1915(b)/(c) Medicaid Waiver pursuant to Section 1(b) to do all of the following:

a. Maintain a local presence in order to respond to the unique needs and priorities of localities.

b. Implement a process for feedback end exchange of information and ideas to ensure communication with consumers, families, providers, and stakeholders regarding disability-specific and general Waiver operations.

c. Establish and maintain systems for ongoing communication and coordination regarding the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems such as local departments of social services, Community Care of North Carolina, hospitals, school systems, the Department of Juvenile Justice, and other community agencies.

SECTION 1.(b) By April 1, 2011, the Department shall prepare and publish a Request for Applications (RFA) for LMEs to seek approval to operate a 1915(b)/(c) Medicaid Waiver. The RFA shall specify operational requirements that will result in replication of the PBH demonstration project, including all of the following:

(1) Disability specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

(2) Administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.

(3) Full accountability of LMEs for all aspects of Waiver operations and for meeting all contract requirements specified by the Department. The Department shall not require LMEs to subcontract any managed care functions or nonservice activities to other entities. However, LMEs that choose to subcontract managed care functions to other entities will be limited to the following:

a. Information systems.

b. Customer service (including call center) operations.

c. Claims processing.

d. Provider, enrollment, credentialing, and monitoring.

e. Professional services.

SECTION 1.(c) By August 1, 2011, the Department shall select LMEs that have been assessed to meet minimum criteria for Waiver operations according to the requirements of the RFA.

SECTION 1.(d) The Department shall require LMEs that have not been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013, to merge with or be aligned through an interlocal agreement with an LME that has been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver. If any LME fails to comply with this requirement, the Department shall assign responsibility for management of the 1915(b)/(c) Medicaid Waiver on behalf of the noncompliant LME to an LME that is successfully operating the Waiver and successfully meeting performance requirements of the contract with the Department. Those LMEs approved to operate the 1915(b)/(c) Medicaid Waiver under an interlocal agreement must have a single LME entity designated as responsible for all aspects of Waiver operations and solely responsible for meeting contract requirements.

SECTION 1.(e) County governments are not financially liable for overspending or cost overruns associated with an area authority's operation of a Medicaid Waiver.

SECTION 1.(f) Providers of targeted case management under the CAP-MR/DD Waiver are qualified to provide the 1915(c) service known as Community Guide under the Innovations Waiver. During the first year of assuming responsibility for Waiver operations, LMEs shall offer to contract with providers that were previously approved to provide targeted case management to individuals with intellectual and developmental disabilities under the CAP-MR/DD Waiver, for the provision of Community Guide services.

SECTION 1.(g) By December 31, 2011, the Department shall determine the feasibility of adding habilitation services to the State Medicaid Plan through the 1915(i) Option as a strategy to address the needs of Medicaid enrollees with IDD who are not enrolled in the Innovations Waiver and are not residing in an intermediate care facility for the mentally retarded (ICF-MR facility).

SECTION 1.(h) The Department shall consider the impact on ICF-MR facilities included in the 1915(b)/(c) Medicaid Waiver to determine and, to the extent possible, minimize potential inconsistencies with the requirements of G.S. 131E-176 and G.S. 131E-178 without negatively impacting the viability and success of the 1915(b)/(c) Medicaid Waiver programs.

SECTION 1.(i) The Department shall discontinue the pilot program to administer the Supports Intensity Scale to people with intellectual and developmental disabilities in non-Waiver LMEs.

SECTION 1.(j) The Department shall establish written policies ensuring alignment of objectives and operational coordination of the 1915(b)/(c) Medicaid Waiver and the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems under the auspices of the Department, including Community Care of North Carolina.

SECTION 1.(k) In the development of the budget for the 2013-2015 fiscal biennium and subsequent biennia, the General Assembly shall consider a reinvestment of at least fifteen percent (15%) of the total projected State savings for that biennium from the operation of the 1915(b)/(c) Waiver, for the purpose of expanding the number of consumers served by the Innovations 1915(c) Medicaid Waiver, or for the purpose of expanding other services that are designed to meet the needs of individuals with intellectual and developmental disabilities.

SECTION 1.(l) By October 1, 2011, the Department, in coordination with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Division of Medical Assistance, LMEs, and PBH, shall submit to the appropriate Oversight Committee of the General Assembly a strategic plan delineating specific strategies and agency responsibilities for the achievement of the objectives and deadlines set forth in this section.

SECTION 1.(m) The Department shall submit status reports to the General Assembly on the restructuring and expansion authorized in this section on January 1, 2012, April 1, 2012, October 1, 2012, February 1, 2013, and October 1, 2013.

SECTION 2. G.S. 122C-115(a) reads as rewritten:

"(a) A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program established pursuant to G.S. 122C-115.1. ~~The catchment area of an area authority or a county program shall contain either a minimum population of at least 200,000 or a minimum of six counties.~~ Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control.

(a1) ~~Effective July 1, 2007, the Department of Health and Human Services shall reduce by ten percent (10%) annually the administrative funding for LMEs that do not comply with the catchment area requirements of subsection (a) of this section. However, an LME that does not comply with the catchment area requirements because of a change in county membership shall have 12 months from the effective date of the change to comply with subsection (a) of this section.~~Effective July 1, 2012, the Department shall reduce the administrative funding for LMEs that do not comply with the minimum population requirement of 300,000 to the level of funding provided to LMEs with a population of 300,000.

(a2) Effective July 1, 2013, the Department shall reassign management responsibilities for Medicaid funds and State funds away from LMEs that are not in compliance with the minimum population requirement of 500,000 to LMEs that are fully compliant with all catchment area requirements, including the minimum population requirements specified in this section.

(b) Counties shall and cities may appropriate funds for the support of programs that serve the catchment area, whether the programs are physically located within a single county or whether any facility housing a program is owned and operated by the city or county. Counties and cities may make appropriations for the purposes of this Chapter and may allocate for these purposes other revenues not restricted by law, and counties may fund them by levy of property taxes pursuant to G.S. 153A-149(c)(22).

(c) Except as authorized in G.S. 122C-115.1, within a catchment area designated in the business plan pursuant to G.S. 122C-115.2, a board of county commissioners or two or more boards of county commissioners jointly shall establish an area authority with the approval of the Secretary.

(d) Except as otherwise provided in this subsection, counties shall not reduce county appropriations and expenditures for current operations and ongoing programs and services of area authorities or county programs because of the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area authority or county program. Counties may reduce county appropriations by the amount previously appropriated by the county for one-time, nonrecurring special needs of the area authority or county program."

SECTION 3. G.S. 122C-115.3(a) reads as rewritten:

"(a) Whenever the board of commissioners of each county constituting an area authority determines that the area authority is not operating in the best interests of consumers, it may direct that the area authority be dissolved. In addition, whenever a board of commissioners of a county that is a member of an area authority determines that the area authority is not operating in the best interests of consumers of that county, it may withdraw from the area authority. An area authority that does not meet the minimum population requirements specified in G.S. 122C-115 may dissolve at any time during a fiscal year. Dissolution of an area authority or withdrawal from the area authority by a county for other reasons shall be effective only at the end of the fiscal year in which the action of dissolution or withdrawal transpired."

SECTION 4. G.S. 150B-1(d) is amended by adding a new subdivision to read:

"(20) The Department of Health and Human Services in implementing, operating, or overseeing new Medicaid Waiver programs or amendments to existing Medicaid Waiver programs."

SECTION 5. This act is effective when it becomes law.