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Trillium
HEALTH RESOURCES

Via Email (denise.baker@dhhs.nc.gov)

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Dear Ms. Baker:

I am General Counsel for Trillium Health Resources and I am responding to the Commission's Reports regarding 10A NCAC Subchapter 27G. Attached hereto please find my public comments to the Reports. I am submitting these public comments as my objections to the Commission's designation of each of rule within 10A NCAC 27G as Necessary without Substantive Public Interest. Simply put, I believe the entirety of 10A NCAC Subchapter 27G should be designated as Necessary with Substantive Public Interest or, in some cases, designated as Unnecessary.

I respectively request that the Commission reclassify each and every rule within 10A NCAC Subchapter 27G as either Necessary with Substantive Public Interest or Unnecessary, consistent with my public comments, before submitting the Reports to the Rules Review Commission. I thank you in advance for the opportunity to provide these public comments and for the Commission's consideration of the same.

Sincerely,

Trillium Health Resources

Richard P. Leissner, Jr.

Encl.

PUBLIC COMMENTS

Applicable to all rules that cite G.S. § 143B-147 as the statutory authority:

Much of 10A NCAC 27G was promulgated effective May, 1996, and has not been significantly updated since that time. Most, if not all of the rules that have not been significantly updated cite G.S. § 143B-147 as the statutory authority. Yet, G.S. § 143B-147 has undergone significant revision since 1996. For instance, in May, 1996, G.S. § 143B-147(a)(1b) authorized the "Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Human Resources [now Department of Health and Human Services] … to adopt rules regarding the … operation of education, prevention, intervention, treatment, rehabilitation and other related services **as provided by** area mental health, developmental disabilities, and substance abuse services authorities…" In 1996, the statute did not contemplate these services being performed by private providers. After the 2001 reform, which gave the Secretary a host of new powers pursuant to G.S. § 122C-112.1, G.S. § 143B-147(a)(1b) was amended to read as follows: "The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services [of the Department of Health and Human Services] shall have the authority to adopt rules regarding the … operation of education, prevention, intervention, treatment, rehabilitation and other related services **as provided by** area mental health, developmental disabilities, and substance abuse services authorities, county programs, **and all providers of public services**…"

This revision is critically consequential, as it expanded the authority the Commission had over the operations of the area authority, to private providers of public services. At the same time, there was a shift in services from the area authorities to private providers that fundamentally altered the nature of the relationship between DMH and the area authorities. This relationship was again fundamentally altered when private providers began contracting directly with the area authorities, versus DMH. Therefore, to the extent the rules in 27G reliant upon G.S. 143B-147(a)(1b) were not amended, revised or clarified (1) to account for the fact that providers, as opposed to area programs, were now authorized to provide public services, and (2) to account for fundamental changes to the relationships between DMH, area authorities and private providers, between 2001 and 2012, such rules are necessarily vague and ambiguous. Moreover, from and after 2001, these rules were also not reasonably necessary to implement or interpret an enactment of the General Assembly, or of Congress, or a regulation of a federal agency.

In addition, G.S. § 143B-147 grants the Commission a host of rulemaking authority that applies to a broad range of things, including service delivery, licensure of facilities, and area authority operations. Almost without exception, the promulgated rules do not cite to a subpart of G.S. §143B-147. This contributes to the vague and ambiguous nature of the rules, because it is unclear what authority within G.S. § 143B-147 is being relied upon.

10A NCAC 27G.0100. GENERAL INFORMATION

.0101 Scope

(b)(2) and (e) are not within the authority delegated to the agency – DHHS, by and through DMH, does not have the authority to accredit Area Programs.[1] In fact, there were previously rules regarding this (Section .0700), but they were repealed in 2009, rendering .0101 vague and ambiguous. Regardless, the powers of the Commission do not include the authority to require that DMH accredit area programs. All references to area program accreditation or service delivery should have been removed from the rules as a result. Because they were not, 27G is unclear and ambiguous.

The rule is unclear and ambiguous. In (a), "agencies" is not defined. "Area programs administering the services within the scope of G.S. 122C" is ambiguous due to the use of the term "administering." (b) is ambiguous because it suggests that only licensed facilities and area programs are subject to the rules, notwithstanding the use of term "agencies" in (a). Also, because a later rule (.0609) strongly implies that an area program is a facility, it is unclear why the two are treated separately in (b). Unlicensed facilities and/or behavioral health providers provide the type of public services referenced in 27G, but are unreferenced here. Thus, any regulations pertaining to unlicensed facilities are outside the scope of 27G as set forth in .0101. (c) is unclear because it suggests that providers with whom an area program contracts with for services is acting as a subcontractor (as opposed to an independent contractor) to perform services on behalf of the area program. Under federal law (42 CFR 438), service providers are specifically not subcontractors of the area programs.

The issues with the .0101 set out above render the entirety of 27G unclear and ambiguous, as clarifying the above terms will necessarily and fundamentally alter the nature and interpretation of the Rules that follow. Moreover, the entirety of 27G is not reasonably necessary to implement or interpret an enactment of the General Assembly, or of Congress, or a regulation of a federal agency. Since the vast majority of 27G was promulgated, State funded behavioral health service delivery has undergone a monumental and significant shift. The General Assembly effectively privatized behavioral health service delivery in 2001 and thereafter enacted several waivers that put Medicaid (but not non-Medicaid) behavioral health services under managed care. In addition, the General Assembly granted the Secretary a host of new powers and duties, set forth in G.S. § 122C-112.1, to allow the Secretary to implement the new delivery system. As a result, and by design, the more than 40 area programs that were providing the vast majority of the services referenced in 27G completely divested of direct service delivery and consolidated into less than 10 Local Management Entities by 2012. Additionally under the reform, the new behavioral health providers contracted with DHHS to provide the services previously performed by the area programs and the area programs began "endorsing" – but not contracting directly with – the providers and monitoring their performance. Later in the reform, and again by design,

[1] For purposes of these public comments, the terms "Area Program," "Area Authority" and "Local Management Entity/LME" all refer to the same type of entity, which today is referred to most commonly as an LME/MCO.

all of the LMEs contracted with the Division of Medical Assistance to become Managed Care Organizations, and began contracting directly with providers of Medicaid and non-Medicaid services. The LMEs also began authorizing the provision of public services and reimbursing the providers of those services. Yet, 27G did not undergo any significant revisions, even though they were promulgated for an entirely different behavioral health service delivery system. In other words, large swaths of 27G are not reasonably necessary to implement or interpret the enactments that privatized behavioral health service delivery. 27G simply was not intended to implement or interpret the current behavioral health system.

.0103: General Definitions

"Facility" is ambiguous, as it could suggest that area programs are facilities. It is also already defined in G.S. § 122-3 and the definitions are not the same. "Private facility" is also ambiguous and unclear, as it suggests area programs can operate a facility, which is not the case. No definitions were added or revised after the 2001 reform, when the General Assembly gave a host of new authority to the Secretary and introduced the term "public services" into G.S. § 122C. There are a host of terms in the rules that are used solely because of the 2001 and subsequent reforms, many of which must be defined or clarified in .0103 in order to make .0103 clear and unambiguous. Moreover, without an updated and current set of definitions, the entirety of 27G is hopelessly confusing and unclear.

10A NCAC 27G.0200 OPERATION AND MANAGEMENT RULES

.0201:

This rule is unclear and ambiguous because it suggests it is applicable to area programs. Neither area programs nor facilities set policy for admission and discharge criteria, client record management, and screenings, as those are established by DHHS in the form of clinical coverage policy manuals and APSM manuals, which are rules pursuant to G.S. § 150B. Also, it is unclear who is responsible for monitoring adherence to the policies – under the rules, it could be DHSR or the LMEs, by and through its contracts with DMH and DHB. However, in today's system, the area program would potentially be responsible for monitoring a lot of this, and particularly to the extent it is also captured in manuals.

0202:

This rule is unclear because .0103 suggests that these rules only apply to licensed facilities, but the best reading of the rule is that it applies to all MH/SAS/IDD service providers. It is unclear who is responsible for monitoring the personnel requirements or who has the authority to monitor and take action on the personnel requirements. The rules suggests DHSR does, but not the area programs, who in fact monitor this type of thing now.

It does not appear the Commission had the authority to promulgate this rule, particularly if it is intended to pertain to non-licensed facilities.

.0204

The term "privileging" is vague and ambiguous.

.0205

The rule is unclear in that it suggests each facility sets the criteria for assessments and treatment plans. In reality, facilities are required to follow promulgated rules, in the form of manuals and coverage policies, for assessment and treatment plans. The rule is unclear in that it seems only to pertain to licensed facilities.

10A NCAC 27G.0500 AREA PROGRAM REQUIREMENTS

.0501:

The Commission did not have the authority to promulgate this rule, pursuant to G.S. § 143B-147. Specifically, the Commission did not have the authority to mandate the services for which the area program is responsible, rendering Sections .1100 - .6900 vague and ambiguous. The rule is vague and ambiguous in that "Disability Groups," "Mental Illness," "Acute Mental Illness," and "Substance Abuse Disorders" are not defined. It is not clear whether the "services" referenced include Medicaid services. Among the required services are Case Management, which was removed from the service array in 2012 and ECIS, which was repealed as a service in 2002. The area program does not provide direct services. It appears from other rules that the "contracts" referenced in .0501 are "subcontracts," as the contractor would be providing services on behalf of an area program, as opposed to providing services as an independent contractor of the area program. However, providers that have a contract with LMEs to provide services, as that term is defined in .0103, are explicitly not "subcontractors" pursuant to 42 CFR 438.

.0502

The Commission did not have the authority to promulgate this rule pursuant to G.S. § 143B-147. Moreover, the rule is inconsistent with G.S. § 122C-142, which states that the area authority "shall use the standard contract adopted by the Secretary." and is therefore unclear. The rule is also ambiguous because it does not specify whether the referenced inpatient services are non-Medicaid or Medicaid services. The rule is also unclear because it is predicated on the assumption that the area program is subcontracting for the services it is not directly providing. The terms general hospital and private hospital are vague and ambiguous.

.0503

The rule is unclear because it assumes the area program may provide services. It appears from the rule that the expectation is that area program must hire the identified staff to provide services. This is inconsistent with the 2001 mental health reform, which effectively privatized non-Medicaid state funded behavioral health services.

.0504

The rule is not reasonably necessary to implement or interpret an enactment of the General Assembly, Congress or a federal agency. The rule assumes that the area program is responsible for providing direct service. Moreover, this makes the rule unclear and ambiguous, as it assumes a direct relationship with clients that the area programs simply do not have.

.0505

The rule is not within the authority delegated to the agency by the General Assembly; the statutory authority cited in the rule is not applicable to the rule. Moreover, the rule is not necessary to implement or interpret an enactment of the General Assembly, Congress or a federal agency. In fact, the rule is contrary to LME obligation, enshrined in its contracts with DMH and DHB, to locate providers outside of its catchment area when needed services are not available to a client within the catchment area.

.0506

The rule is not within the authority delegated to the agency by the General Assembly; the statutory authority cited in the rule is not applicable to the rule. Moreover, the rule is not necessary to implement or interpret an enactment of the General Assembly, Congress or a federal agency. By design, the processes outlined in .0506 have not been in place for more than five (5) years.

.0507

This rule is not within the authority delegated to the Secretary or Commission by the General Assembly and is not reasonably necessary to implement or interpret an enactment of the General Assembly, Congress or a federal agency. There are State Personnel rules that already speak to the need for evaluations of the area director.

10A NCAC 27G.0600 AREA AUTHORITY OR COUNTY PROGRAM MONITORING OF FACILITIES AND SERVICES

.0601

The rule is vague and ambiguous in that the term "public services" includes Medicaid services, but it is unclear the extent to which Medicaid is within the scope of 27G. "Provider of public services" is vague and ambiguous. "Outpatient services," while defined in .0103, is nevertheless vague and ambiguous. .0601 is the first section of 27G that makes extensive use of the terms "provider," "LME," "public services," and "community based provider."[2] As is made clear in .0606, this entire section .0600 assumes that the providers are contracted with DHHS and that the LME merely "endorses" the providers, thereby giving DHHS oversight authority of the providers that DHHS no longer has or exercises. Because the rules do not account for the current system of delivery, they are not necessary to implement or interpret an act of the General Assembly and so are vague and ambiguous.

.0602

"Complaint investigation" is unclear because, in .0602, it is limited to the investigation of a provider, but later in .600 it is clear "complaints" also include ones made against the LME/MCOs. But nothing in .0602 clarifies or mentions DHHS's oversight role in complaints. "Local Monitoring" and "Monitoring" is unclear, because read in conjunction with .0601 does not include monitoring of Level I incidents.

.0603

Incident reports pertain to "public services," which includes Medicaid and non-Medicaid services, yet DMH has promulgated the manual regarding the reporting of incidents and there is no companion manual issued by DHB. The manual may contain numerous inconsistencies with this rule. The rule is unclear and ambiguous.

.0604

Incident reports pertain to "public services," which includes Medicaid and non-Medicaid services, yet DMH has promulgated the manual regarding the reporting of incidents and there is no companion manual issued by DHB. The manual may contain numerous inconsistencies with this rule. The rule is unclear and ambiguous.

.0605

Incident reports pertain to "public services," which includes Medicaid and non-Medicaid services, yet DMH has promulgated the manual regarding the reporting of incidents and there is no companion manual issued by DHB. The manual may contain numerous inconsistencies with this rule. The rule is unclear and ambiguous.

[2] The fact that 8(b) states "community based providers not requiring State licensure" only reinforces the ambiguity regarding facility licensure.

.0606

There is nothing regarding the referral of complaints to LMEs pertaining to Category C or D providers, rendering this rule unclear and ambiguous. Again, the term "public services" is used, which terms is vague and ambiguous. (b) is entirely unclear, as it states "when the LME is a subject of the complaint, the LME shall refer the complaint concerning a Category A provider…" How can a complaint about an LME concern a Category A provider? How can (b) be squared with the definition of a complaint investigation in .0602? It is unclear what authority DHSR has to investigate or resolve a complaint concerning a Category A provider, because the term "complaint" is not properly defined. It is unclear what authority DMH has to investigate and/or resolve a complaint regarding a Category B provider and it is unclear why DHSR would not have that authority. It is also unclear what distinction there is, if any between a complaint involving a Local Management Entity and one involving a Category A or Category B provider. (c) is unclear because it requires the LME to refer complaints concerning a Category A provider's violation of a "North Carolina rule" to DHSR, apparently regardless of whether the rule pertains to licensure. Clearly, the rules intend for the LME to have monitoring and oversight responsibilities (see Section .7000), and this rule muddies those waters considerably. (d) is unclear; "community based ICF/MR" is undefined. There is no authority cited that gives DHSR authority to investigate any complaint against an ICF-MR, however defined. (e) references 10A NCAC 26C.0501 – 0504 and thus assumes that the Category B providers have a contract with DMH. As DHHS no longer directly contracts with providers for public service delivery or pays their claims, it is unclear how the Secretary has the authority to suspend their funding. That authority almost certainly belongs to the LME. It is unclear what authority DMH has to determine which "agency" (undefined) leads investigations, when the LME is the party that contracts with the providers. (f) references "endorsement," which is not defined and was used during a period of time when DMH directly contracted with providers and the LMEs "endorsed" those providers within its catchment area and "withdrew endorsement" when providers engaged in sufficiently bad acts. This model of service delivery no longer exists.

.0608

(a) only pertains to Category A and B providers, and not C and D providers, which presumably also need oversight; this portion of the rule is vague and unclear. This rule assumes a contractual relationship between DMH and the providers (see (a)(4)) and suffers from many of the same problems as .0606. (a) states the procedures apply to Category A and B providers, but (a)(2) pertains to "all providers," which renders the rule unclear and ambiguous. Additionally, (a)(3) and (a)(4) each require the LME to refer Category A providers to DHSR, but for different reasons.

.0609

The rule is unclear and ambiguous in that it states the LMEs must have a quality improvement process pursuant to .0201(a)(7). However, .0201(a)(7) states that "The governing body

responsible for each facility or service…" and the LME is not a facility (see G.S. § 122C-3, which states that facilities contract with area authorities, meaning area authorities cannot be facilities.) Moreover, incident reporting is covered in a Manual promulgated by DMH, further rendering this rule unclear and ambiguous. Moreover, LME obligations for incident reporting is set forth in its contract with DMH, creating further confusion regarding the rule.

.0610

The rule is not within the authority delegated to DHHS or the Commission by the General Assembly. The LMEs do not have the authority or jurisdiction to "ensure the procedures outlined in G.S. § 108A, Article 6, are initiated;" or to "ensure the procedures outlined in G.S. 7B, Article 3, are initiated" and neither DHHS nor the Commission have the power to grant such authority. The procedures outlined in G.S. § 108A, Article 6, pertain to the Departments of Social Services. The procedures outlined in G.S. § 7B, Article 3, pertain to the court system, which "has exclusive, original jurisdiction over any case involving a juvenile who is alleged to be abused, neglected, or dependent." While the LMEs have a duty to report, the LMEs cannot ensure that DSS or the court system initiates procedures once a report is made. This defect in the rule also renders it vague and ambiguous.

10A NCAC 27G.0700 ACCREDITATION OF AREA PROGRAMS AND SERVICES

This section was repealed due to the reform (privatization) of the behavioral health program in North Carolina. It is highly likely .0700 is not the only section of 27G that should have been repealed at the time of the reform. However, because the remainder of 27G was not amended to reflect the reform, 27G is fundamentally flawed. Nearly all of the rules are based on a system where the area programs provided services, which services were monitored by DMH, as opposed to the system we have now, where private providers perform the services and the LME monitors the service.

10A NCAC 27G.0800 WAIVERS AND APPEALS

.0800 – .0807

These rules suffer from the same lack of clarity all the rules promulgated prior to 2009 and not updated or amended thereafter.

.0808

The rule is unclear and ambiguous. "Contractor" is not defined in the Rules. G.S. 122C-151.3 and -151.4 were amended in 2013 to state "This section does not apply to LME/MCOs, enrollees, applicants, providers of emergency services, or network providers subject to Chapter 108D of the General Statutes." Due to placement of commas, these two statutes can only mean

G.S. 122C-151.3 and -151.4 do not apply to LME/MCOs (area programs) full stop. .0808 simply cannot be reconciled with G.S. 122C-151.3, as amended in 2013.

.0810

The rule is unclear and ambiguous. G.S. 122C-151.3 and -151.4 were amended in 2013 to state "This section does not apply to LME/MCOs, enrollees, applicants, providers of emergency services, or network providers subject to Chapter 108D of the General Statutes." Due to placement of commas, these two statutes can only mean G.S. 122C-151.3 and -151.4 do not apply to LME/MCOs (area programs) full stop. .0810 simply cannot be reconciled with G.S. 122C-151.3, as amended in 2013.

.0811

The rule is unclear and ambiguous. G.S. 122C-151.3 and -151.4 were amended in 2013 to state "This section does not apply to LME/MCOs, enrollees, applicants, providers of emergency services, or network providers subject to Chapter 108D of the General Statutes." Due to placement of commas, these two statutes can only mean G.S. 122C-151.3 and -151.4 do not apply to LME/MCOs (area programs) full stop. .0811 simply cannot be reconciled with G.S. 122C-151.3, as amended in 2013.

.0812

The rule is unclear and ambiguous. G.S. 122C-151.3 and -151.4 were amended in 2013 to state "This section does not apply to LME/MCOs, enrollees, applicants, providers of emergency services, or network providers subject to Chapter 108D of the General Statutes." Due to placement of commas, these two statutes can only mean G.S. 122C-151.3 and -151.4 do not apply to LME/MCOs (area programs) full stop. .0812 simply cannot be reconciled with G.S. 122C-151.3, as amended in 2013.

10A NCAC 27G.0900 GENERAL RULES FOR INFANTS AND TODDLERS

Given the authority cited, it appears this section pertains to licensing. However, the rules in this section are unclear and ambiguous because it is unclear whether DHSR or the LME/MCO is responsible for oversight. Moreover, this program was transferred to Public Health in 2002, and the rules should have been transferred with the program.

.0902

G.S. § 150B-1(d) is cited as statutory authority, but it does not grant authority for this rule. G.S. § 150B-1(d) lists "exemptions from rule making" and includes "The Department of Health and Human Services in adopting new or amending existing medical coverage policies for the State Medicaid and NC Health Choice Programs…", "The Department of Health and Human Services

in implementing, operating or overseeing new 1915 b/c Medicaid Waiver programs or amendments to existing 1915 b/c Medicaid Waiver programs," and "The Department of Health and Human Services with respect to the content of … Waivers approved by the Centers for Medicare and Medicaid Services…" If the statutory authority is accurate, .0902 does not need to be a rule. The above exemptions also highlight the fundamental problem of 27G not distinguishing between Medicaid and non-Medicaid services. DHHS has promulgated a slew of manuals, rules, and policy manuals that supplement – or are intended to supplement – 27G – the regulation of public behavioral health service delivery. We have an iterative set of behavioral health regulations that appear to be applicable to the LME/MCOs in the current environment – 27G (and other administrative code sections), and the regulations created by DHHS in the form of APSM manuals and clinical coverage policy manuals. However, with clarification concerning the iterative nature of the administrative rules and added layers of manuals, and without a resolution of conflicting provisions, this is largely unworkable and causes significant confusion and lack of clarity.

.0903

G.S. § 150B-1(d) is cited as statutory authority, but it does not grant authority for this rule. G.S. § 150B-1(d) lists "exemptions from rule making" and includes "The Department of Health and Human Services in adopting new or amending existing medical coverage policies for the State Medicaid and NC Health Choice Programs…", "The Department of Health and Human Services in implementing, operating or overseeing new 1915 b/c Medicaid Waiver programs or amendments to existing 1915 b/c Medicaid Waiver programs," and "The Department of Health and Human Services with respect to the content of … Waivers approved by the Centers for Medicare and Medicaid Services…" If the statutory authority is accurate, .0903 does not need to be a rule. The above exemptions also highlight the fundamental problem of 27G not distinguishing between Medicaid and non-Medicaid services. DHHS has promulgated a slew of manuals, rules, and policy manuals that supplement – or are intended to supplement – 27G – the regulation of public behavioral health service delivery. We have an iterative set of behavioral health regulations that appear to be applicable to the LME/MCOs in the current environment – 27G (and other administrative code sections), and the regulations created by DHHS in the form of APSM manuals and clinical coverage policy manuals. However, with clarification concerning the iterative nature of the administrative rules and added layers of manuals, and without a resolution of conflicting provisions, this is largely unworkable and causes significant confusion and lack of clarity.

.0904

G.S. § 150B-1(d) is cited as statutory authority, but it does not grant authority for this rule. G.S. 150B-1(d) lists "exemptions from rule making" and includes "The Department of Health and Human Services in adopting new or amending existing medical coverage policies for the State Medicaid and NC Health Choice Programs…", "The Department of Health and Human Services in implementing, operating or overseeing new 1915 b/c Medicaid Waiver programs or

amendments to existing 1915 b/c Medicaid Waiver programs," and "The Department of Health and Human Services with respect to the content of … Waivers approved by the Centers for Medicare and Medicaid Services…" If the statutory authority is accurate, .0903 does not need to be a rule. The above exemptions also highlight the fundamental problem of 27G not distinguishing between Medicaid and non-Medicaid services. DHHS has promulgated a slew of manuals, rules, and policy manuals that supplement – or are intended to supplement – 27G – the regulation of public behavioral health service delivery. We have an iterative set of behavioral health regulations that appear to be applicable to the LME/MCOs in the current environment – 27G (and other administrative code sections), and the regulations created by DHHS in the form of APSM manuals and clinical coverage policy manuals. However, with clarification concerning the iterative nature of the administrative rules and added layers of manuals, and without a resolution of conflicting provisions, this is largely unworkable and causes significant confusion and lack of clarity.

.0905

This rule is vague and ambiguous because the provisions only make sense if the area programs actually provide services. The rules also appear to conflict with the LMEs obligations under HIPAA and 42 CFR Part 2.

10A NCAC 27G.1100 PARTIAL HOSPITALIZATION FOR INDIVIDUALS WHO ARE ACUTELY MENTALLY ILL

This entire section (.1100) is not necessary to implement or interpret an act of the General Assembly, Congress or a federal agency; it was not amended to reflect the 2001 behavioral health reform. The term "facility" is vague and ambiguous and, based on other rules could include the area program. Also, based on the statutory authority cited, it is unclear whether DMH, DHSR or the LME is responsible for monitoring adherence to Section .1100. The rule is also unclear and ambiguous because clinical coverage policy manuals also set forth requirements for these services and may conflict with the rules. This section has not been amended since 1996 and so was not promulgated to implement or interpret an enactment of the General Assembly, Congress or a federal agency.

10A NCAC 27G.1200 PSYCHOSOCIAL REHABILITATION FACILITIES FOR INDIVIDUALS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

This entire section is not necessary to implement or interpret an act of the General Assembly, Congress or a federal agency; it was not amended to reflect the 2001 behavioral health reform. The term "facility" is vague and ambiguous and, based on other rules could include the area program. Also, based on the statutory authority cited, it is unclear whether DMH, DHSR or the LME is responsible for monitoring adherence to this Section. The rule is also unclear and ambiguous because clinical coverage policy manuals also set forth requirements for these

services and may conflict with the rules. This section has not been amended since 1996 and so was not promulgated to implement or interpret an enactment of the General Assembly, Congress or a federal agency.

10A NCAC 27G.1300 RESIDENTIAL TREATMENT FOR CHILDREN OR ADOLESCENTS

.1301

The rule is unclear and ambiguous because (a) says the rules of section 1300 only apply to a residential treatment facility that provides "level II" services, but (b) references a level III facility and requires that it be licensed. The rule appears to apply to level II and level III facilities. Level II and Level III services are not defined, lending to the lack of clarity of the rule. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities, and which may conflict with .1301. The rule is unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule. This rule has not been amended since 1996 and so was not promulgated to implement or interpret an enactment of the General Assembly, Congress or a federal agency.

.1302

The rule is unclear and ambiguous because (a) says the rules of section 1300 only apply to a residential treatment facility that provides "level II" services, but (b) references a level III facility and requires that it be licensed. The rule appears to apply to level II and level III facilities. Level II and Level III services are not defined, lending to the lack of clarity of the rule. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities, and which may conflict with .1302. The rule is unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule. This rule has not been amended since 1996 and so was not promulgated to implement or interpret an enactment of the General Assembly, Congress or a federal agency.

.1303

The rule is unclear and ambiguous because (a) says the rules of section 1300 only apply to a residential treatment facility that provides "level II" services, but (b) references a level III facility and requires that it be licensed. The rule appears to apply to level II and level III facilities. Level II and Level III services are not defined, lending to the lack of clarity of the rule. It is unclear if this rule applies to Medicaid or non-Medicaid services. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities, and which may conflict with .1303. The rule is unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule. This rule has not been amended since 1996 and so was not promulgated to implement or interpret an enactment of the General Assembly, Congress or a federal agency.

.1304

The rule is unclear and ambiguous because (a) says the rules of section 1300 only apply to a residential treatment facility that provides "level II" services, but (b) references a level III facility and requires that it be licensed. The rule appears to apply to level II and level III facilities. Level II and Level III services are not defined, lending to the lack of clarity of the rule. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities, and which may conflict with .1304. The rule is unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule. This rule has not been amended since 1996 and so was not promulgated to implement or interpret an enactment of the General Assembly, Congress or a federal agency.

10A NCAC 27G.1400 DAY TREATMENT FOR CHILDREN AND ADOLESCENTS WITH EMOTIONAL OR BEHAVIORAL DISTURBANCES

This entire section is not necessary to implement or interpret an act of the General Assembly, Congress or a federal agency; it was not amended to reflect the 2001 behavioral health reform. The term "facility" is vague and ambiguous and, based on other rules could include the area program. Also, based on the statutory authority cited, it is unclear whether DMH, DHSR or the LME is responsible for monitoring adherence to this Section. The rule is also unclear and ambiguous because clinical coverage policy manuals also set forth requirements for these services and may conflict with the rules. This section has not been amended since 1996 and so was not promulgated to implement or interpret an enactment of the General Assembly, Congress or a federal agency.

10A NCAC 27G.1500 INTENSIVE RESIDENTIAL TREATMENT FOR CHILDREN AND ADOLESCENTS WHO ARE EMOTIONALLY DISTURBED OR WHO HAVE A MENTAL ILLNESS

These rules are vague and ambiguous because it is unclear whether they apply to Medicaid or non-Medicaid services. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with .1500. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.1700 RESIDENTIAL TREATMENT STAFF SECURE FOR CHILDREN OR ADOLESCENTS

The section is vague and ambiguous because DHHS has developed other policies and procedures that would appear to apply to these facilities, and which may conflict with this section. The rule

is unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.1800 INTENSIVE RESIDENTIAL TREATMENT FOR CHILDREN OR ADOLESCENTS

These rules are vague and ambiguous because DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.1900 PSYCHIATRIC RESIDENTIAL TREATMENT FOR CHILDREN AND ADOLESCENTS

These rules are vague and ambiguous because DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.2100 SPECIALIZED COMMUNITY RESIDENTIAL CENTERS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.2200 BEFORE/AFTER SCHOOL AND SUMMERD EVELOPMENTAL DAY SERVICES FOR CHILDREN WITH OR AT RISK FOR DEVELOPMENTAL DELAYS, DEVELOPMENTAL DISABILITIES, OR ATYPICAL DEVELOPMENT

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.2300 ADULT DEVELOPMENTAL AND VOCATIONAL PROGRAMS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.2400 DEVELOPMENTAL DAY SERVICES FOR CHILDREN WITH OR AT RISK FOR DEVELOPMENTAL DELAYS, DEVELOPMENTAL DISABILITIES OR ATYPICAL DEVELOPMENT

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.2500 EARLY CHILDHOOD INTERVENTION SERVICES (ECIS) FOR CHILDREN WITH OR AT RISK FOR DEVELOPMENTAL DELAYS, DEVELOPMENTAL DISABILITIES, OR ATYPICAL DEVELOPMENT AND THEIR FAMILIES

This Section was repealed in 2011, but it is not apparent why in the Rule itself. However, it reinforces the lack of clarity regarding the remainder of the services outlined in 27G, because it is entirely possible that other Sections should have been repealed as well. This rule cited as its statutory authority 20 USC Section 1401. This same rule is cited as authority for .0900, but why weren't those rules repealed?

10A NCAC 27G.3100 NONHOSPITAL MEDICAL DETOXIFICATION FOR INDIVIDUALS WHO ARE SUBSTANCE ABUSERS

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.3200 SOCIAL SETTING DETOXIFICATION FOR SUBSTANCE ABUSE

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.3300 OUTPATIENT DETOXIFICATION FOR SUBSTANCE ABUSE

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.3400 RESIDENTIAL TREATMENT/REHABILITATION FOR INDIVIDUALS WITH SUBSTANCE ABUSE DISORDERS

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.3500 OUTPATIENT FACILITIES FOR INDIVIDUALS WITH SUBSTANCE ABUSE DISORDERS

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.3600 OUTPATIENT OPIOID TREATMENT

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers and only portions have been amended since the 2001 reform. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.3700 – 10A NCAC 27G.3900

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with these sections. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.4000 – 10A NCAC 27G.4300

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers and only portions have been amended since the 2001 reform. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.4400 – 10A NCAC 27G.4500

These rules are vague and ambiguous because DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule.

10A NCAC 27G.5000 – 10A NCAC 27G.6900

These rules are vague and ambiguous because these rules were promulgated prior to the Commission having authority to adopt rules regarding private providers and only portions have been amended since the 2001 reform. Moreover, DHHS has developed other policies and procedures that would appear to apply to these facilities/services, and which may conflict with this section. The rules are unclear and ambiguous because it is unclear whether DMH, DHSR or the LME has the authority to monitor compliance with the rule. Rule .5900 concerns Case Management, which providers no longer provide; therefore the rules should have been repealed. This calls into question which other rules in Sections .1100 - .6900 should also have been repealed. It also calls into question both the statutory authority used to justify Sections .1100 - .6900, and whether these sections are reasonably necessary to implement or interpret an enactment of the General Assembly, or of Congress, or a regulation of a federal agency.

10A NCAC 27G.7000 LOCAL MANAGEMENT ENTITY RESPONSE TO COMPLAINTS

.7001

The term “provider categories” is unclear and ambiguous and does not reflect the fact that area LMEs contract directly with providers for both Medicaid and non-Medicaid behavioral health services. The rules in section .7000 “also govern the procedures for Local Management Entities when investigating providers according to 10A NCAC 27G.0606.” As set forth hereinabove, .0606 is itself unclear and ambiguous. Section .0606 presumes that LMEs merely “endorse” providers and the term “endorse” is not defined. Moreover, it is unclear what distinction, if any, there is between Category A and Category B providers, referenced in .0606 and “provider categories” referenced in .7001.

.7002

The rule is unclear and ambiguous because the term "public services" includes Medicaid services, but there is no distinction between the two in the rule. The term "complaint" is not properly defined. It is unclear what authority is being used to establish the client's rights referenced in (b). Medicaid clients have rights mandated by federal law, yet there is no reference to the Division of Health Benefits, which manages Medicaid. It is unclear what authority supports the LME's obligation to refer any complaints to DMH. The term "appeals" is vague and unclear. There is no authority mandating referral of a complaint by an LME and "refer the matter to the appropriate State or local government agency" is vague and unclear. In the rule, it is entirely unclear which local government agency is responsible for regulation and oversight of "the provider," rendering (c) entirely vague and ambiguous. "Home Local Management Entity" is not defined and is vague and ambiguous. The rule does not contemplate a contractual relationship between the LME and the providers and so is not reasonably necessary to implement or interpret an enactment of the General Assembly, or of Congress, or a regulation of a federal agency. It is impossible to determine when to apply .7002, versus .7003, and so the rule is unclear and ambiguous.

.7003

The term "providers" is not defined, but presumably it only applies to Class A & B providers, which are licensed. It is unclear then, why this rule does not also refer to investigations by DHSR. The rule requires a plan of correction for all substantiated complaint investigations, and provides an avenue for appeal. However, it is unclear if this applies to complaints regarding the provision of Medicaid services or non-Medicaid services and does not contemplate a contractual relationship between the LME and the provider. Furthermore, (11) references revocation or suspension of funding by DMH, pursuant to 10A NCAC 26C.0501, which is vague and ambiguous because DMH does not have the authority to suspend or revoke funding to providers in the non-Medicaid context under the current system of delivery. DMH does not have the authority to dictate which agency leads provider investigations or which agencies need to be involved in provider investigations. The term "plan of correction" is vague and ambiguous. This rule appears to exceed the authority granted to the Secretary under G.S. § 122C-112.1(a)(29). The rule is unclear in that it does not detail the consequences to a provider for failing to implement a plan of correction. It is unclear how and when an issue which the LME is investigating gets referred to DMH and it is also unclear what authority DMH has to take any action on that referral, or what action DMH is actually authorized to take. Given the LME's mandate in other rules to refer violations of rules to DHSR, it is unclear why the LME is required in .7003 to cite rule violations in their investigative findings to the providers.

.7004

This rule is unclear and ambiguous because "non-Medicaid funded services" is not restricted to state funded behavioral health services (see 10A NCAC 27G.0103). Moreover, the rule is vague

and ambiguous because this appears to be first reference in 27G to the LME's ability to deny, reduce or terminate a client's services. There are no rules concerning the utilization review process referenced in .7004. Without that critical context, the rule is hopelessly unclear.