February 19, 2019

Via Electronic Mail only (denise.baker@dhhs.nc.gov)
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Division of MH/DD/SAS
N.C. Department of Health and Human Services
306 N. Wilmington Street, Bath Building
Raleigh, NC 27699-3001

RE: 10A NCAC Subchapter 27G, 28G and 29D Public Comments

Dear Ms. Baker:

On behalf of Vaya Health, attached hereto please find our public comments to the Commission's Reports regarding 10A NCAC Subchapter 27G, 28G and 29D. We are submitting these public comments as our formal objections to the Commission's designation of each rule within 10A NCAC 27G as "Necessary without Substantive Public Interest." We believe the entirety of 10A NCAC Subchapter 27G should be designated as "Necessary with Substantive Public Interest" or, in some cases, designated as "Unnecessary." Although the bulk of our comments focus on Subchapter 27G, we also provide specific comments for the Commission's consideration regarding Subchapters 28G and 29D.

As outlined in more detail in our comments, we respectfully request that the Commission reclassify each and every rule within 10A NCAC Subchapter 27G as either "Necessary with Substantive Public Interest" or "Unnecessary", before submitting the Reports to the Rules Review Commission. We thank you in advance for the opportunity to provide these public comments.

Sincerely,

Vaya Health

Tracy J. Hayes

Tracy J. Hayes, JD, CHC
General Counsel & Chief Compliance Officer

Encl.

cc: dmhddsasrules@dhhs.nc.gov

VAYA HEALTH PUBLIC COMMENTS

10A NCAC 27G – OVERALL COMMENT

The rules are vague and ambiguous and not within the authority of DMH and/or the Commission.

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. However, G.S. § 143B-147 has undergone significant revision since 1996. 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…" The statute did not contemplate these services being performed by private providers. After the 2001 mental health 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[1], to private providers of public services. At the same time, area authorities shifted from being the providers of public services to serving as the manager of public services. This fundamentally altered the nature of the relationship between DMH and the area authorities. Therefore, to the extent the rules in 27G reliant upon G.S. 143B-147(a)(1b) were not amended, revised or clarified after the 2001 mental health reform (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/DD/SAS, area authorities and private providers, between 2001 and 2012, such rules are by definition 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.

[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.

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.

Specific examples of the overall rule being vague and ambiguous or contrary to current clinical guidelines include the following:

1) LME/MCOs are variously referred to in the rules as "area programs," "area authorities," and "local management entities," which should be streamlined and made consistent where possible.
2) Any reference to area programs "providing" services are ambiguous and should be removed, since area programs are no longer permitted to directly provide services.
3) Any language related to endorsement should be removed, since endorsement is no longer a function of the North Carolina mental health system.
4) References to DMA should be updated to reflect the urrent Department of Health Benefits (DHB).
5) All references to specific versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), should be updated to reflect "the most up to date version of the DSM."
6) All references to "substance abuse" should be updated to "substance use" in accordance with current national best practice guidelines.
7) The titles of individual rules within the Subchapter are vague and ambiguous, e.g. there are multiple rules entitled "Scope" or "Definitions" or "Staff Requirements" or similar, making it difficult for the reader to differentiate between rules within the Subchapter.
8) General lack of specificity that makes it difficult to hold providers accountable when a deficiency is identified:
    a. For enhanced services, there is a lack of minimum expectations regarding therapeutic face-to-face contact by licensed staff with member and/or family. Minimums should be specified.
    b. Lack of specificity related to "direct care staff", it would be more beneficial to identify by minimum requirement, i.e. licensed, QP, AP, or paraprofessional.
    c. When a requirement is stated, it should include specifics about proof of how the requirement is met.
    d. When experience requirements are specified, the rule should include language to the effect that "Experience must be documented and verifiable via resume and job application employment history in personnel files."
    e. When staffing expectations in terms of number of staff present are described as "one staff member present if only one client is in the program, and two staff members present when two or more clients are in the program," the rule should include specific requirements as to staff level mix, i.e. "at least one QP or one QP and one paraprofessional." Likewise, when there are specifications about number

of staff present per number of members being served, the professional level of the staff present should be specific.

f. When staffing ratios are specified, the rule should include language to the effect that "Documentation that reflects the staff present each day with the total number of clients in attendance for each date the program is in operation should be readily available upon request to evidence compliance with required staffing ratios."
g. When requirement for "an emergency on call staff readily available by telephone or page and able to reach the facility within 30 minutes" is specified, the rule should include language to the effect that "Staffing schedules/documentation must clearly reflect who the assigned emergency on-call staff person is for each date of service."
h. The phrase "Clinical consultation shall be provided by a qualified mental health professional to each facility at least twice a month" appears in staffing requirements for multiple services. It should be specified if and when the consultation should be face-to-face.
i. In addition, the level of qualified mental health professional who may provide clinical consultation for each service type should be specified, i.e. "Documentation that includes the following should be maintained and available upon request during monitoring/investigations: dates the consultation was held, the QMHP that facilitated the meeting, staff present, and topics covered."
j. When family involvement is required for a service, the rule should include language to the effect that "documentation of family involvement in meetings, counseling, phone consultations, etc. should be maintained in the client's record."
k. For residential services that specify that a licensed professional should see the member, there should be a specification of minimum face to face contact requirements.

9) The Subchapter is lacking a section on telemedicine, which is now an important component of the clinical continuum.
10) The Subchapter should be rewritten to utilize consumer-focused, recovery-oriented language to reflect current Department guidance and national best practices.
11) All gender-specific references should be made gender-neutral. For example, references to "Chairman" should be revised to "Chairperson." If the Chair of any Committee or Governing Board referenced within the Rules is a person who does not identify as male, the rule is of necessity vague, unclear and ambiguous.

10A NCAC 27G.0100. GENERAL INFORMATION

<u>10A NCAC 27G.0101 Scope</u>

.0101(a) This rule is unclear, ambiguous and vague.

- The term "agencies" (or "agency" in the singular) is not defined within the Subchapter. This is problematic, for example, because pursuant to G.S. § 122C-3(20(b)), the term "local management entity" is defined as meaning "an area authority, county program or consolidated human services agency." LMEs do not deliver services pursuant to G.S.

122C, and it is unclear whether "agencies" as used in this section of the Subchapter is intended to refer to LMEs. It is also unclear which "person" is covered by the term agency.

- "area programs administering such services within the scope of G.S. 122C" is ambiguous because it is unclear as to the scope of such "administering" functions. Further, area programs (i.e. area authorities, as defined in 10A NCAC 27G .0103(7)) do not "administer" services of consolidated human services agency, which may or may not be included in the undefined term "agencies".
- The rule is vague and ambiguous because "mental health" services are not defined in G.S. 122C or in the Subchapter, as such the entire Subchapter and sections relating to "mental health" services are unclear, vague, ambiguous and unnecessary.

.0101(b) This rule is unclear, ambiguous, vague and unnecessary.

- (b) & (b)(1) This rule suggests licensed facilities only are subject to the Subchapter, notwithstanding the use of "facilities and agencies" in subpart (a) of this rule. This rule also suggests that the extent to which licensed facilities must comply with this rule is to "receive and maintain" the licenses, however, the rules in this Subchapter appear to extend beyond licensure requirements. For example, actions that may be taken by LMEs pursuant to this Subchapter would not necessarily result in a loss of DHSR licensure by a licensed facility. 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)
- This rule is misleading, unclear, ambiguous and vague for these reasons.
- (b) & (b)(2) Area programs are not accredited by DMH/DD/SAS, which lacks authority to accredit area programs. This is reflected in the repeal of *Section .0700 – Accreditation of Area Programs and Services* in 2009. Area programs also do not provide services. Therefore, all references in this rule and in the Subchapter to "accreditation" of programs and services are unnecessary. Further, any requirement for area programs to comply with the rules is likewise unnecessary, ambiguous, and vague since the authority under which DMH/DD/SAS has cited for requiring area programs to comply with this Subchapter is inapplicable.
- (b)(2) and (e) are also not within the authority delegated to the agency – DHHS, by and through DMH, does not have the authority to accredit Area Programs. All references to area program accreditation or service delivery should have been removed from the rules as a result of the repeal of *Section .0700 – Accreditation of Area Programs and Services* in 2009. Because they were not, 27G is unclear and ambiguous.

.0101(c) This rule is unclear and ambiguous because it suggests that the contracts area programs can enter into with persons (which is defined as including "area programs") are for the provision of services that the area programs provide. Area programs do not directly provide services, therefore, it is unclear whether the providers with whom area programs enter into

contracts with necessarily subject to the rules of this Subchapter. In addition, it is unclear whether the "facility" that contracts with another "person" must be a licensed facility. It is further 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.

.0101(d) This rule is unclear and ambiguous. "Mental health" is not a defined term so it is unclear what services are intended to be subject to the Subchapter. Likewise, "program" is not a defined term and it is unclear by the context whether such term is intended to mean an "area program" or a generic type of program or something entirely different. Also, this Rule is ambiguous as to whether licensed facilities only are subject to the Subchapter.

.0101(e) DMH/DD/SAS lacks authority to deny or revoke area program service accreditation. As expressed above, area programs are not accredited by DMH/DD/SAS. This is reflected in the repeal of *Section .0700 – Accreditation of Area Programs and Services* in 2009. Therefore, all references in this rule and in the Subchapter to "accreditation" of programs and services are unnecessary and lack authority.

The unclear, ambiguous, vague and unnecessary nature of all or parts of 10A NCAC 27G .0101, which sets forth the Scope of the entire Subchapter, renders the entire Subchapter unclear, ambiguous, vague and/or unnecessary. Clarifying the cited terms and issues will fundamentally alter the nature, interpretation and scope of the Rules that follow in this Subchapter. 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 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, 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, almost the entirety of 27G is no longer 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.

10A NCAC 27G.0102 Copies of Rules

This rule is misleading, ambiguous and unnecessary as it appears copies of the rule are available at no cost through the North Carolina Office of Administrative Hearings. Specifically, NCOAH's website states: "The NCAC is available at no charge on the OAH website: http://reports.oah.state.nc.us/ncac.asp. OAH updates this website weekly. Loose leaf copies of rules are available by contacting the Office of Administrative Hearings, Rules Division, 6714 Mail Service Center, Raleigh, NC 27699-6700; phone: 919-431-3000; or email to: oah.postmaster@oah.nc.gov. The Official North Carolina Administrative Code is available by subscription from ThomsonReuters and may be ordered directly from West Group by calling 1-800-762-5272, ordering from the online store at www.west.thomson.com, or by writing to: ThomsonReuters Post Office Box 64526 Eagan, MN 55164-0526."

10A NCAC 27G.0103 General Definitions

"Accreditation" should be removed as unnecessary and erroneous. DMH/DD/SAS does not have accreditation authority over area programs and area programs do not directly provide services.
"Administering medication" is vague, ambiguous and unclear. This definition includes the word "drug," which is an undefined term. It is unclear whether "drug" is intended to be synonymous with "medication" or broader in scope.
"Alcohol abuse" and "Alcohol dependence" are unnecessary because in May 2013, the American Psychiatric Association issued a fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which integrated the two DSM–IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications.
"Area program" should be revised, and thus as written, it is unnecessary. Area programs do not provide services. It also states that area programs are synonymous with area authorities, which do not deliver services under G.S. 122C, so this definition is also unclear and ambiguous.
"Facility" as used herein is ambiguous, as it could suggest that area programs are facilities, and should be revised to exclude "area authorities". It is also already defined in G.S. § 122-3 and the definitions are not the same.
"Medication" as used herein is incomplete, it should include "or symptoms" at the end of the definition.
"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 .0104 Staff Definitions

All of these definitions are unclear and ambiguous as to whether the staff identified must have received a degree or the equivalent from an accredited or unaccredited school, college, university or program. To the extent these definitions are inconsistent with the NC Medicaid State Plan and/or NC Medicaid Clinical Coverage Policies (and applicable to Medicaid-funded services), they should be clarified. These definitions do not clearly differentiate between fully licensed and provisionally licensed practitioners or professionals. Furthermore, these staff definitions do not include all of the relevant healthcare professionals, e.g., peer support specialist and certified family partner.

10A NCAC 27G.0200 OPERATION AND MANAGEMENT RULES

10A NCAC 27G .0201 Governing Body Policies

This rule is unclear and ambiguous because it suggests it is applicable to area programs. For example, the term "Governing body" is defined to mean "in the case of an area authority, the area board". Area authorities do not deliver these services, so this Section and rule, as it applies to area authorities, are unnecessary, unclear and ambiguous. Further, 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 much of this, and particularly to the extent it is also captured in manuals.

(a)(10) is vague, unclear, ambiguous and contrary to best practice where it references "voluntary non-compensated work performed by a client" – Therapeutically, this should not be acceptable.

(a)(15) is vague, unclear, and ambiguous where it references services of volunteers, including supervision and requirements for maintaining client confidentiality - Specific language should be included related to student interns (supervision, allowable activities and client confidentiality).

Finally, the rule is vague and ambiguous because it lacks an additional necessary requirement for the provider to have in place a process for conducting and documenting internal investigations of incidents.

10A NCAC 27G .0202 Personnel Requirements:

Client rights and confidentiality requirements, as referenced herein, may be inconsistent with HIPAA requirements and therefore may be confusing, unclear and ambiguous. 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. The term "facility" as defined in G.S. 122C-3(14) includes an "area facility" and thus this rule is unclear, ambiguous and unnecessary to the extent that the provision of services is required by the area program as a provider of service. It is also 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. Finally, it does not appear the Commission had the authority to promulgate this rule, particularly if it is intended to pertain to non-licensed facilities.

10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals
The term "privileging" is not defined and makes this rule unclear and ambiguous. As written, subpart (c) appears to require competencies demonstrated "at such time as a competency-based employment system is established by rulemaking" only. This leaves requirements for competencies at other times vague, unclear and ambiguous. Further, this whole section is vague, unclear and ambiguous because: (i) it lacks detailed language related to prior experience (e.g. employee working in a public school after school program part-time, does not correlate to working with SPMI children in a day treatment program); (ii) the rule should include specific requirements regarding proof of execution of supervision plans, not just initiation of a documented supervision plan; and (iii) the core skills list is comprised of broad vague categories and should be more specific.

10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals
The term "privileging" is not defined and makes this rule unclear, vague and ambiguous. As written, subpart (c) appears to require competencies demonstrated "at such time as a competency-based employment system is established by rulemaking" only. This leaves requirements for competencies at other times vague, unclear and ambiguous.

10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan
The term "Governing body" is defined to mean "in the case of an area authority, the area board". Area authorities do not deliver these services, so this rule, as it applies to area authorities, is unnecessary, unclear and ambiguous. The rule is unclear in that it seems only to pertain to licensed facilities. The rule is also 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. Finally, section (c) of the rule, which states, "The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days" is inconsistent with NC Medicaid Clinical Coverage Policies 8A and 8C, which have the force and effect of a rule pursuant to G.S. 108A-54.2. The CCPs specify plan shall be developed within 15 business days. Therefore, because the rule is inconsistent with another promulgated rule, it is by definition, vague, unclear and ambiguous. Ultimately, the rule should specify which entity is responsible for the comprehensive clinical assessment and when/who can make an addendum only, versus a new CCA.

10A NCAC 27G .0206 Client Records
The term "facility" as defined in G.S. 122C-3(14) includes an "area facility", this rule is unclear, ambiguous and unnecessary to the extent that the provision of services is required by the area program as a provider of service. DSM IV has been superseded by DSM-V and ICD-9-CM has

been superseded by ICM-10-CM, therefore these references are outdated and unnecessary, unclear and ambiguous.

10A NCAC 27G .0207 Emergency Plans and Supplies
The term "facility" as defined in G.S. 122C-3(14) includes an "area facility", this rule is unclear, ambiguous and unnecessary to the extent that the provision of services is required by the area program as a provider of service. The term "appropriate local authority" is confusing and vague.

10A NCAC 27G .0208 Client Services
The term "facility" as defined in G.S. 122C-3(14) includes an "area facility", this rule is unclear, ambiguous and unnecessary to the extent that the provision of services is required by the area program as a provider of service.

10A NCAC 27G .0209 Medication Requirements
(a)(3) Opioid treatment programs have expanded beyond methadone and this rule leaves medication requirements concerning those other OTPs vague, unclear and ambiguous.

10A NCAC 27G .0212 Disclosure of Financial Interest of Providers of MH/DD/SA services to Potential Clients
G.S. § 122C-3(20b) defines LME as an area authority effective October 2019, and the use of LME in this section, while the term area authority is used elsewhere, may be confusing and unnecessary.

10A NCAC 27G .0300 PHYSICAL PLANT RULES

10A NCAC 27G .0302 Facility Construction/Alterations/Additions
This rule is contrary to the best interest of consumers served because it lacks a requirement for a written plan for residents/safety during periods of constructions (given special needs of MH/SU/IDD populations having sensitivities to noise, strangers, etc.).

10A NCAC 27G.0500 AREA PROGRAM REQUIREMENTS

10A NCAC 27G .0501 Required Services
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. Finally, Sections (8) through (10) and Section (13) are ambiguous in that they refer to benefit codes that no longer exist; they should be updated with current benefit plan codes.

10A NCAC 27G .0502 Area Program/ Hospital Agreement

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. References to "general hospital" and "private hospital" are vague and ambiguous in that they imply that specialty and public hospitals, including municipal hospitals, are excluded. These terms should be replaced with "hospital." Section (c) requires DMH/DD/SAS to review contracts when services are provided out of state; however, this rule is ambiguous as to whether the "services" referred to are meant to be only inpatient hospital services, or any type of services, and whether the "written agreement" referred to is the agreement with the service provider or a different party. In addition, requiring DMH/DD/SAS to review written agreements to ensure compliance with paragraph (b) and to determine whether comparable in-state services are available is vague because it is not clear whether DMH/DD/SAS contract review is required prior to inception of services, although this is implied. If that is the case, such prior review would hamper effective treatment if a patient could be forced to move from an out-of-state provider to an in-state provider after inception of services. The requirement that DMH/DD/SAS review agreements, presumably before inception of services, is also unnecessary because DMH/DD/SAS has the authority to review any contract upon request.

10A NCAC 27G .0503 Staff Requirements

This rule is ambiguous in that it has varying requirements for licensure and certification. For example, it requires a psychologist to be licensed, but not a psychiatrist. This rule also does not define what "qualified" means with respect to a developmental disabilities professional or a records manager. Section (5) is ambiguous because it does not reflect current terminology for licensure/certification of alcoholism and drug abuse professionals. Further, 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.

10A NCAC 27G .0504 Client Rights Committee

The rule is not reasonably necessary to implement or interpret an enactment of the General Assembly, Congress or a federal agency. This rule is vague in that area authorities no longer provide services but instead oversee the provision of services by contracted providers, however, the rule assumes that the area program is responsible for providing direct services. This makes

the rule unclear and ambiguous, as it assumes a direct relationship with clients that the area programs simply no longer have.

10A NCAC 27G .0505 Notification Procedures for Provision of Services
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. Further, section (a) is vague in that it references operation of a service by an area program, which is no longer permitted. In addition, this provision may be unnecessary under Medicaid reform. Finally, this rule does not define "service," which could be construed broadly to include any type of service contract to which an LME/MCO is a party.

10A NCAC 27G .0506 Communication Procedures for Out of Home Community Placement
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. Finally, this rule is vague in that it references "county programs," which no longer exist independently of LME/MCOs.

10A NCAC 27G .0507 Area Board Annual Evaluation of an Area Director
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. Section (b) is ambiguous in its wording: "Area Boards shall evaluate, but not be limited to, the Area Director's performance in each of the following areas . . . .". Section (b)(3)(A) refers to "program development" in the context of consumer/family involvement in system management activities, but it is ambiguous in that it does not specify the types of programs to which this applies. Section (b)(3)(B) refers to "quality management" in the context of consumer/family involvement in system management activities, but it is ambiguous in that it does not specify what is being managed for quality. Section (b)(3)(C) refers to "community development" in the context of consumer/family involvement in system management activities, but it is ambiguous in that it does not specify what community this is referring to.

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

10A NCAC 27G .0601 Scope
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", and the fact that 8(b) states "community based providers not requiring State licensure" only reinforces the ambiguity regarding facility licensure. 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 delivery system resulting from the 2001 mental health reform, they are not necessary to implement or interpret an act of the General Assembly and so are vague and ambiguous.

10A NCAC 27G .0602 Definitions

"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 LMEs. But nothing in .0602 clarifies or mentions the Department's oversight role in complaints.

"ICF/MR" is completely inappropriate and should be revised to reflect current terminology, i.e. Intermediate Care Facility for Individuals with Intellectual and/or Developmental Disabilities or ICF/IID. All references to "Mentally Retarded" or "MR" should be stricken from the Rules and it is quite frankly appalling that the Commission has left this offensive language unaddressed since 1996.

"Local Monitoring" and "Monitoring" are unclear, because read in conjunction with .0601 do not include monitoring of Level I incidents. Further, these definitions will likely require significant revision in light of Medicaid Transformation, in order to clarify which entities have authority to conduct monitoring of behavioral health providers.

10A NCAC 27G .0603 Incident Response Requirements For Category A and B Providers

The rule is unclear and ambiguous. 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. Section (c)(2)(D) is unclear, vague and ambiguous in that it does not specify a timeframe for the provider to submit its written report to the LME (the report must be "issued" within three months, but no timeframe is specified for it to be "sent" to the LME, nor does the rule specify the mechanism for notification – mail, fax, email, etc.) Section (c)(3) is vague and ambiguous because it does not specify the mechanism for notifications.

10A NCAC 27G .0604 Incident Reporting Requirements For Category A and B Providers

The rule is unclear and ambiguous. 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. Further, the current rule permits incident reports, to be submitted via mail, in person, facsimile, or encrypted electronic means. This is vague, unclear and ambiguous because DMH/DD/SAS expectation communicated to the LMEs

is that incident reports should only be accepted via the Department's electronic Incident Response Improvement System (IRIS), unless being submitted by an out-of-state provider.

10A NCAC 27G .0606 Referral Of Complaints To Local Management Entities Pertaining To Category A or Category B Providers

There is nothing in the Subchapter 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 is vague and ambiguous. Section (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. Section (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, which is the sole matter over which DHSR has jurisdiction. Clearly, Subchapter 27G intends for the LME to have monitoring and oversight responsibilities (see Section .7000), yet this rule muddies those waters considerably. Section (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. Section (e) references 10A NCAC 26C.0501 – 0504 and thus assumes that the Category B providers have a contract with DMH/DD/SAS. As DHHS no longer directly contracts with behavioral health 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. Section (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.

10A NCAC 27G .0608 Local Monitoring

Section (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. Section (a) further 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.

10A NCAC 27G .0609 Local Management Entity Reporting Requirements

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.

10A NCAC 27G .0610 Requirements Concerning the Need for Protective Services

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 county 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 2001 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 services.

10A NCAC 27G.0800 WAIVERS AND APPEALS

10A NCAC 27G .0800 – .0807

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

10A NCAC 27G .0801 Submission of Requests for Waivers from Rules

The rules are vague, unclear and ambiguous because rules should be written to address the minimum acceptable standards. If there are minimum standards that apply to all, there should be little to no need of waivers, and the rule does not establish sufficiently detailed criteria regarding the Commission's or respective Division Director's consideration of a waiver request, how the Commission or Division ensures the health, safety or welfare of clients when a waiver is

requested, or the basis upon which a requestor can seek a waiver. For any reason? Further, the rule refers to the "Director of DFS", which no longer exists.

10A NCAC 27G .0802 Contents of Waiver Requests
Section (4)(c) is vague, unclear, ambiguous and contrary to the rights of consumers because it does not specify the type of confirmation the requestor must provide to verify that the health, safety or welfare of clients will not be threatened. Is a mere statement to that effect sufficient? Section (6) is vague, unclear and ambiguous because it implies that a private facility cannot be a contracted provider of the area program, and because there is no longer a Department of Correction.

10A NCAC 27G .0804 Waivers Requested by Commission
This rule is unnecessary and could be covered by Section .0802. The rule is also unclear about why a member of the Commission would need to request a waiver, or upon whose behalf the request would be made.

10A NCAC 27G .0805 Procedure for Waivers by Division Director
The rule is unclear because it does not specify which Division.

10A NCAC 27G .0806 Waivers Requested by Division Director
The rule is unclear because it does not specify which Division. Further, the rule is unnecessary because it is redundant of Section .0805.

10A NCAC 27G .0808 Appeals Procedures for Contract Providers
The rule is unclear and ambiguous. "Contractor" and "Contract Providers" are 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.

10A NCAC 27G .0810 State MH/DD/SA Appeals Panel Administrative Review Procedures
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. Further, Section (o) is vague, unclear and ambiguous in that "personal services" are not defined and the term does not encompass the full array of administrative (i.e. non-provider) contracts that may be entered into by the LME.

10A NCAC 27G .0811 State MH/DD/SA Appeals Panel Hearing Procedures

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. Further, the rule is vague and ambiguous because it does not specify whether the parties may attend the hearing telephonically, or must attend in person.

10A NCAC 27G .0812 State MH/DD/SA Appeals Panel Hearing Decisions

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.

10A NCAC 27G .0813 Waiver Of Licensure Rules

The rule is vague, unclear, ambiguous and confusing in that it outlines a different process than .0803, Procedure for Waivers by Commission, and includes the right to appeal to OAH, which is not included in Section .0803. The reference to LME/MCO Governing Body approval is vague, unclear and ambiguous in that it specifies no criteria by which LME/MCOs should consider any such request for approval from a contracted provider.

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, the rules are ambiguous where they specify that area programs are involved in the administration of the Early Intervention/Infant-Toddler Program. The North Carolina Early Intervention Branch, part of the NC Division of Public Health, is the "lead agency" defined under federal regulations to administer this federal program, including dispute resolution. The Early Intervention Program is administered locally through Children's Developmental Services Agencies (CDSAs) for children with special needs. Area programs are not involved in this Early Intervention Program except to the extent that they manage Medicaid- or state-funded mental health, intellectual/developmental disability, or substance use services for children between the ages of 3 to 6 who are eligible for Early Intervention services. Because this program was transferred to Public Health in 2002, the rules should have been transferred with the program. Furthermore, this section could benefit from review by a clinician.

10A NCAC 27G .0901 Scope

Section 3(b) is ambiguous in that it is not clear who of the entities listed should be reimbursed for travel expenses, and who is responsible to pay for those expenses. For example, existing

public services may already be compensated for providing transportation, and in that case, should they be compensated again? Section 3(c) is ambiguous in that it does not delineate what is not an "inclusive center-based setting." It just says that such a center "may be . . ." and that these settings "also include . . .". **Section 5(b)(vii) should replace the phrase "mental retardation" with "intellectual or developmental disability" for consistency with modern usage and other provisions in the rules.** Section 5(b)(xxvii) is ambiguous and in that it does not specify what "significant parental concern" relates to or means.

10A NCAC 27G ..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. There is 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 NC Medicaid clinical coverage policies promulgated pursuant to G.S. § 108A-54.2. However, without 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 among LMEs, Department staff, and contracted providers, creating difficulties in monitoring and enforcement of such rules by the LMEs.

10A NCAC 27G .0903 General Requirements for Infants and Toddlers
Same comment as .0902, plus the Title of the rule is completely misleading – is this a rule outlining requirements for infants and toddlers to follow? The preamble is ambiguous in that it is not clear who is responsible to do what. It states: "For all facilities servicing infants and toddlers . . . there shall be: (1) an assessment . . .". It is not clear whether this means that the facility is responsible to perform an assessment, order one, or just have one on file. It is also ambiguous in that it does not specify whether there should be an assessment for each child the facility is treating, if that is intended. Section 1(a) is ambiguous in that there is no longer a Section 303.344(a)(2) in the Code of Federal Regulations. Section 1(e) is ambiguous in that it does not specify what eligibility refers to. Section 1(f) is ambiguous because it references the "North Carolina Infant-Toddler Program Manual," which appears to have been superseded. Section 2 is ambiguous in that it is not clear who is responsible to do what. It states: "There shall be a habilitation plan," but it does not specify who should prepare it or what the facility's

responsibilities are. Section 3 is ambiguous since it does not specify who is ultimately responsible for ensuring that review and revision of the IFSP occur; it only specifies the participants in the process in subsection (c). Section 3(d) is ambiguous in that it does not specify who is responsible for arranging meetings and providing notice to families. Section 3(g) is ambiguous in that it does not define "eligible child."

10A NCAC 27G .0904 Surrogate Parents

Same comment as .0902, plus Section (a), (b), and (d) reference the area program's responsibility to assure the availability of surrogate parents and to select surrogate parents. However, this is ambiguous in light of mandated, current guidance in the "NC Infant-Toddler Program Notice of Child and Family Rights" (2013), which specifies that the NC Infant-Toddler Program appoints a surrogate parent.

10A NCAC 27G ..0905 Procedural Requirements

This rule is vague and ambiguous because the provisions only make sense if the area programs actually provide services. Moreover,

- Section (a) is ambiguous in that it refers specifically to 34 C.F.R. § 303.402; however, this specific federal regulation does not address the topics listed under Section (a). Instead, these requirements are separately addressed in different regulations under Subpart E of that regulation.
- Section (b) specifies that parents of an eligible child have the right to mediation of complaints, but it is ambiguous in that it does not define "eligible child."
- Section (b)(1) is ambiguous in that it refers to an area program's "proposal or refusal to initiate or change the identification, evaluation, or placement of the child, or the provision of appropriate early intervention services to the child and the child's family," but area programs no longer provide evaluations or services. It is also unclear what "identification" of a child refers to.
- Section (b)(3) is ambiguous in that it specifies that a request for resolution of a complaint must be sent to area program directors; however, the current, mandated guidance in the "NC Infant-Toddler Program Notice of Child and Family Rights" (2013) specifies that the Early Intervention Branch State Office handles such complaints.
- Portions of Section (b) are not within the statutory authority of the Commission under N.C. Gen. Stat. § 143B-147(b) to the extent that this rule requires area programs to administer dispute resolution, which conflicts with other applicable statutory requirements. LME/MCOs are required to follow N.C. Gen. Stat. § 108D with respect to mediations and appeals relating to managed care actions, which are heard at the NC Office of Administrative Hearings.
- Section (b)(6)(A) is ambiguous in that it refers to 34 C.F.R. § 303.421 as defining the qualifications of an impartial person, but this specific federal regulation does not specify the qualifications of an impartial person.
- Section (b)(6)(C) is ambiguous in that it requires area directors to appoint mediators to serve in mediations or administrative proceedings, which conflicts with other state guidance as noted above that directs CDSAs to handle such proceedings.

- Section (c) is ambiguous in that it requires the director of the area program to schedule administrative proceedings to hear complaints, although other state guidance as noted above directs CDSAs to handle such proceedings.
- Section (d)(1)(F) is not within the authority of the Commission if this rule permits the hearing officer to "specify the type and scope of the early intervention services to be offered the child" and if such services refer to medical or behavioral health services, since these types of services require the judgment of a licensed health professional. In addition, federal regulations at 34 C.F.R. § 303.435 or § 303.443 do not require the hearing officer to be a licensed health professional.
- Section (e) is ambiguous in that it refers to 34 C.F.R. § 303.422, which does not address the rights of parents in administrative proceedings but only addresses surrogate parents.
- Sections (g) and (h) are ambiguous in that they refer to 34 C.F.R. § 303.424 and § 303.425, which do not exist in the federal regulations.
- Section (k), requiring that a disclosure of confidential information between an area program and a contract agency be made only with the written consent of the parents, is ambiguous and not within the statutory authority of the Commission, since N.C. Gen. Stat. § 122C-52(b) permits use and disclosure of confidential information by covered entities (including area programs and contracted providers) if permitted or required under the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Part 164, Subpart E.

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 mental 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 NC Medicaid clinical coverage policies promulgated pursuant to G.S. § 108A-54.2 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 mental 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 NC Medicaid clinical coverage policies promulgated pursuant to G.S. § 108A-54.2 also

set forth requirements for these services and may conflict with the rules. These rules are vague and ambiguous because it is unclear whether they apply to Medicaid or non-Medicaid services. 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

10A NCAC 27G .1301 Scope

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 thus appears to apply to level II and level III facilities. Level II and Level III services are not defined, contributing to this lack of clarity. 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.

10A NCAC 27G .1302 Staff

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 thus appears to apply to level II and level III facilities. Level II and Level III services are not defined, contributing to this lack of clarity. 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.

10A NCAC 27G .1303 Operations

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 thus appears to apply to level II and level III facilities. Level II and Level III services are not defined, contributing to this lack of clarity. 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.

10A NCAC 27G .1304 Physical Plant

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 thus appears to apply to level II and level III facilities. Level II and Level III services are not defined, contributing to this lack of clarity. 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.

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 mental 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 NC Medicaid clinical coverage policies promulgated pursuant to G.S. § 108A-54.2 also set forth requirements for these services and may conflict with the rules. These rules are vague and ambiguous because it is unclear whether they apply to Medicaid or non-Medicaid services. 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 .1401 Scope

Section (c) is vague, unclear and ambiguous in that it refers to "recreational therapy" even though recreational activities are a service exclusion within the applicable NC Medicaid clinical coverage policy.

Section (d) is vague, unclear and ambiguous in that it does not specify that while education can take place in the same setting as Day Treatment, it is not part of the reimbursable service, because educational instruction is a service exclusion within the applicable NC Medicaid clinical coverage policy.

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 .2101 Scope

The term “facility” as defined in G.S. § 122C-3(14) includes an “area facility”, this Section .2100 and rule are unclear, ambiguous and unnecessary to the extent that the provision of services is required by the area program as a provider of service. It is unclear and ambiguous what “independent living skills” means. The term “ICF/MR” is outdated, inappropriate and no longer recognized by Medicaid.

10A NCAC 27G .2102 Staff

The term “facility” as defined in G.S. § 122C-3(14) includes an “area facility”, this rule is unclear, ambiguous and unnecessary to the extent that the provision of services is required by the

area program as a provider of service. In (a), it is unclear whether the individual must be a graduate of an accredited or unaccredited college or university. The terms "waking hours" and "sleeping hours" are vague. The qualifications of "direct care staff members" who are required to be on duty for specific hours is vague, unclear, ambiguous and confusing (in particular given the requirement in (b) that "at least one registered nurse or licensed practical nurse must be on the grounds of the facility at all times"). "Medical care shall be available" likewise is unclear.

10A NCAC 27G .2103 Operations

(a) The term "facility" as defined in G.S. 122C-3(14) includes an "area facility", this rule is unclear, ambiguous and unnecessary to the extent that the provision of services is required by the area program as a provider of service. As written, it appears that the maximum number of clients that can ever be served at a location is 30. This does not seem correct and is therefore unclear and ambiguous.

(b) This rule is unclear and ambiguous because of the uncertainty as to what "adequate changes of personal clothing" means. For example, "adequate" for what purpose.

(c) This rule is unclear and ambiguous because "daily training activities" is not defined. It is unclear as to the types of activities that could qualify as "daily training activities".

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. The title of the rule contains a typographical error.

10A NCAC 27G .2201 Scope

The term "facility" as defined in G.S. § 122C-3(14) includes an "area facility", thus this rule and Section are unnecessary to the extent that the provision of services is required by the area program as a provider of service.

10A NCAC 27G .2202 Staff

The term "center" is used for the first time in this Section and it is unclear and ambiguous whether "center" means "facility" or something different. It is unclear whether the program director must be a graduate of an accredited or unaccredited college or university, and what qualifications the direct care staff must have, and whether the direct care staff member shall count toward the minimum of two staff member requirement in subpart (c).

10A NCAC 27G .2203 Operations

This rule is unclear as it discusses the before/after school operation of the day program in terms of months of local school operation and the summer operation of the day program in terms of weeks of local school operation. There are months during which there is an overlap of when local school is in and out of operation. It is also unclear whether transportation time is considered covered by this service. It is unclear what types of activities parents/ legally responsible persons must participate in.

10A NCAC 27G .2204 Physical Plant

This rule is unnecessary, unclear and ambiguous as there are no area-operated programs or contracted agency centers who provide this service on behalf of the area program, since area programs do not provide direct services. Section (a) is unclear and ambiguous whether the ratio of square fee per child applies to all children who receive services at the center or applies to children who "use the area at any one time", as such distinction is made in (b).

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 .2301 Scope

The term "facility" as defined in G.S. § 122C-3(14) includes an "area facility", thus this rule and Section .2300 are unnecessary to the extent that the provision of services is required by the area program as a provider of service.

10A NCAC 27G .2302 Definitions

The term "facility" as defined in G.S. § 122C-3(14) includes an "area facility", thus this rule is unnecessary to the extent that the provision of services is required by the area program as a provider of service. This rule is confusing, as "integrated work setting" would appear to imply a site where non-disabled and disabled people work together, but that is not how this rule is written. Also, as written "where an individual…work together" is unclear and ambiguous grammatically. It is unclear and ambiguous as to what would qualify as "another program serving persons with disabilities."

10A NCAC 27G .2303 Staff

It is unclear whether the program director must be a graduate of an accredited or unaccredited high school or receive his/her GED from an accredited school. The term "facility" as defined in G.S. § 122C-3(14) includes an "area facility", thus this rule is unnecessary to the extent that the provision of services is required by the area program as a provider of service. In subpart (e)(2), it

is unclear if the minutes referenced mean meeting minutes of a safety committee as described in (e)(1) or minutes for any meeting by the site. Either way, it is vague, unclear and ambiguous.

10A NCAC 27G .2304 Operations
"Governing board" is not a defined term, so it is unclear what this is. To the extent that this Section includes Medicaid-funded services (which is not clear), Medicaid readability and language requirements differ. Its application should be made clear and unambiguous in this rule and Section.

10A NCAC 27G .2305 Physical Plant
This rule is vague in terms of what responsibility the ADVP site has to follow through on recommendations of the "outside safety consultant," which term is also vague and unclear.

10A NCAC 27G .2306 Client Eligibility and Admissions
This rule is unclear whether Medicaid-funded services are covered, and should be clarified to explain they are not. Further, area programs do not provide services so it is unclear why a QDDP of the area program would have to certify eligibility of clients for ADVP services. Subpart (b)(3) is unnecessary. All references to the area program in this rule should be removed, as they are unnecessary.

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 .2401 Scope
This rule is vague in terms of defining what setting would be considered "a less restrictive environment" than the developmental day services. "Specialized licensed child care centers" is not a defined term and therefore is unclear and ambiguous.

10A NCAC 27G .2402 Staff
(a) It is unclear whether the "designated director" must be a graduate of an accredited or unaccredited college or university.
(b) It is unclear whether "student trainees and supervised volunteers" are considered staff members. It is also unclear as to what the age requirements for supervised volunteers and student trainees is.
(c) It is vague as to what level of supervision must be provided to each child. For example, can it be passive supervision, eyes-on supervision, etc.

(d), (e) and (g) It is unclear as to whether "student trainees and supervised volunteers" are considered staff members for the purpose of meeting the minimum staff member requirements in these subparts.
(h) This subpart is unnecessary to the extent it references area programs, since they do not provide services

10A NCAC 27G .2403 Operations
(b)(1) it is unclear what the "individual outcome plans" must include.
(d)(2) It is unclear what types of "parent training seminars" would be required to be provided.
(e) It is unclear who the environmental rating agencies are who would score each center.

10A NCAC 27G .2404 Physical Plant
This rule is unnecessary, unclear and ambiguous as there are no area-operated programs or contracted agency centers who provide this service on behalf of the area program, since area programs do not provide direct services.
(a) It is unclear and ambiguous whether the ratio of square fee per child applies to all children who receive services at the center or applies to children who "use the area at any one time", as such distinction is made in (b).

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 through .3900

10A NCAC 27G .3100 through .3900 are duplicative and thus, in many cases, unnecessary. A better approach would be to create one basic standard for all substance use services and then to specify variations specific to each service type in the rule specific to that service type. Moreover, to the extent the rules are intended to cover both Medicaid and non-Medicaid funded services, the rules may conflict with NC Medicaid Clinical Coverage Policies promulgated pursuant to G.S. § 108A-54.2. The terms "substance abuse" and "substance abuser" are outdated. It is not clear whether all services included within these sections are still considered evidence-based, best practices.

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 .3102 Staff

Section (c) is unclear in that the current acceptable licenses are Certified Substance Abuse Counselor or Licensed Clinical Addictions Specialist, which are not referenced in the rule.
Section (d) is vague,ambiguous and unclear in that it does not specify a specific curriculum – can staff just look it up on WebMD?
Section (e)'s reference to "continuing education" is vague in that it does not specifcy how much, how often or by what means.

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 .3202 Staff

Same comments as .3102, plus there is a question as to whether the staff to client ratio in (a) is an evidence-based ratio.

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 .3302 Staff

Section (a) is vague and ambiguous in that it does not specify whether the supervision is face-to-face, telephonic, or how often supervision should occur.
The term "available" in section (b) is vague, unclear and ambiguous.

10A NCAC 27G .3303 Operations
The reference in section (a) to 8 hours per day, 5 days per week is vague and ambiguous as it does not specify Monday through Friday and does not clarify whether holidays are applicable.

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 .3402 Staff
Section (a)(1) contains a typographical error ("incrument" should be "increment").
Section (b) is vague, unclear, ambiguous and confusing in that it directly conflicts with (a)(10 through (a)(3).
Section (d) is vague, unclear, ambiguous and confusing in that it does not clarify what happens if the individual changes jobs. Does the 26 months start over or is it cumulative? How would a provider verify?
Section (e) reference to continuing education is vague, unclear and ambiguous. All references to training within .3402 are vague and do not provide sufficient specificity to allow for appropriate monitoring and enforcement by the LME. What kind of training? Is an annual review of WebMD sufficient?

10A NCAC 27G .3403 Operations
The phrase "have access to" in section (a) is unclear, vague and ambiguous.
The phrase "schools for minors" in section (a)(2) is unclear, vague and ambiguous.

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 .3502 Staff
Same comments as above comments for .3102, .3202, .3302, and .3402 related to Staff requirements.

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 .3601 Scope

The phrase "approved for use" in section (b) is unclear because it does not specify approved by whom. The rules go far beyond the title "Scope."

10A NCAC 27G .3602 Definitions

It is unclear and confusing for the Definitions to appear after the substance rules in .3601.

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 .4402 and .4502

Section (a) in both rules is vague and ambiguous because it does not specify that staffing schedules must clearly document the dates and hours the LCAS/CCS is on site.

10A NCAC 27G .4503

Section (d) is vague and ambiguous because the services the client receives should be clearly documented in the client's record to include times/ length of service provided, which is not specified in 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. Further, the rules in the 27G.5000 series are ambiguous in that they do not clearly specify whether they apply to Medicaid-funded services, to state-funded services, or to both types of services. If they are intended to apply to Medicaid-funded services, then all regulations in the 27G.5000 series should be updated to correspond to the requirements of the NC Medicaid State Plan, Clinical Coverage Policies, the recently approved 1115 Medicaid Waiver and other federal Waivers currently in effect. For example, the eligibility criteria for ACT services in Section 27G.5703(b) are inconsistent with eligibility criteria in Section 3.2.1 of the State-funded ACT Clinical Coverage Policy.

10 NCAC 27G. 5003

Section (a) is ambiguous in that is requires protocols and procedures to be approved by the area program's medical director or designee, as well as the director of the appropriate disability unit of the area program; however, area programs are no longer providers of service, and providers of services are legally independent organizations responsible for development and implementation of their operations in compliance with state requirements.

10 NCAC 27G .5102

Section (a) is ambiguous in that it specifies the duties of a "Program Director," but it does not define a Program Director.

10 NCAC 27G .5103

Section (a) is ambiguous in that it does not define which governing body it refers to.

10 NCAC 27G .5500
Section (d) should replace the phrase "mentally retarded" with "intellectual or developmental disability" for consistency with modern usage and other provisions in the regulations.

10 NCAC 27G .5503
Section (b)(2) is vague in its reference to "commensurate wage basis," which is not defined.

10 NCAC 27G .5602
Section (b), requiring a staff member to be present in the facility except when a client is capable of remaining in the home or community without supervision, is vague in that it does not specify an outside time limit for leaving the client alone or require that the client's plan specify an outside time limit.

10 NCAC 27G .5700 series
Section 27G.5702(d): The requirement that area programs develop a program description and policies for ACT services is inconsistent with the program description and requirements promulgated by NC DHHS Divisions through Clinical Coverage Policies for Medicaid- and state-funded ACT services.

10 NCAC 27G .5800 series
Section 27G.5803(b)(1) is ambiguous since it references the provision of supported employment services by area programs, and area programs are no longer providers of service.
Section 27G.5803(b)(1)(B) is vague in its reference to "commensurate wage basis," which is not defined.

10 NCAC 27G .5900 series
The rules in the Section 27G.5901 series are vague in that area authorities no longer provide case management services.

10A NCAC 27G .6001 Scope
Because the scope of the Subchapter provides that area programs provide services directly to members and the term "facility" as defined in G.S. 122C-3(14) includes an "area facility", this Section and rule are unclear, ambiguous and unnecessary to the extent that the provision of inpatient hospital services are required by the area program as a provider of services. Therefore this rule and all subsequent rules made part of this Section .6000 are unnecessary as they relate to the area program. Further "substance abuse" and "mental retardation" are not recognized under DSM-V, so references to the same are outdated and unnecessary.

10A NCAC 27G .6002 Staff
The term "substance abuse" is not recognized under DSM-V, so references to the same are outdated and unnecessary. "Mental health" is not a defined term and therefore it is unclear, ambiguous and vague. In section (b) it is unclear whether the individual must be a graduate of an

accredited or unaccredited college or university and whether the supervisory or management experience has to be post-graduation.

10A NCAC 27G .6003 Operations
This rule is unclear and ambiguous. The term "facility" should be made clear to exclude "area facilities" operated by "area authorities", as area programs/authorities do not provide services.

10A NCAC 27G .6101 Scope
Because the scope of the Subchapter provides that area programs provide services directly to members, this section and rule are unclear, ambiguous and unnecessary to the extent that the provision of emergency services are required by the area program as a provider of services. Therefore this rule and all subsequent rules made part of this Section .6100 are unnecessary as they relate to the area program. Also it is unclear why emergency services would be required for non-enrollee families.

10A NCAC 27G .6102 Staff
This rule is unnecessary, unclear and ambiguous. The area program does not provide services. Further, the term "facility" should be made clear to exclude "area facilities" operated by "area authorities".

10A NCAC 27G .6103 Operations
This rule is unclear and ambiguous, as area programs/authorities do not provide services.

10A NCAC 27G .6201 Scope
Because the scope of the Subchapter provides that area programs provide services directly to members, this Section and rule are unclear, ambiguous and unnecessary to the extent that the provision of outpatient services are required by the area program as a provider of services. Therefore this rule and all subsequent rules made part of this Section .6200 are unnecessary as they relate to the area program.

10A NCAC 27G .6202 Operations
(a) and (b) This rule is unnecessary as the area program does not provide services.

10A NCAC 27G .6301 Scope
Area authorities do not provide support services, including "companion respite," so to the extent the term "provider" includes the area authority, this rule and all subsequent rules in this Section are unnecessary and unclear. Notably the Section states it is for "individuals of all disability group," however the Rules within this Section do not clarify to disability groups covered by this Section and for whom the services is intended. Therefore this rule and all subsequent rules made part of this Section .6300 are unnecessary as they relate to the area program.

10A NCAC 27G .6302 Operations

The term "Governing body" is defined to mean "in the case of an area authority, the area board". Area authorities do not deliver these services, so it is unclear why the area board would have the responsibilities listed in this Rule, including having and maintaining direct contracts with providers of respite services.

It is also unclear whether the term "provider" as used within this Rule and Section refer to an individual or is intended to refer to an organization contracted with the area authority to provide (or cause to be provided) the companion respite services.

The rule is also generally confusing as to whether there are different requirements for when adults or minors are in "facilities" providing respite services.

Overall, this rule appears to be unnecessary.

10A NCAC 27G .6401 Scope

(a) This rule is unnecessary, unclear and/or vague.

- The term "substance abuse disorder" is no longer recognized as a diagnosis under DSM-V and should be removed. Therefore, references to it are unnecessary.
- In (a)(1), "personal or regular living activities" is not a defined term, therefore the type of assistance covered within this Section .6400 is unclear and vague.

(b) This rule is unnecessary, confusing and unclear.

- This rule starts off with "If these Rules are in conflict," it is unclear to which "Rules" are being referred.
- Pursuant to the Innovations Waiver, "personal care services" are now offered under the "Community Living and Support" definition. It is unclear whether language in this Rule applies to "personal care" as used within the Community Living and Support definition, or any other equivalent service offered through Medicaid.

10A NCAC 27G .6402 Staff

This rule is unclear, ambiguous and vague.

(c) is restrictive in requiring that staff must be "employed" rather than independently contracted to provide personal assistance. The Rule is also not clear by whom the individual must be employed.

(c)(1) of this rule does not clarify whether the high-school diploma or its equivalent must be from an accredited high school and therefore this Rule is unclear.

(c)(2) does not explain the type, level, amount or duration of training required by the person providing personal assistance.

(d) is unclear, ambiguous and vague because it does not explain by whom individuals providing personal assistance "shall be specifically informed". It is also too restrictive in requiring that staff must be "employed" rather than independently contracted to provide personal assistance. The Rule is also not clear by whom the individual must be employed.

10A NCAC 27G .6403 Operations

This rule is outdated and unnecessary to the extent it discusses "case management" services.

10A NCAC 27G .6501 Scope

(a) This rule fails to identify whether the EAP is voluntary, free or confidential, therefore it is vague, ambiguous and unclear. It is also unclear as to the purpose of this provision in this subchapter, therefore this rule and all subsequent rules made part of this Section .6500 are unnecessary as they relate to the area program.

(b) This rule is unclear as to what extent EAP must be offered "in partnership with employers with whom the area program has a written agreement". This rule is unclear as to which "employers" the area program should have a written agreement. There is no statutory basis cited for this requirement identified.

10A NCAC 27G .6502 Staff

This rule is vague and unclear as the purpose for the area programs to be responsible for planning and implementing employee assistance programs for other employers (and not for its own employees) is confusing and unnecessary. It is unclear as to which employers from the "public and private sector" the area program should have a written agreement.

10A NCAC 27G .6503 Operations

The role of area programs is undefined and so it is unclear as to how this rule applies to area programs and therefore it is unnecessary.

10A NCAC 27G .6601 Scope

Some area authorities offer what is known as "therapeutic foster care" for the MH/SU/IDD services provided in a foster care setting, however, the term "specialized foster case services" is not understood to be covered by such definition. In any event, "specialized foster care services" is and undefined, confusing, unclear, ambiguous and vague term. Area programs do not provide "specialized foster care", therefore this rule and all subsequent rules made part of this Section .6600 are unnecessary as they relate to the area program.

10A NCAC 27G .6602 Approved Foster Homes

This rule is unnecessary as it applies to the area program, as the area program does not provide foster services. Further, foster homes are not licensed by the Department of Human Resources, and therefore this rule is also unclear, vague and unnecessary for this reason. In addition, there is no Chapter 10 to the NCAC, and therefore it is unclear, vague, ambiguous and unnecessary for references to "Title XX foster care special services funds as specified in 10 NCAC 41F and J" to be made.

10A NCAC 27G .6603 Placement Care Agreement

(a) This rule is unnecessary because the area program does not negotiate placement care agreements and does not directly contract for specialized foster care services.

(b) This rule is unnecessary since area programs do not sign or enter into placement care agreements or contracts for specialized foster care services.

10A NCAC 27G .6701 Scope
The terms “forensic services,” “offenders” and “alleged offenders” are not defined terms in this subchapter and therefore are vague, unclear and ambiguous. Since area programs do not provide “forensic services”, this rule and all subsequent rules made part of this Section .6700 are unnecessary to the extent they relate forensic services to be provided by the area program.

10A NCAC 27G .6702 Operations
Since the area program does not conduct forensic screening or evaluations, this section is unnecessary in this subchapter.

10A NCAC 27G .6801 Scope
In general this rule is unnecessary, as “area programs” are not required to provide prevention services. In addition “prevention services” are not defined and it is unclear and ambiguous. Since area programs do not provide “prevention services”, this rule and all subsequent rules made part of this Section .6800 are unnecessary to the extent they relate to area programs.

10A NCAC 27G .6802 Staff
This rule is unnecessary, unclear and ambiguous because 1. Area programs are not required to deliver services; and 2. Prevention services are not a defined term and could apply to non-mental health, substance and IDD services, which does not appear to be the intent of the Chapter 10A. Further, there are no qualifications for the “director of prevention services” identified, thereby making this vague, as well.

10A NCAC 27G .6900 – Consultation and Education Services
In general, this section is unnecessary, as it does not appear to be required or completed.

10A NCAC 27G .6901 Scope
The term “mental health” is not defined and the term “mental retardation” and “substance abuse disorders” should be changed as they are not recognized by DSM-V. It is also unclear as to whether “consultation and education services” are a subset of “prevention services” and the type of services to be described to the general population under 10A NCAC 27G .6800. It is unclear if and how this section relates to other sections in this subchapter. To the extent “consultation and education services” are a subset of “prevention services”, this rule and all subsequent rules made part of this Section .6900 are unnecessary to the extent they relate to area programs since area programs do not provide prevention services.

10A NCAC 27G .6902 Staff
The term “designated director” is not defined in this Subchapter, and therefore is ambiguous and unclear. It is unclear what qualification a “designated director” must have.

10A NCAC 27G .6903 Operations
This is unclear as to “mental health” which is not a defined term. “Area programs” are not responsible for delivering services so (a) and (b) appear unnecessary.

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

10A NCAC 27G .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.

10A NCAC 27G .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, and the process for Medicaid complaints is outlined at N.C.G.S. Chapter 108D. 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.

10A NCAC 27G ..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.

10A NCAC 27G .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.

10A NCAC 28H – WRIGHT SCHOOL

The entirety of the rules are vague, ambiguous and unclear. Section (a)(2) through (a)(4) use outdated, inappropriate terminology

10A NCAC 29D .0612

This regulation references rules that have been repealed or re-codified. Section 10 NCAC 14K.0365 does not exist, and section 10A NCAC 29D.0602 has been repealed.

10A NCAC 29D .0701

Section (a): This section is ambiguous in that it refers to section 10A NCAC 26A.0100 as addressing procedures governing rulemaking hearings; however, the current section 26A.0100 governs copies of rules being available for public inspection. For clarity, it should reference section 26A.0100 et seq. This section also refers to APSR 10-7, which no longer exists and was presumably replaced by APSM 10-7.
Section (b): This section is ambiguous in that it refers to section 10A NCAC 26A.0400, which does not currently exist. This section also refers to APSR 10-3, which no longer exists and was presumably replaced by APSM 10-3.

10A NCAC 29D .0801

Section (a) is vague in that it references operation of a service by an area program, which is no longer permitted. In addition, this provision may be unnecessary under Medicaid reform.
This regulation is an exact duplicate of the regulation at 10A NCAC 27G.0505, so one of them is unnecessary.