JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

October 11, 2011
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Health and Human Services met on Tuesday, October 11, 2011 at 10:00 A.M. in Room 643 of the Legislative Office Building. Members present were: Senator Louis Pate, Representative Nelson Dollar, and Representative Justin Burr, Co-Chairs; Senators Austin Allran, Doug Berger, Stan Bingham, Harris Blake, Jim Davis, James Forrester, Fletcher Hartsell, Martin Nesbitt, William Purcell, and Tommy Tucker; and Representatives Martha Alexander, William Brisson, William Current, Mark Hollo, Pat Hurley, Marian McLawhorn and Fred Steen. Representative Verla Insko was also present.

Lisa Hollowell, Lee Dixon, Denise Thomas, Donnie Charleston, Karlynn O'Shaughnessy, Shawn Parker, Theresa Matula, Amy Jo Johnson, Jan Paul, Susan Barham, Lisa Wilks, Joyce Jones, Pat Porter, Rennie Hobby, Candace Slate, and Dina Long provided staff support to the meeting. A Visitor Registration Sheet is attached and made a part of the minutes (See Attachment 1).

Chairman Burr called the meeting to order and welcomed members and guests. He asked for a motion to approve the minutes from the September 20, 2011 meeting. The motion was made by Chairman Dollar and the minutes were approved.

Chairman Burr asked Lisa Hollowell from Fiscal Research to begin the morning session on Pre-Kindergarten. Ms. Hollowell provided a copy of the Special Provision from Session Law 2011-145 - the Budget Act, for reference. (See Attachment No. 2) She also provided a chart depicting the changes brought about by the Special Provision in the Pre-K program and how it compares to the More at Four program. (See Attachment No. 2a) Additional points of interest included these:

- Registration and Standards for Pre-K will now be located within the NC Child Care Commission, a 17 member organization which is appointed by the Governor and General Assembly. The Division of Child Development and Early Education (DCDEE) is guided by the Commission rules. Within the Budget bill this past year, two additional members with early childhood development expertise were added to the Commission.
- Section 10.7(g) directs the DCDEE to phase in a new policy in which child care subsidies will be paid, to the extent possible, only for child care in the higher quality centers and homes. There will be allowances for counties with an inadequate number of the 3-5 star programs.
- The intended interpretation of the eligibility standard for prekindergarten cited in the provision was to be 75% of the State Median Income. Twenty percent of the children can have <u>other</u> risk factors regardless of income. No more than 20% of the children can be identified above the income or have other at-risk factors. Children representing those whose families are within 75% of the State Median Income combined with the 20% of other at-risk factors would yield a total of 100% of those to be served as "at-risk". The Department began

to implement the program at the passage of the legislation, in the manner as prescribed by the law.

Ms. Hollowell was asked her opinion about the potential the impact on the budget if Judge Manning's ruling is enforced. She responded that she believes that the Governor's Executive Order requires the Department of Health and Human Services (DHHS) and the Department of Public Instruction (DPI) to develop a plan to assess and to identify the number of at-risk children who are not being served; and it is up to the General Assembly as to whether additional funds will be appropriated for this effort. In the past, the number of children served via this program has been capped by the funds appropriated.

Chairman Dollar asked Ms. Hollowell, as an analyst, what her observations were of the quality of instruction in the 4-5 star classrooms compared to the More at Four classrooms. She answered that the More at Four program within the private setting could only be located in a four or five star facility. Many of the four or five star facilities provide instruction from the approved More at Four curriculum. Many have teachers with some higher education or a Bachelor's degree. She reported that she believed that the More at Four standards go a little higher as far as the birth to kindergarten add-on, and the teacher to child ratio is better. Now, all the four or five star facilities will be required to teach from the same approved curricular as the More at Four - NC Pre-K program.

Ms. Drupti Chauhan from the Research Division provided an outline of the court opinion and various Orders related to Prekindergarten and the 2011 Appropriations Act. (See Attachment No. 3) After providing a summary of the court activities from 2004 to present, Ms. Chauhan answered questions. Senator Hartsell asked if there was a court mandated definition of "at-risk" in any of the reports. Ms. Chauhan responded that she did not think that there was and she would check. She thought this was part of the issue because there appeared to be no uniform agreed upon definition.

Ms. Chauhan was asked if the State was moving forward with the program based on Judge Manning's Order. She said that the Order was valid and that is the law right now. It would seem then that four year olds deemed eligible cannot be kept out of a Pre-K program. A stay has not been asked for from that Order so it is pending in the Court of Appeals now.

Ms. Hollowell was also asked how the Judge's ruling affected the budget. She said that DHHS was no longer requiring the co-payment that was directed within the budget. The co-payment, by estimation, was going to generate about $13M. This money could have been used to serve additional children. The program has always been capped by the budgeted money. In regard to the prior question about the definition of "at-risk", Ms. Hollowell reported that when the program was created by the General Assembly "at-risk" was not defined. Rather, the legislature left that up to a Task Force to work with DHHS and DPI to determine the criteria for "at-risk". For the most part the administrating agency was given the authority to establish the "at-risk" eligibility criteria.

It was reported that the Department has identified additional kids that could be served based on Judge Manning's ruling and that this addition would exceed the budget limitation. Chairman Burr added that the definition of "at-risk" had not been seen from the court system and it would be up to the General Assembly to define "at-risk." Senator Hartsell wondered if the point was to create an entitlement that is based on constitutional bases or is it to create a program. Chairman Burr said we would have to go through the appeals process to have it addressed.

Dr. Deborah J. Cassidy, Director of the NC Division of Child Development and Early Education, DHHS provided an update of the implementation of the Pre-K program. (See Attachment No. 4) Additional points of interest included:

- Under the SFY 11-12, approximately $13M in allocations would be realized from the parent co-payments for the NC Pre-K program. Judge Manning's ruling to eliminate co-pays reduced the amount of services by $13M and reduced the number of slots by 2,623.
- Because it was important to not lower the quality of the program, it was decided to reduce the number of children served in order to maintain the high quality of the More at Four program rather than reduce rates paid to Pre-K contractors. The allocation for the cost per slot for each of the contractors was the same as last year. The total allocation was lower due to the 20% cut; consequently, not as many children could be served.
- Local administrative structure committees have flexibility to differentiate slot rates. DCDEE sent an amount for the slots within each of the communities but local communities can differentiate. An example, public schools could make a 50% contribution to the slot rate making it possible for the committee to fund other slots at a higher rate.
- Currently, there are some classrooms that are not licensed because they are in public schools but they will be required to be licensed by July 1, 2012.
- Based on Judge Manning's ruling on, DCDEE changed how they were defining "at-risk" to children who are income eligible (at 75% or less of the State Median Income) and/ or have a defined disability, and had no co-pay assessed to the families.
- The estimated expansion of 20,000 more children by SFY 12-13 may not be realistic due to financial and capacity issues. DCDEE is recommending a slower pace in enrollment.
- Some subsidized child care funds will be held back to provide higher subsidy reimbursement rates for 4 & 5 star programs when the literacy curriculum is adopted and implemented.
- Phase I of the Subsidized Early Education for Kids (SEEK) program is underway for subsidized child care in about 2/3 of the counties for time and attendance; Phase II for payments will begin in the Spring of 2012; full implementation will be July 1, 2012.
- There is a waiting list this year of over 50,000 for child care subsidy and 13,500 for Pre-K. The income qualification is the same for subsidy and Pre-K, 75% of Median Income. Some of the children are probably on the same waiting lists. There are between 80,000 – 85,000 children receiving child care subsidy every month.

Chairman Burr asked if there were any substantive dollars left from the SFY 10-11 budget and have there been any funds in previous years. Dr. Cassidy responded that there may have been some funds carried forward that was left unspent in some counties. Ms. Hollowell clarified that according to the report at the end of June, there was approximately $8.5M that was unexpended based on the direct service allocation of $411.3M. Chairman Burr commented that several counties had over $100,000 left in each county that could certainly serve enough slots if it was fully used. In trying to find a way to fill slots, he said that perhaps spending the funds budgeted would be a good start in the future and perhaps cover the dollars that the Governor wants to make sure are spent.

Chairman Dollar speculated that if Judge Manning had not taken action to disallow the co-pays that we would actually be serving in the Pre-K program approximately 2,800 more children which would account for about 45% of the $30M the Governor wants for the program. Dr. Cassidy said the calculations were correct but that reports from several counties indicated that the co-pay was preventing some parents from enrolling their children. On the other hand, Chairman Dollar pointed out that there are those on the waiting list willing to pay the co-pay in order to get in the program but cannot because a slot does not exist. Chairman Dollar asked for an estimate of what the additional

cost would be to move forward over the next 4 – 5 years with the program the Governor has recommended and that DCDEE has lain out. Dr. Cassidy said she would get the information. Chairman Burr added that in SFY 09-10 there were $13.8M unspent subsidy dollars by DCDEE.

Senator Tucker reminded the Committee that the potential for substantial savings could be realized if we could roll in the responsibilities of Smart Start under DCDEE. He said he thought $13M could be saved in overhead and fringe costs by eliminating Smart Start. Since its inception in 1994, the State has spent $2.8B on Smart Start.

Senator Hartsell asked if there was any discussion about a funding model different from the current student per capita model such as a teacher allocation model that might be more efficient and more strategic, and has anyone assessed what the differences might be. Dr. Cassidy responded that the idea had been discussed. She said that last year, More at Four was poised to request that the State Board consider an allocation that paid the teacher rather than a per child basis. The problem was if you paid the teacher then all the children in that classroom would have to be Pre-K children rather than blending them with others. Otherwise, you would have to have a highly qualified teacher for a class that might just have 6 Pre-K children and in private child care would dramatically increase the cost of the program.

Senator Berger requested the calculations on increasing the teacher/per student ratio. Dr. Cassidy said she would get the information for the Committee.

Senator Nesbitt voiced his concern over the 50,000 children on a list waiting to get into Pre-K. He said the list was actually an "unserved list" because these children will not be able to get into Pre-K next year because they will have aged out. He said that Judge Manning has determined that these children are entitled to this service. Chairman Burr asked Lisa Hollowell to explain how the More at Four program actually began under DHHS. Ms. Hollowell said the program was created in S.L. 2001-424 as a result of the Governor's request for funding for this type of program. There were no guiding principles at that time and it was the General Assembly that put those principles in a special provision. The special provision called for DHHS, in collaboration with DPI and a Task Force to develop the program standards. It also required in law that it build upon the existing child care subsidy system. Separate systems developed over the years and then the program was moved into DPI and now back under DHHS.

Linda Piper, Executive Director of the North Carolina Licensed Child Care Association (NCLCCA), read from a prepared statement explaining the importance and the contribution that the private child care providers offer. She voiced their concerns, and encouraged the General Assembly to include the NCLCCA in deliberations and in decisions being made. (See Attachment No. 5)

Kevin Campbell, a private provider from Mecklenburg County explained why the Pre-K system should first look to the private sector to serve "at-risk" children and then the public sector. His suggestion keeps children in their neighborhoods, creates private-sector jobs, and does not negatively impact taxpayers. (See Attachment No. 6)

Dana Ramsey, Vice President of Operations for Childcare Network with 60 locations in 20 counties across the State, gave reasons why licensed private providers were a viable and necessary part of the Pre-K solution. She also offered ways to improve the system through collaboration. (See Attachment No. 7)

Chairman Dollar asked each of the panel members if the changes made by the General Assembly in the Budget bill to the program were positive changes. Ms. Ramsey responded that she thought the changes operationally would be successful and she was happy with the implementation. She said that DCDEE's involvement with already licensing, regulating, and visiting schools on a regular basis is an effective way to monitor the program. Financially, the cuts have caused a 3% loss in slots in the classroom, a loss of some local funding, and the cuts have impacted the ability to find and retain high quality teachers with Pre-K licenses particularly. Mr. Campbell said that he agreed with Ms. Ramsey. Operationally, the move to DCDEE was a good move. Financially, it has reduced funds but as Dr. Cassidy stated earlier, if the per slot reimbursement had stayed the same; quality would have stayed the same with less children being served. Ms. Piper said that feedback from providers indicated that they had not been involved with More at Four and would like to be involved with Pre-K. As the system moves forward with DCDEE there should be more of an opportunity to bring more of the private providers to the table.

Chairman Dollar asked panel members if Judge Manning had not disallowed the ability to have co-pays, would there not be more money in the system with the ability to serve more children this year. Ms. Ramsey responded that during the initial enrollment process, some families turned away from their slot based on that requirement and those tended to be the most "at-risk" families. Mr. Campbell added that collecting co-pays in child care subsidy is very difficult. He said a system in place to collect the co-pay would be very beneficial, such as a third party to collect the fees.

Senator Tucker asked Dr. Cassidy if there would be an opportunity for providers to have input in some of the decisions being made. Dr. Cassidy responded that DCDEE was in the process of developing an Advisory Committee that will consist of providers from around the State as well as contractors. They are hoping to have the first meeting the end of October or the first of November. She said that DCDEE realized some of the questionable practices that have been mentioned and would like to have things more standardized.

Dr. Pat Porter, Consultant to the Legislative Oversight Committee on Health and Human Services provided an overview of the 1915 (b) (c) Medicaid Waiver and how North Carolina plans to implement the Waiver statewide. (See Attachment No. 8) Several points of interest mentioned included:

- The majority of states operate under the 1915(c) waiver (in NC this waiver is known as CAP-IDD); only very few states operate under the 1915(b) Managed Care Waiver.
- The combined (b) (c) Waiver defines responsibility to the State for assuring that all eligible individuals have access to providers, choice of providers, and medically necessary services and supports. Also included is extensive and well defined quality standards with requirements for the Local Management Entities (LMEs) to be evaluated by external contractors.
- With the statewide expansion of the (b)(c) waiver there will be a single point of accountability. This will be especially helpful for the General Assembly and the Health and Human Services Oversight Committee to be able to clearly see who is responsible at any point and time.
- The State will know in advance what the cost of the program will be for the upcoming year.
- The LME will be required to pay for medically necessary services for all Medicaid enrollees and people enrolled in the Innovations Waiver which is focused on people with intellectual and developmental disabilities.

Shawn Parker and Jan Paul from the Research Division provided a copy of the Bill Summary for H.B. 916 which directs DHHS to move forward with the statewide expansion of the 1915 (b)(c) Waiver. Legislation also sets specific parameters for the expansion. Ms. Paul reviewed service and program requirements and Mr. Parker addressed the changes in LME catchment requirements. (See Attachment No. 9)

Ms. Paul said that overall the DHHS is directed to create a local system to achieve the goals of easy access to care, managing the delivery of necessary care, and providing continuity of care to those eligible for services. Specifically, DHHS is directed to do the following things:

- Adhere to the PBH demonstration model that has been shown to be effective in operating the management of a public resource system for service delivery.
- Statewide, designate a network of single LMEs that operate according to either the Merger Model, where one large LME is formed by the merger of two or more smaller LMEs or by Interlocal Agreement among LMEs where one LME is designated as the leader for the operation and management of all waiver functions.
- Use managed care strategies, including care coordination and utilization management in order to curb rising costs in the State's Medicaid Program while not sacrificing the provision of necessary services as well as the appropriate level of services.
- Phase out the Community Alternatives Program for Mentally Retarded/Developmentally Disabled Individuals (CAP/MR-DD Waiver) as well as the utilization management functions currently performed on a contract basis.
- Design the Innovations Waiver – (defined near the top of page 2 of the Bill Summary) to serve eligible people within aggregate funding limits.

The Act also gives the Department oversight responsibility for all LMEs approved to operate a 1915(b) (c) Waiver to ensure that the approved LME's do the following:

- Maintain a local presence in order to address unique community needs;
- Implement a process to enable consumers, families, providers and stakeholders to provide feedback and to exchange information.

The Department must also ensure that LMEs comply with three specific operational requirements:

1. They must maintain disability specific infrastructure and competency to address various needs of all disabilities covered by the Waiver;
2. LMEs are mandated to perform specified administrative and clinical functions and standards, such as financial reporting, quality management, staffing, and customer service.
3. LMEs are fully accountable for all aspects of Waiver operations and have to meet all contract requirements specified by the Department. LMEs are allowed to subcontract functions to other entities in only seven specific areas specified in Section 1(a) of the Act.

- Under the Act, County governments are not financially liable for overspending or cost overruns associated with an area authority or single/multi-county program's provision of services under a 1915(b)/(c) Waiver that exceeds that program's risk reserve and Medicaid fund balance.
- During the first year of operation LMEs are required to approve those who had provided Targeted Case Management under the CAP-MR/DD Waiver to provide the Community Guide Service.
- The legislation directs DHHS by December 31st of this year to complete a feasibility study regarding adding habilitation services for certain persons with intellectual and developmental

disabilities who are not enrolled in the Innovations Waiver and not residing in an Intermediate Care Facility for the Mentally Retarded through the Medicaid (i) option.

- DHHS is directed to discontinue a pilot program to administer the Supports Intensity Scale to individuals with intellectual and developmental disabilities in non- (b) (c) Waiver LMEs.
- DHHS also must evaluate and minimize any inconsistencies between 1915(b) (c) Waiver operations and our Certificate of Need laws.
- The Act requires future General Assemblies to consider reinvesting 15% or more of the projected savings from operating the Waiver to increase the number of consumers served by the Innovations Waiver or to expand services for persons with IDD.
- DHHS must adopt written policies to align objectives of the 1915(b) (c) Waiver and the care of eligible consumers with other managed care systems, including Community Care of North Carolina.

Finally, the Act requires DHHS to submit a strategic plan and status reports to the General Assembly regarding the progress of the restructuring and expansion. This plan is to be developed in coordination with LMEs, PBH and other key stakeholders.

Mr. Parker reviewed the provisions applicable to the compliance requirements and operational size of the LMEs under the Act. He indicated that the bill had two major time frames:

- August 1, 2011, DHHS selected LMEs that assessed to meet the minimum requirements. Based on the RFA process that some LMEs are still involved in, January 2013- DHHS is directed to either merge or direct an interlocal agreement for any LME not operating under 1915(b)(c) Waiver.

The bill made two changes in statutes to two catchment requirements:

- July 2012- An LME's minimum population must be 300,000 (at least 7 LMEs will be required to engage in mergers or interlocal agreements to meet this requirement). If they fail to meet the minimum population by statute there is a direction to change the administration funding rate.
- July 2013- The minimum population of LMEs must be 500,000. If they fail to meet this requirement, their Medicaid and State funds would be reassigned. A note for consideration by the Committee – there was a potential problem with Durham, Johnston, and Cumberland Counties who have determined to have an interlocal agreement to operate a 1915(b)(c) Waiver and would not meet the single 500,000 population. It would require legislative action to either account for a total population within the entity of the LME or whether LMEs operating in this type agreement would be accepted under the statute. The Department is engaged in negotiations with these LMEs to resolve the issue.

Mr. Parker said presently under this model there would be 13-14 LMEs with 12 points of operation for Medicaid (twelve managed care organizations). For illustrative purposes, Mr. Parker provided a map of projected LME arrangements by 2013. (See Attachment No. 9a)

Dr. Beth Melcher, Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services Development, DHHS provided an update on the expansion of the 1915 (b)(c) Waiver statewide. She said that DHHS has been asked to achieve a list of items through H.B. 916 and that all of those items are incorporated into the Strategic Plan that is nearly complete. She said that

underlining the list of activities is a real commitment to a series of values and priorities that the General Assembly has put forward to the Department. Dr. Melcher stated that there is a commitment to utilize the tools of managed care to be more effective and efficient in using the resources available. (See Attachment No. 10) Items of interest included:

- The initial draft plan was posted on the DHHS website requesting input from stakeholders. Many suggestions were received along with numerous questions that will be addressed in a final document. Feedback from stakeholders resulted in significant changes and improvements to the plan. After final edits the plan should be available shortly.
- The strategic plan has six objectives with action steps. The action steps have a series of activities with specific time lines, time frames, and will identify who is responsible for accomplishing the objectives. Objective 1, is to oversee the whole system change; Objective 2, looks at how DHHS will partner with the LME/Managed Care Organizations (MCO's); Objective 3, looks at how to support the development of best practice, services and supports; Objective 4, is about communication with the various stakeholder groups; Objective 5, is centered around increasing the knowledge of the system; and Objective 6, focuses on the collaboration with CCNC and the importance of the integration of primary health care with behavioral health.
- The LME's moving forward to become MCO's will be identified by the end of October.
- Critical to success is that there be a strong process for evaluation in order to know if goals and outcomes are being achieved and that adjustments can be made if necessary.

Chairman Dollar stated that after the Strategic Plan had been received, he understood that members of the Committee could still ask questions and make additional adjustments as necessary. Dr. Melcher agreed and said to call if there were questions or additions needed to be made. Chairman Dollar also stated that he wanted to make sure that all is being done to see that the LMEs are working with CCNC to coordinate medical care for quality purposes and also to manage dollars. He also requested that the definitions be included in the Strategic Plan that would explain the types of services being provided under care coordination and case management.

Senator Tucker asked if all was being done to get input from stakeholders. Dr. Melcher replied that she wished there was a way to develop multiple strategies to receive input. Going forward there is a mechanism for input through Intra-departmental Monitoring Teams (IMTs) which is the actual implementation of how it is going in your community. A larger structure is being developed with conversations around who are the best people to serve. Input can be gathered through customer satisfaction surveys and town hall meetings. Senator Tucker also said he understood that providers had complained about redundant audits and the inability to receive cash flow. Dr. Melcher said the cash flow issue is not a (b) (c) waiver MCO issue but may be related to some of the State's cash flow issues and the payments to the LMEs.

Secretary Cansler added that there continues to be cash flow issues in the mental health arena that these issues are carried over from one year to the next. There is currently $30M in unpaid bills but there is a monthly allotment of cash used to try to catch up with that debt. The hospitals and other facilities have not been totally funded for a while causing cash flow problems and cash runs out before the end of the year causing additional problems. He said it was difficult to catch up when budget cuts have been put in place and we are behind already. Addressing the issue on stakeholder input, he added that it was a challenge but that DHHS was dedicated to finding the best means possible and they were doing their best.

Steve Jordan Director of the Division on MH/DD/SAS, DHHS gave an update on the CAP-/IDD Waiver renewal. (See Attachment No. 11) Items of interest included:

- The process of renewing the Waiver started 14 months ago with work groups meeting, which included input from stakeholders, and people working on separate and independent service definitions. The renewal proposal then went to DMA and the Physicians Advisory Group. There was then a 45 day comment period; then comments were implemented into the revised document and then sent back to the Physicians Advisory Group for review with an additional 15 day comment period.
- With cost overruns in the CAP Waiver at $31M last year, CAP slots were frozen, emergency CAP slots eliminated this allowed the DHHS to end the year with $5M over budget instead of $31M.
- Moving augmentative communication into the regular Medicaid state plan portion that a recipient receives opened up the availability for people on the waiting list who may have only needed augmentative communication and did not require a CAP slot.
- The number of hours for Habilitative Services during a monthly time frame was reduced from 172 hours to 129 hours which equals approximately 1 ½ hours per day over the course of a month.
- A revision to adult participants' parent-service providers not allowed to provide services over 40 hours a week will now have exceptions around medical necessity. This is not automatic. There will need to be justification to show that an increase in paid parent provider service hours does not increase seclusion or reduce the availability for the person to go into the community.
- Those families choosing Self-Direction must be connected with an employer of record or fiscal intermediary who would recruit the individual to work with their son or daughter. The agency would do the payroll and billing, and would be responsible for the hiring and firing of the individuals. Self-Direction will be a part of the Innovations Waiver.

Michael Watson, Deputy Secretary for Health Services, DHHS addressed governance issues related to the 1915 (b) (c) Waiver. (See Attachment No. 12) Mr. Watson began by noting that the (b)(c) Waiver modification and the CAP Waiver renewal require CMS approval and that these are just two of the many items at CMS under review. He said one issue that has arisen from the 1915 (b)(c) Waiver is how community mental health services are governed and managed. As the LMEs move into the role of MCOs under the 1915 (b)(c) Waiver, there are specific issues that may provide barriers to the successful operation of the (b)(c) waiver under G.S. 122C. These barriers are currently being carefully reviewed and the overall plan would be to come back in a Session in November with a limited request to the General Assembly to allow the Secretary the opportunity to waive some provisions of 122C for a set period of time, and then to have the opportunity in the Short Session to have further discussions regarding any permanent changes that may need to be made. Issues of concern included:

- LME Board – Dealing with the number of counties involved in each LME, the size and composition of a board may present a problem- the current statute requires a county commissioner from every county; in addition the LME/MCOs will now need to have members of the board with the skills and expertise to handle a very specialized business.
- Financial Management Issues – LMEs are listed in 122C as a potential public guardian and yet are restricted from being guardians for individuals for whom they might authorize and manage care. This needs attention and resolution. There may also be issues in transition around population penalties.

Representative Hurley asked Mr. Watson what could be done to make sure the guardianship issue is addressed correctly. He said that there was a work group that included Social Services, LMEs and others involved with the guardianship issue who would be putting together very specific recommendations regarding the issue.

Senator Nesbitt suggested that if DHHS had changes they wanted to make to governance issues of the LMEs that they bring very specific requests rather than general requests. Secretary Cansler responded that any waiver governance discussion made before the General Assembly in November would be a temporary request to allow him to waive several key items on a time limited basis until such time the Legislature could act on a permanent solution. He said DHHS did not want to change the governance so much as make sure it is a workable situation. Chairman Pate suggested that a subcommittee be formed from members of the HHS Oversight Committee to work with DHHS and stakeholders to try to work proactively towards a plan of governance for the LMEs as they move forward. With Committee member involvement some hurdles might be avoided and it will speed things along so it will be ready for the Short Session in May. Chairman Dollar encouraged discussions between the County Commissioners Association, LMEs, and others to continue negotiations and to continue to work on the details of the issues.

Secretary Lanier Cansler gave a brief update on budget issues. Listed are the items below:

- DHHS is working to achieve the budget target set by the Legislature. DHHS will hit the target in non-Medicaid – implementing administrative reductions to achieve approximately $9M in reductions and finalizing the reductions that will take place with respect to non-profits. DHHS has made all the other reductions and put in place all related issues.
- Regarding Medicaid, the Secretary reviewed a list of items that the $356M budget has laid out. He said the Department may be $100M short. Less than $40M is related to timing in getting approval from CMS; $13M is related to federal mandates with inflationary increases; $13M is inflation related to the nursing home industry (because to eliminate that inflation, eliminates the case mix system that the Legislature put into place, although that was not the intent of the Legislature); there were some overstatements in the budget totaling about $17M; and the rest is related to whether or not CCNC can achieve target and if other targets can be achieved.
- There is a Medical Care Advisory Committee made up of consumers and providers looking at the issues. The problem is if they are $100M short, then they must determine what to do with the program, state fund amendments have to be submitted in order for that to happen, and there must be federal approval. To get $100M, DHHS will have to come up with $300M-$400M in reductions because these can only be in place for 3-4 months out of this year. DHHS is weighing their options to see what can be done without damaging the safety net further. Focus is on how to continue to better manage services by determining when prior authorization is appropriate; when is limiting the number of visits appropriate, and how to provide the most cost effective care.
- Depending on how quickly the aged and disabled population can be enrolled into the program, CCNC has the tools to save in excess of $90M.
- The Secretary is weighing all of the options and any major proposed adjustments made to the budget would be discussed before the HHS Oversight Committee.
- In regard to the Department of Justice and Medicaid issues related to personal care services and adult care homes discussed during the last LOC meeting, the Institute of Mental Disease (IMD) – Assessments will begin in the next two weeks on facilities that have been identified as potential IMDs. The process should be finished in February.

- DHHS hopes to hear soon from CMS granting an extension of time on the I Waiver proposal regarding time to decide how to deal with issues related to adult care homes, and Personal Care Services.
- There has been an initial meeting with DOJ and other meetings will be set up to plan a schedule to work with them through negotiations.

There being no further business, the meeting adjourned at 3:25 PM.

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Senator Louis Pate, Co-Chair

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Representative Nelson Dollar, Co-Chair

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Representative Justin Burr, Co-Chair

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Rennie Hobby, Committee Clerk