NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

REPORT TO THE 2015 REGULAR SESSION OF THE 2015 GENERAL ASSEMBLY OF NORTH CAROLINA

DECEMBER 2014

December 9, 2014

To: Members of the 2015 Regular Session of the 2015 General Assembly

Pursuant to Article 23A of Chapter 120 of the North Carolina General Statutes, the Joint Legislative Oversight Committee on Health and Human Services has been meeting to examine the systemwide issues affecting the development, budgeting, financing, administration and delivery of health and human services. Accordingly, the Committee respectfully submits the following report on issues studied during the 2014 interim.

Respectfully,

Senator Ralph Hise, Jr.,
Co-Chair

Representative Justin Burr
Co-Chair

Representative Mark Hollo
Co-Chair

TABLE OF CONTENTS

COMMITTEE MEMBERSHIP

House Members	Senate Members
Representative Justin Burr, Co-Chair	Senator Ralph Hise, Jr., Co-Chair
Representative Mark Hollo, Co-Chair	Senator Austin Allran
Representative Marilyn Avila	Senator Chad Barefoot
Representative William Brisson	Senator Tamara Barringer
Representative Nelson Dollar	Senator Don Davis
Representative Beverly Earle	Senator Earline Parmon
Representative Bert Jones	Senator Louis Pate
Representative Donny Lambeth	Senator Gladys Robinson
Representative Susan Martin	Senator Jeff Tarte
Representative Tom Murry	Senator Tommy Tucker
Representative Michael Wray	Senator Mike Woodard
Representative Carl Ford, Advisory	Senator Ben Clark, Advisory
Representative John Torbett, Advisory	Senator Fletcher Hartsell, Jr., Advisory
	Senator Floyd McKissick, Jr., Advisory
	Senator Shirley Randleman, Advisory

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Fiscal Research Division:	
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Steve Owen	Denise Thomas
Legislative Drafting Division:	
Joyce Jones	Ryan Blackledge
Lisa Wilks	
Research Division:	
Theresa Matula	Susan Barham
Jennifer Hillman	Amy Jo Johnson
Sara Kamprath	Jan Paul
Patsy Pierce	Barbara Riley

EXECUTIVE SUMMARY OF RECOMMENDATIONS

The following is an executive summary of the recommendations from the Joint Legislative Oversight Committee on Health and Human Services. These recommendations, and the findings upon which they are based, can be found under the Committee Findings and Recommendations section of this report. These recommendations have been arranged by topic and represent the work of three subcommittees.

Medical Examiners

MEDICAL EXAMINER RECOMMENDATION 1A:
MANDATE MINIMUM MEDICAL EXAMINER TRAINING AND ORIENTATION STANDARDS

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to fund and mandate medical examiner orientation and training requirements.

MEDICAL EXAMINER RECOMMENDATION 1B:
NORTH CAROLINA MEDICAL EXAMINATION SYSTEM ACQUIRE NATIONAL ACCREDITATION

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to require the Department of Health and Human Services to develop and submit a plan for the Office of the Chief Medical Examiner to become nationally accredited. The plan, including the major milestones, an implementation timeline, and funding requirements, shall be submitted by April 1, 2015.

MEDICAL EXAMINER RECOMMENDATION 2:
INCREASE MEDICAL EXAMINER FEE FROM $100 TO $250 PER CASE

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to increase the statutory medical examiner fee from $100 to $250 per case.

MEDICAL EXAMINER RECOMMENDATION 3:
DHHS STUDY THE FEASIBILITY OF REPLACING APPOINTED MEDICAL EXAMINERS WITH MEDICOLEGAL DEATH INVESTIGATORS

The Joint Legislative Oversight Committee on Health and Human Services directs the Department of Health and Human Services to study the use of medicolegal death investigators to conduct death scene investigations. The Department shall report the findings and recommendations, including the: 1) number of MDI positions to be established; 2) proposed MDI position description and salary; 3) implementation plan; 4) associated costs, including salary; and 5) training requirements to the Committee no later than March 1, 2015.

MEDICAL EXAMINER RECOMMENDATION 4:
APPROPRIATE FUNDS TO UPGRADE THE MEDICAL EXAMINER INFORMATION SYSTEM (MEIS)

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to appropriate funds to be used to upgrade the MEIS to meet national accreditation standards and improve medical examiner investigations and reporting.

MEDICAL EXAMINER RECOMMENDATION 5A:
REIMBURSE AUTOPSY CENTERS AT COST

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to appropriate funds to the Office of the Chief Medical Examiner to be used to increase the contracted rates to reimburse the regional autopsy centers at or near actual costs (approximately $2,800).

MEDICAL EXAMINER RECOMMENDATION 5B:
ESTABLISH TWO FORENSIC PATHOLOGIST FELLOWSHIPS

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to appropriate funds to establish one forensic pathologist fellowship each at the Wake Forest University and East Carolina University regional autopsy centers. The purpose of the fellowships is to enhance the regional centers' ability to recruit and retain board-certified, forensic pathologists. A condition of the fellowship is a commitment to practice in one of the State autopsy centers for a specified period of time following the completion of the fellowship.

MEDICAL EXAMINER RECOMMENDATION 5C:
ENHANCE REGIONAL INFRASTRUCTURE OF THE STATEWIDE MEDICAL EXAMINER SYSTEM

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to provide capital funding to 1) replace the Wake Forest University and East Carolina University autopsy centers, 2) repair and renovate the Mecklenburg autopsy center, and 3) construct two additional State-operated autopsy centers to serve the southeastern and western regions of the State.

Medicaid Reform/ Division of Medical Assistance (DMA) Reorganization

MEDICAID REFORM/ DMA REORGANIZATION RECOMMENDATION:
REFORM OF THE MEDICAID AND HEALTH CHOICE PROGRAMS IS NEEDED TO ADDRESS THE RISING OVERALL COSTS OF THE PROGRAMS

The Joint Legislative Oversight Committee on Health and Human Services recommends that the General Assembly support the enactment of legislation by the General Assembly during the 2015 Session to accomplish reform of the Medicaid and Health Choice programs to a new health care system that will, within three years if feasible, achieve all of the following features:

- **Shared Financial Risk**. The new health care system should share the financial risk between the State and providers and contractors by shifting 100% of the utilization risk to providers or other contractors within three years if feasible, while the State should continue to bear the risk for changes in the number of eligible beneficiaries.

- **Defined, Measureable Goals for Health Outcomes, Quality of Care, Patient Satisfaction, and Cost**. The new health care system should define measurable goals for health outcomes, quality of care, patient satisfaction, and cost, based on appropriate local, national, and industry standards. The goals should be designed to allow the program to measure progress toward the goals, to increase comparability of services, and to achieve greater budget predictability for the State. Payment methodologies should reflect a relationship between reimbursement and the defined goals.

- **Accountability for Coordinated Care, Positive Health Outcomes, and Controlling Costs**. The new health care system should operate like a health insurance company in that the program is held accountable for ensuring coordinated care across the entire health care continuum and for producing positive health outcomes while controlling utilization costs. In order to hold the program accountable, the General Assembly should delegate the authority to control *all* payment rates, policies, and methodologies, as well as the scope and level of covered services provided, within the budget approved by the General Assembly. The program should not be held accountable for the growth and mix of the population of eligible beneficiaries, and the General Assembly should retain control of Medicaid and Health Choice eligibility criteria and thresholds.

- **Regional Access to Care**. The new health care system should ensure continuity of access to care across the State and address local needs through regional, financially sustainable organizations. The program should assure an adequate supply of appropriate providers within reasonable proximity of all beneficiaries, and should address the unique needs of both urban and rural communities. To this end, preference should be given to provider-led organizations that can achieve all of the reform goals.

- **Administrative Efficiencies**. Administrative policies and procedures utilized by the new health care system should minimize duplication, minimize consumption of the total Medicaid dollar, and support effective monitoring, enforcement, and decision-making. Administrative policies and procedures should be designed to achieve the most efficient program administration possible at the lowest reasonable cost to the State, thereby increasing the overall value of the Medicaid and Heath Choice program dollars spent.

Traumatic Brain Injury

TRAUMATIC BRAIN INJURY RECOMMENDATION 1A:
DESIGN A STATE MEDICAID TBI WAIVER

The Joint Legislative Oversight Committee on Health and Human Services supports the Department of Health and Human Services efforts to develop a TBI home and community based Medicaid waiver and to seek legislative authority to submit the waiver to the federal Centers for Medicare and Medicaid Services (CMS), including the necessary funds appropriated for the purposes of waiver implementation.

TRAUMATIC BRAIN INJURY RECOMMENDATION 1B:
AUTHORIZE DHHS TO SUBMIT A STATE MEDICAID TBI WAIVER FOR APPROVAL BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation to authorize the Department of Health and Human Services to prepare and submit a TBI waiver application for approval by the federal Centers on Medicare and Medicaid Services.

TRAUMATIC BRAIN INJURY RECOMMENDATION 1C:
APPROPRIATE STATE GENERAL FUNDS TO BE USED AS THE STATE MATCH FOR A MEDICAID TBI WAIVER

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation to appropriate $2.2 million beginning in Fiscal Year 2015-16 to be used as the State matching funds for a Medicaid TBI waiver.

TRAUMATIC BRAIN INJURY RECOMMENDATION 1D:
ESTABLISH A TRAUMATIC BRAIN INJURY SUBCOMMITTEE DURING THE INTERIM FOLLOWING THE 2015 SESSION

The Joint Legislative Oversight Committee on Health and Human Services may exercise its authority under G.S. 120-208.2(d) to establish a Subcommittee on Traumatic Brain Injury during the interim following the 2015 Regular Session for the purpose of continuing to monitor the development and implementation of a TBI Waiver for the State of North Carolina.

TRAUMATIC BRAIN INJURY RECOMMENDATION 2:
DHHS NEEDS TO PROVIDE MORE SUPPORT FOR LME/MCO EFFORTS TO IDENTIFY VETERANS WHO ARE ELIGIBLE FOR FEDERALLY FUNDED TBI SERVICES

The Joint Legislative Oversight Committee on Health and Human Services directs the DHHS to provide needed supports to LME/MCOs to determine veterans' status, and connect veterans to the appropriate resources to address mental and/or behavioral health issues that may be the result of a TBI that occurred prior or subsequent to any type of discharge from the armed forces.

TRAUMATIC BRAIN INJURY RECOMMENDATION 3:
DHHS SHOULD ENSURE THAT LME/MCOS SCREEN, IDENTIFY, AND COLLECT DATA ON INDIVIDUALS IN NEED OF TBI TREATMENT AND SERVICES

The Joint Legislative Oversight Committee on Health and Human Services directs DHHS to work with the Brain Injury Association of North Carolina, the Brain Injury Council of North Carolina, the LME/MCOs, and other interested stakeholders to gather valid and reliable data on the number of individuals per county (i) with TBI, (ii) the level of TBI, (iii) the acute, rehabilitation, or long term care needs, and (iv) veterans status.

COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee on Health and Human Services met four (4) times between September 2014 and December 2014. This section of the report provides a brief overview of topics and presenters for each meeting and a summary of the proceedings for each meeting. Detailed minutes and handouts from each meeting are available in the Legislative Library. Agendas and handouts for each meeting are available at the following link:
http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=144

Overview of Topics and Presenters

September 9, 2014

- **Comments from the Secretary**
  Dr. Aldona Wos, Secretary, Department of Health and Human Services (DHHS)
- **State Contracting Process**
  Sherri Garte, Deputy State Purchasing Officer, Department of Administration
- **DHHS Restructuring Initiatives**
  Dr. Aldona Wos, Secretary, DHHS
- **DMA Operational/Consulting Contracts**
  Dr. Aldona Wos, Secretary, DHHS
- **DHHS Budget Close-Out**
  Pam Kilpatrick, Assistant State Budget Officer, Office of State Budget and Management
- **Medicaid Budget Update**
  Rudy Dimmling, Acting Director of Finance, Division of Medical Assistance, DHHS
- **NC Fast Update**
  Joe Cooper, Chief Information Officer, DHHS
- **Dix Property Update**
  Speros Fleggas, Deputy Secretary, Department of Administration
- **Appointment of Subcommittees**

October 14, 2014

- **Comments from the Secretary**
  Dr. Aldona Wos, Secretary, Department of Health and Human Services (DHHS)
- **Ebola Update**
  Dr. Megan Davies, State Epidemiologist & Chief, Epidemiology Section, Division of Public Health, DHHS
- **Medicaid Budget Update**
  Rudy Dimmling, Acting Director of Finance, Division of Medical Assistance, DHHS
- **Report on Program of All-Inclusive Care for the Elderly (PACE)** (S.L. 2014-100, Section 12H.34(a))

Sandra Terrell, Acting Chief Operating Officer, DMA, DHHS

Linda Shaw, Executive Director, NC PACE Association

Aimee Reimann, Chair, NC PACE Association; COO, United Church Homes & Services, Newton, NC

- **Updates on Behavioral Health Continuum of Care**
  - **Use of State Appropriations for Behavioral Health Urgent Care Centers and Facility-Based Crisis Centers** (S.L. 2014-100, Section 12F.5(b))
    Dave Richard, Deputy Secretary, Behavioral Health and Developmental Disabilities Services, DHHS
  - **NC Statewide Telepsychiatry Program (NC STeP)**
    Chris Collins, Director, Office of Rural Health & Community Care, DHHS

    Dr. Sy A. Saeed, Director, NC Statewide Telepsychiatry Program; Director, East Carolina University Center for Telepsychiatry and e-Behavioral Health

November 18, 2014

- **Comments from the Secretary**
  Dr. Aldona Wos, Secretary, Department of Health & Human Services (DHHS)
- **Medicaid Budget Forecast**
  Rudy Dimmling, Acting Director of Finance, Division of Medical Assistance (DMA), DHHS
- **Medical School Funding** (S.L. 2014-100, Sec. 11.20)
  Kevin FitzGerald, Senior Vice President and Chief of Staff, UNC General Administration
- **Behavioral Health Liabilities and Budget Deficit**
  Pam Kilpatrick, Assistant State Budget Officer, Office of State Budget and Management

  Jim Slate, Director, Division of Budget and Analysis, DHHS

  Dale Armstrong, Director, Division of State Operated Healthcare Facilities, DHHS
- **DHHS Request for Position/Budget Flexibility**
  Mark Gogal, Director, Division of Human Resources, DHHS
- **Vital Records – Electronic Death Records**
  Catherine Ryan, State Registrar

  Reese Edgington, Project Manager Office Director, DHHS

December 9, 2014

- **Comments from the Secretary**
  Dr. Aldona Wos, Secretary, Department of Health & Human Services (DHHS)
- **Medicaid Budget Forecast/Status of Budget Reductions** (S.L. 2013-360 and S.L. 2014-100)
  Rudy Dimmling, Acting Director of Finance, Division of Medical Assistance, DHHS
- **Subcommittee Reports**
  - **Subcommittee on Medical Examiners**
    Jan Paul, Committee Staff, Research Division, NCGA

- **Subcommittee on Traumatic Brain Injury**
  Denise Thomas, Committee Staff, Fiscal Research Division, NCGA
- **Subcommittee on Medicaid Reform/DMA Reorganization**
  Jennifer Hillman, Committee Staff, Research Division, NCGA

- **Presentation of Committee Report**
  Theresa Matula, Committee Staff, Research Division, NCGA

Summary of Committee Proceedings

September 9, 2014

Representative Justin Burr presided over the Joint Legislative Oversight Committee on Health and Human Services meeting on September 9, 2014.

Dr. Aldona Wos, Secretary, Department of Health and Human Services (DHHS), addressed the Committee with comments on the status of the Medicaid budget, progress toward building a sustainable and accountable Department, and the transformation occurring in the Division of Medical Assistance.

Meagan Davies, State Epidemiologist and Chief of the Epidemiology Section, DHHS, presented an update on the Ebola virus and recent steps taken by the Department to protect the citizens of the State.

Sherrie Garte, Deputy State Purchasing Office, Division of Purchase and Contract, Department of Administration, reviewed the definition of a sole source contract, the definition of a personal services contract, and the criteria for determining the appropriate use of each type of contract. She also reviewed the procurement process and the conditions under which competition can be waived during the procurement process.

Next, Secretary Wos discussed restructuring initiatives in the Department, including the addition of the first ever Chief Information Officer and Chief Financial Officer to strengthen the Office of Internal Audit. Dave Richards, Deputy Secretary, Behavioral Health and Developmental Disabilities Services, followed with an explanation of the organizational and structural changes that have improved the delivery of mental health services. Mark Gogal, Director, Human Resources, DHHS, presented a review of staffing improvements, staffing barriers, opportunities for improving staffing levels, and an update on filling the two new actuary positions in the Division of Medical Assistance (DMA) authorized by the General Assembly.

Secretary Wos explained that the Medicaid budget finished the year in the best shape in five years. With the assistance of their contractor, Alvarez and Marsal, the Department is experiencing increased predictability in the Medicaid program for day-to day operations and developing a better forecasting model. Robin Cummings, Medicaid Director, provided additional details about the contract with Alvarez and Marsal. Melissa Glynn, Managing Director, Alvarez and Marsal, Public Sector Services, reported on the scope of work in the expanded contract with DHHS, initial outcomes in the business information function, and improved collection practices for drug rebates owed to DMA.

Pam Kilpatrick, Assistant State Budget Officer, Office of State Budget and Management, reported on the Fiscal Year 2013-2014 final DHHS budget and expenditures, Medicaid and mental health closeout, approved carry forwards, and General Fund reversions by division for DHHS.

Rudy Dimmling, Acting Finance Director, DMA, DHHS, presented an overview of historical Medicaid enrollment and expenditures and a weekly spend analysis. He also provided information on current and historical expenditures for the following: LME/MCO services, pharmacy expenditures, skilled nursing facilities, and dental services. Mr. Dimmling concluded his presentation with information on the development of a forecast and budget model.

The Committee was next updated on NC FAST by a series of presenters. First, Angela Taylor, Office of NC FAST, updated the Committee on the in-scope programs of NC FAST, including the time lines for implementation of the various stages of future projects and the challenges and solutions faced by the State and counties. Wayne Black, Director, Division of Social Services,

DHHS, discussed the processing status of United States Department of Agriculture (USDA) Food and Nutrition Service (FNS) applications and recertifications. Sheila Platts, DMA, discussed the impact on NC FAST functionality by the Medicaid requirements brought forth by the Affordable Care Act.

Speros Flaggos, Deputy Secretary, Department of Administration, gave a brief update on the status of the negotiations between the City of Raleigh and the State on the sale of the Dorothea Dix Hospital property.

The final agenda item was the appointment of members to subcommittees.

October 14, 2014

Senator Ralph Hise presided over the Committee meeting on October 14, 2014. The first agenda item for the Joint Legislative Oversight Committee on Health and Human Services featured comments from Dr. Aldona Wos, Secretary, Department of Health and Human Services (DHHS).

The Committee then heard from Megan Davies, State Epidemiologist and Chief of the Epidemiology Section, Division of Public Health, DHHS. Dr. Davies briefed the Committee on the number of cases and deaths related to Ebola, as well as the partnership outreach the Department has conducted within the State. Dr. Davies also commented on the training and exercise drills taking place throughout the State to address concerns about Ebola.

Next, the Committee received a Medicaid Budget Update from Rudy Dimmling, Acting Director of Finance, Division of Medical Assistance(DMA), DHHS. He reviewed the DMA Finance Section realignment and explained the management improvements. Mr. Dimmling also provided an update on the forecasting process, enrollment trends, and an expenditure analysis. He specifically addressed pharmaceutical expenditures indicating that net drug expenditure growth is outpacing gross expenditure growth due to the increased use of generic drugs which have a lower associated rebate component than brand drugs. Finally, Mr. Dimmling addressed backlog concerns.

The next item on the agenda was a report on Program of All-Inclusive Care for the Elderly (PACE). Sandra Terrell, Acting Chief Operating Officer, DMA, DHHS, gave a general overview of the PACE program and its current enrollment. This overview included information related to costs and funding as well as services. Ms. Terrell indicated the purpose of the PACE Program is to provide Medicaid beneficiaries, family, caregivers, and professional health care providers the flexibility to meet a person's health care needs while continuing to live safely in the community. Her presentation was followed by a presentation from Linda Shaw, Executive Director, NC PACE Association, and Aimee Reimann, Chair, NC PACE Association and COO of United Church Homes and Services. They also provided an overview of the program and of the individuals served by the program, noting that 90% of those served are dually eligible for Medicare and Medicaid and almost half have dementia as a significant diagnosis. Additionally, they provided information about PACE programs nationally and identified some challenges the program may face in the future.

The Committee then received an update on the Behavioral Health Continuum of Care in the form of two presentations. The first presentation addressed the use of state appropriations for behavioral health urgent care centers and facility-based crisis centers. Dave Richard, Deputy Secretary, Behavioral Health and Developmental Disabilities Services, DHHS, discussed the allocation plans for these funds that involved an 18-month committment for all new service projects. He explained the functions of behavioral health urgent care centers and facility-based crisis units. Mr. Richard's presentation was followed by a presentation on the North Carolina Statewide Telepsychiatry Program. First, Chris Collins, Director, Office of Rural Health and Community Care, provided

some background on the program and its implementation. He also addressed the program's performance measures, financial reports, and the on-going implementation of the project. Dr. Sy Saeed, Director, NC Statewide Telepsychiatry Program and the Director of the East Carolina University Center for Telepsychiatry and e-Behavioral Health, gave an overview of the data gathered from the first ten months of the program. He addressed the program's timeline required by the legislative plan and each result of the steps within that timeline, indicating that the Statewide Telepsychiatry Program is either ahead of schedule or on time with all of the defined timelines. He supplied the Committee with a proposed sustainability model and opportunities for the Program's future.

November 18, 2014

Representative Mark Hollo was the presiding chair for the meeting on November 18, 2014. After the meeting was called to order, Dr. Aldona Wos, Secretary of the Department of Health and Human Services (DHHS) was asked to make comments to the Committee.

Next, the Committee received a Medicaid Budget Forecast from Rudy Dimmling, Acting Director of Finance, Division of Medical Assistance (DMA), DHHS. Mr. Dimmling provided the Committee information on the following: Q1 Total Expenditure Analysis, SFY 2013-14 Claims Expenditure Analysis, Checkwrite Expenditures Year-to-Date, Actual Expenditures vs. Budget, SFY 2015 Full-Year Forecast, and information on the Forecast/Budget Model.

Kevin FitzGerald, Senior Vice President and Chief of Staff, UNC General Administration, updated the Committee on Medical School Funding as required by Sec. 11.20 of S.L. 2014-100. He compared the similarities and the differences in the structure, funding and scope of the Brody School of Medicine at East Carolina University and the University of North Carolina, School of Medicine. Lastly Mr. FitzGerald discussed the following future critical healthcare needs: State funding, competition for preceptor spots, changes in the healthcare landscape, demographic challenges, and the health and well-being of North Carolina. Dr Roper, Dean of the UNC School of Medicine, and Dr. Cunningham, Dean of the ECU Brody School of Medicine, also attended the meeting and responded to a number of questions from the Committee members.

The next item on the agenda was Behavioral Health Liabilities and Budget Deficit. Pam Kilpatrick, Office of State Budget and Management, provided information on the Department of Health and Human Services' mental health liabilities. The presentation included: (1) an overview of the mental health budget, (2) year-end liabilities, (3) factors contributing to the gap between spending and revenues, and (4) measures to address mental health liabilities. Following the presentation by Ms. Kilpatrick, the Committee heard from Jim Slate, Director, Division of Budget and Analysis, DHHS, and Dale Armstrong, MBA, FACHE, Director, Division of State Operated Healthcare Facilities, DHHS. Mr. Slate and Mr. Armstrong continued to update the Committee on the Department's behavioral health liabilities and budget deficit. Contributing factors discussed included: changes by CMS on surveying/certification issues, closure of Dorothea Dix Hospital, patient/resident increased acuity, inflation, and changes in payor mix. Also provided was a facility shortfall timeline and a breakout of mental health liabilities by fiscal year from 2009-2014. Finally, the presentation concluded with an overview of initiatives completed, initiatives in progress, and the goals of the Division of State Operative Healthcare Facilities.

Next, Mark Gogal, Director, Division of Human Resources, DHHS, explained the need for position and budget flexibility at DHHS. Items discussed include: current staffing challenges, DHHS

vacancy and turnover rates, pay equity issues, status of 2014 initiatives, position/budget requests for 2015, and administrative efficiencies.

Catherine Ryan, State Registrar, and Reese Edgington, Project Manager Office Director, DHHS, provided an overview of the Vital Records Electronic Death Registration System (EDRS). North Carolina is one of only 6 states that does not have an EDRS. Currently, North Carolina Death Registration is an 84-year old system, registering 83,000 North Carolina deaths each year. It takes 60 to 90 days to register a death and report death data. According to the presenters, an EDRS will accelerate processing to register a death and report death data from 60-90 days to 0-7 days. The presenters provided cost estimates for both in-house development and a commercial off-the-shelf Electronic Death Registration System. The presenters responded to questions from the Committee.

December 9, 2014

Senator Ralph Hise presided over the Committee meeting on December 9, 2014. The first agenda item featured comments from Dr. Aldona Wos, Secretary of the Department of Health and Human Services (DHHS). Next Rudy Dimmling, Acting Director of Finance, Division of Medical Assistance, DHHS, presented information on the Medicaid Budget Forecast/Status of Budget Reductions, as required by S.L. 2013-360 and S.L. 2014-100.

The Committee received reports from three subcommittees. Jan Paul, Committee Staff, presented the report from the Subcommittee on Medical Examiners. Denise Thomas, Committee Staff, presented the report from the Traumatic Brain Injury Subcommittee. Finally, Jennifer Hillman, Committee Staff, presented the report from the Medicaid Reform/Division of Medical Assistance Reorganization Subcommittee.

Finally, Theresa Matula, Committee Staff, presented for Committee consideration a draft report from the Joint Legislative Oversight Committee on Health and Human Services to the 2015 General Assembly.

SUBCOMMITTEES

During the 2014 Interim, three subcommittees of the Joint Legislative Oversight Committee on Health and Human Services were appointed: Medical Examiner Subcommittee, the Medicaid Reform/Division of Medical Assistance (DMA) Reorganization Subcommittee and the Traumatic Brain Injury Subcommittee. The three subcommittees presented reports to the Joint Legislative Oversight Committee on December 9, 2014. Minutes for the Subcommittee meetings are on file in the Legislative Library. Handouts and agendas are available online at the following link: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=144&sFolderName=\HHS Subcommittees by Interim\2014-15 HHS Subcommittees.

Medical Examiner Subcommittee

Pursuant to G.S. 120-208.2(d), the Medical Examiner Subcommittee was authorized to study the following issues:

1) Progress and recommendations by the Department of Health and Human Services, Division of Public Health, on the adequacy of current fees, the categories of professionals appointed as medical examiners, and the qualifications of and training requirements for medical examiners, as required by S.L. 2014-100 (SB 744), Section 12E.6(b). The Subcommittee may also consider information from other sources regarding qualifications for medical examiners, training requirements, continuing education, and adequate rates to recruit and retain quality examiners.
2) The overall structure and capacity of the Office of the State Medical Examiner, including an examination of the pros/cons of having a central office versus creating regional offices, and the adequacy of overall funding for the local examiners: transportation, contracts, staffing, training, and information technology, etc.
3) The Department's progress in developing and implementing a system of oversight to achieve operational efficiencies and quality assurance, as required by S.L. 2014-100 (SB 744), Section 12E.6(c).
4) The Subcommittee is also authorized to work with the Joint Legislative Oversight Committee on Justice and Public Safety upon request, as required by S.L. 2014-100 (SB 744), Section 17.3.

Below is a list of the Members and staff of the Medical Examiner Subcommittee.

Senate Members	House Members
Senator Jeff Tarte, Chair	Representative Mark Hollo, Chair
Senator Tommy Tucker	Representative Justin Burr
Senator Chad Barefoot	Representative Donny Lambeth
Senator Don Davis	Representative Carl Ford
	Representative William Brisson
Clerks	
Olivia McCormick, Senate Clerk	Sam Blanton, House Clerk
Staff	
Denise Thomas, Fiscal Research Division	Susan Jacobs, Fiscal Research Division
Joyce Jones, Legislative Drafting Division	Amy Jo Johnson, Research Division
Barbara Riley, Research Division	Susan Barham, Research Division
Jan Paul, Research Division	

Medicaid Reform/Division of Medical Assistance (DMA) Reorganization Subcommittee

In addition to the Medical Examiner Subcommittee and pursuant to G.S. 120-208.2(d), the chairs jointly determined that a Medicaid Reform/Division of Medical Assistance (DMA) Reorganization Subcommittee was necessary to study the following issues:

1) Efforts by the Department of Health and Human Services to: (1) consult with stakeholder groups, study and recommend options for Medicaid reform that will provide greater budget predictability and (2) to not commit the State toward any particular course on Medicaid reform including not submitting any reform-related State plan amendments, waivers, or grant application nor enter into any contracts related to implementing Medicaid reform, as required by S.L. 2014-100 (SB 744), Section 12H.1.
2) The Program Evaluation Division Report, *Options for Creating a Separate Department of Medicaid Require Transition Planning*, (March, 2013) and any subsequent report updates.
3) House Bill 1181 North Carolina Medicaid Modernization, Third Edition, and House Bill 1181 North Carolina Medicaid Modernization, Sixth Edition.
4) Any other studies and recommended options to improve Medicaid budget predictability and the overall operations of the Medicaid program.

Below is a list of the Members and staff of the Medicaid Reform/DMA Reorganization Subcommittee.

Senate Members	House Members
Senator Ralph Hise, Chair	Representative Justin Burr, Chair
Senator Louis Pate	Representative Mark Hollo
Senator Fletcher Hartsell	Representative Marilyn Avila
Senator Floyd McKissick	Representative Nelson Dollar
	Representative Donny Lambeth
	Representative William Brisson
Clerks	
Susan Fanning, Senate Clerk	Dina Long, House Clerk
Staff	
Susan Jacobs, Fiscal Research Division	Steve Owens, Fiscal Research Division
Denise Thomas, Fiscal Research Division	Deborah Landry, Fiscal Research Division
Ryan Blackledge, Legislative Drafting	Karlynn O'Shaughnessy, Fiscal Research Division
Jennifer Hillman, Research Division	Theresa Matula, Research Division
Amy Jo Johnson, Research Division	

Traumatic Brain Injury Subcommittee

Session Law 2014-100 (SB 744), Section 12I.2, directed the Joint Legislative Oversight Committee on Health and Human Services to establish a Traumatic Brain Injury (TBI) Subcommittee for the purpose of examining the issues outlined below.

1) Existing TBI services and any deficiencies in service array, quality of services, accessibility, and availability of services across each age group of persons with TBI regardless of the age at which the trauma occurred.

2) Current inventory, availability, and accessibility of residential facilities specifically designed to service individuals with TBI.
3) Existing TBI-specific service definitions for children and adults who receive services through federally funded programs, including Medicaid, federal block grants, and the Veterans Administration; through State-funded programs, including the Traumatic Brain Injury Trust Fund; through county-funded programs; and through other funding sources, as well as the need for additional or revised service definitions to meet the specific needs of those with TBI.
4) Current reimbursement rates tied to settings that treat adults with TBI and the adequacy of these reimbursement rates.
5) Current accessibility to TBI services, service information, educational materials, and family resources; and any deficiencies that need to be addressed.
6) Current status of TBI-specific screening, assessment, triage, and service referrals for children, adults, and veterans; and any deficiencies that need to be addressed.
7) This State's current organizational model for providing comprehensive needs assessment, information management, policy development, service delivery, monitoring, and quality assurance for children and adults with TBI as compared to TBI organizational structures in other states; and specific organizational models to manage services for persons with TBI that are well coordinated for all citizens, including veterans.
8) Any other matters related to TBI services for children, adults, veterans, and their families.

Below is a list of the Members and staff of the Traumatic Brain Injury Subcommittee.

Senate Members	**House Members**
Senator Louis Pate, Chair	Representative Marilyn Avila, Chair
Senator Tamara Barringer	Representative Bert Jones
Senator Shirley Randleman	Representative Susan Martin
Senator Mike Woodard	Representative Tom Murry
	Representative Beverly Earle
Clerks	
Edna Pearce, Senate Clerk	Susan Lewis, House Clerk
Staff	
Denise Thomas, Fiscal Research Division	Susan Jacobs, Fiscal Research Division
Joyce Jones, Legislative Drafting Division	Ryan Blackledge, Legislative Drafting Division
Patsy Pierce, Research Division	Sara Kamprath, Research Division

COMMITTEE FINDINGS AND RECOMMENDATIONS

Findings and Recommendations from the Joint Legislative Oversight Committee on Health and Human Services are provided in this section. The findings and recommendations have been categorized by topic and represent the work of the Committee's three subcommittees.

Medical Examiner

The current North Carolina Medical Examiner System operates within the North Carolina Department of Health and Human Services (DHHS), Division of Public Health. The Office of the Chief Medical Examiner (OCME) is located in Raleigh. As of the time of this report, there were 447 active Medical Examiners appointed by the OCME, and 14 full-time, board-certified forensic pathologists working to serve three regional autopsy centers. In addition to the Office of the Chief Medical Examiner in Raleigh, three regional contract autopsy centers are operated by East Carolina University Brody School of Medicine, Wake Forest University Health Services, and the Mecklenburg County Medical Examiner's Office.

The Medical Examiner System in the State should consist of a coordinated professional network of dedicated State and local resources in order to perform high quality death investigations on a timely basis on all appropriately identified deaths occurring in the State. This should be accomplished through a regionalized approach using a combination of forensically trained pathologists, appointed medical examiners, and certified death investigation personnel. The system should retain central authority and data collection to insure the quality of death investigations statewide and encourage data analysis and research to guide public policy and system improvements.

The current primary goals of system reform as identified by DHHS are:

- To stabilize the existing regional Medical Examiner system and reduce high caseloads for OCME forensic pathologists.
- To move toward having all autopsies performed by a board-certified forensic pathologist.
- To require OCME to make quality improvement and assurance efforts.
- To identify and direct internal existing resources to enhance OCME.
- To improve the quality of Medical Examiners through training and selection criteria.

The current primary recommendation objectives of DHHS are:

- To support the statewide Medical Examiner system regional model.
- To improve the quality of death scene investigations.
- To support existing statewide autopsy services.

MEDICAL EXAMINER FINDING 1:
ADEQUATELY TRAIN MEDICAL PROFESSIONALS TO PERFORM FUNCTIONS OF MEDICAL EXAMINER.

Most medical examiners in the State are private practice physicians with an interest in death investigation who voluntarily participate in the medical examiner system. In many areas of the State, recruitment, training and retention of qualified physician medical examiners is difficult; thus, the Medical Examiner System has relied upon non-physician medical personnel, such as physician assistants, nurse practitioners, nurses, and emergency medical technicians/paramedics, to perform

the death investigation. The training necessary to fully support the medical examiner system is significant and varies from a basic knowledge of what can cause deaths and how to complete a death certificate to highly specialized forensic training to perform complex medicolegal autopsies. The capacity for this training is not routinely and easily available throughout the State.

MEDICAL EXAMINER RECOMMENDATION 1A:
MANDATE MINIMUM MEDICAL EXAMINER TRAINING AND ORIENTATION STANDARDS

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to fund and mandate medical examiner orientation and training requirements.

MEDICAL EXAMINER RECOMMENDATION 1B:
NORTH CAROLINA MEDICAL EXAMINATION SYSTEM ACQUIRE NATIONAL ACCREDITATION

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to require the Department of Health and Human Services to develop and submit a plan for the Office of the Chief Medical Examiner to become nationally accredited. The plan, including the major milestones, an implementation timeline, and funding requirements, shall be submitted by April 1, 2015.

MEDICAL EXAMINER FINDING 2:
INCREASE MEDICAL EXAMINER FEE

G.S. 130A-387 authorizes a Medical Examiner to be paid a fee of $100 per investigation. The current fee structure fails to recognize the increased costs of Medical Examiner services and variation in death investigations with respect to providers and case complexity. The fee has not been increased since 2005.

MEDICAL EXAMINER RECOMMENDATION 2:
INCREASE MEDICAL EXAMINER FEE FROM $100 TO $250 PER CASE

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to increase the statutory medical examiner fee from $100 to $250 per case.

MEDICAL EXAMINER FINDING 3:
STUDY MEDICOLEGAL DEATH INVESTIGATOR (MDI) PROGRAM

Individuals with medical expertise should conduct the medical aspect of death investigations. In many areas of the State, there are insufficient resources to employ full time personnel to assist in the performance of death investigations. Currently, G.S. 130A-382 authorizes the Chief Medical Examiner to appoint, under certain circumstances, specified non-physicians with qualifying credentials to serve as acting county medical examiner. Physician assistants, nurse practitioners, nurses, coroners and emergency medical technicians/paramedics currently serve in this capacity in North Carolina. The position of Medicolegal Death Investigators (MDI) in the State should be

legislatively authorized and established, the role of the MDI clearly defined, and the MDI training and educational requirements specifically prescribed by the Office of the Chief Medical Examiner.

MEDICAL EXAMINER RECOMMENDATION 3:
DHHS STUDY THE FEASIBILITY OF REPLACING APPOINTED MEDICAL EXAMINERS WITH MEDICOLEGAL DEATH INVESTIGATORS

The Joint Legislative Oversight Committee on Health and Human Services directs the Department of Health and Human Services to study the use of medicolegal death investigators to conduct death scene investigations. The Department shall report the findings and recommendations, including the: 1) number of MDI positions to be established; 2) proposed MDI position description and salary; 3) implementation plan; 4) associated costs, including salary; and 5) training requirements to the Committee no later than March 1, 2015.

MEDICAL EXAMINER FINDING 4:
PROVIDE RESOURCES TO UPGRADE THE MEDICAL EXAMINER INFORMATION SYSTEM (MEIS)

The Medical Examiners Information System is comprised of multiple applications utilizing a variety of technologies supporting the Office of the Chief Medical Examiner (OCME) in developing reports of investigation, autopsy reports and toxicology reports. The current system uses disparate and obsolete technology. Further, no consistent information technology strategic approach is used. Information continues to be documented manually on paper by medical examiners and then is manually entered into MEIS by OCME staff. This process gives rise to a consistent backlog of ME cases needing to be entered into MEIS, inefficient and sometimes untimely document workflow between approving offices, inadequate data capture to be provided for comprehensive statewide analytics and for accreditation, and also creates issues from a technical perspective.

MEDICAL EXAMINER RECOMMENDATION 4:
APPROPRIATE FUNDS TO UPGRADE THE MEDICAL EXAMINER INFORMATION SYSTEM (MEIS)

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to appropriate funds to be used to upgrade the MEIS to meet national accreditation standards and improve medical examiner investigations and reporting.

MEDICAL EXAMINER FINDING 5:
ENHANCE REGIONAL MEDICAL EXAMINER SYSTEM

Workload demands and changing demographics in the State have made it difficult to recruit and retain trained professionals to serve as medical examiners and to complete death investigations in a timely and efficient manner. The use of regional centers to serve specific geographic regions of the State increases the capacity to conduct quality and complex death investigations in a timely manner, yet allow for oversight under the central coordinating authority of the Chief Medical Examiner. Based on a cost study completed by DHHS in September 2014, OCME's cost per autopsy is $2,813.

MEDICAL EXAMINER RECOMMENDATION 5A:
REIMBURSE AUTOPSY CENTERS AT COST

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to appropriate funds to the Office of the Chief Medical Examiner to be used to increase the contracted rates to reimburse the regional autopsy centers at or near actual costs (approximately $2,800).

MEDICAL EXAMINER RECOMMENDATION 5B:
ESTABLISH TWO FORENSIC PATHOLOGIST FELLOWSHIPS

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to appropriate funds to establish one forensic pathologist fellowship each at the Wake Forest University and East Carolina University regional autopsy centers. The purpose of the fellowships is to enhance the regional centers' ability to recruit and retain board-certified, forensic pathologists. A condition of the fellowship is a commitment to practice in one of the State autopsy centers for a specified period of time following the completion of the fellowship.

MEDICAL EXAMINER RECOMMENDATION 5C:
ENHANCE REGIONAL INFRASTRUCTURE OF THE STATEWIDE MEDICAL EXAMINER SYSTEM

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation by the General Assembly to provide capital funding to 1) replace the Wake Forest University and East Carolina University autopsy centers, 2) repair and renovate the Mecklenburg autopsy center, and 3) construct two additional State-operated autopsy centers to serve the southeastern and western regions of the State.

Medicaid Reform/ Division of Medical Assistance (DMA) Reorganization

MEDICAID REFORM/ DMA REORGANIZATION FINDING:
REFORM OF THE MEDICAID AND HEALTH CHOICE PROGRAMS IS NEEDED TO ADDRESS THE RISING OVERALL COSTS OF THE PROGRAMS

The efficient and effective delivery of Medicaid and Health Choice services is of vital importance to Medicaid and Health Choice beneficiaries, the Department of Health and Human Services, Members of the General Assembly, and the citizens of the State. The Medicaid and Health Choice budget represents a significant portion of the State budget, and reliable forecasting is imperative to sustainable funding. The Subcommittee on Medicaid Reform/Division of Medical Assistance (DMA) Reorganization reviewed legislation considered during the 2014 Session, heard from three states on their approaches to reform and Medicaid service delivery, and received comments from stakeholders. The Subcommittee received a Medicaid budget analysis from Steve Owen of the Fiscal Research Division demonstrating that the current fee-for-service Medicaid model will continue a trend of constantly increasing Medicaid costs. Medicaid Directors from Florida, Ohio, and Virginia presented examples of how increased care management in their states has helped to control Medicaid costs.

MEDICAID REFORM/ DMA REORGANIZATION RECOMMENDATION: REFORM OF THE MEDICAID AND HEALTH CHOICE PROGRAMS IS NEEDED TO ADDRESS THE RISING OVERALL COSTS OF THE PROGRAMS

The Joint Legislative Oversight Committee on Health and Human Services recommends that the General Assembly support the enactment of legislation by the General Assembly during the 2015 Session to accomplish reform of the Medicaid and Health Choice programs to a new health care system that will, within three years if feasible, achieve all of the following features:

- **Shared Financial Risk**. The new health care system should share the financial risk between the State and providers and contractors by shifting 100% of the utilization risk to providers or other contractors within three years if feasible, while the State should continue to bear the risk for changes in the number of eligible beneficiaries.
- **Defined, Measureable Goals for Health Outcomes, Quality of Care, Patient Satisfaction, and Cost**. The new health care system should define measurable goals for health outcomes, quality of care, patient satisfaction, and cost, based on appropriate local, national, and industry standards. The goals should be designed to allow the program to measure progress toward the goals, to increase comparability of services, and to achieve greater budget predictability for the State. Payment methodologies should reflect a relationship between reimbursement and the defined goals.
- **Accountability for Coordinated Care, Positive Health Outcomes, and Controlling Costs**. The new health care system should operate like a health insurance company in that the program is held accountable for ensuring coordinated care across the entire health care continuum and for producing positive health outcomes while controlling utilization costs. In order to hold the program accountable, the General Assembly should delegate the authority to control *all* payment rates, policies, and methodologies, as well as the scope and level of covered services provided, within the budget approved by the General Assembly. The program should not be held accountable for the growth and mix of the population of eligible beneficiaries, and the General Assembly should retain control of Medicaid and Health Choice eligibility criteria and thresholds.
- **Regional Access to Care**. The new health care system should ensure continuity of access to care across the State and address local needs through regional, financially sustainable organizations. The program should assure an adequate supply of appropriate providers within reasonable proximity of all beneficiaries, and should address the unique needs of both urban and rural communities. To this end, preference should be given to provider-led organizations that can achieve all of the reform goals.
- **Administrative Efficiencies**. Administrative policies and procedures utilized by the new health care system should minimize duplication, minimize consumption of the total Medicaid dollar, and support effective monitoring, enforcement, and decision-making. Administrative policies and procedures should be designed to achieve the most efficient program administration possible at the lowest reasonable cost to the State, thereby increasing the overall value of the Medicaid and Heath Choice program dollars spent.

Traumatic Brain Injury

Persons suffering from a severe traumatic brain injury (TBI) require an array of short and long-term treatment, rehabilitation, and home and community support services. Often these individuals and their families have limited or no insurance coverage or other resources to cover the cost of these services. Many states have developed specific programs and infrastructure to address the needs of persons with TBI and their families/caregivers. Data from the National Association of State Head Injury Administrators (NASHIA) indicates that 40 states provide intensive TBI services funded with Medicaid waivers, trust funds, or a combination. North Carolina is one of the ten states which do not use a Medicaid TBI waiver or trust fund.

The findings and recommendations below are based on information provided to the Subcommittee.

TRAUMATIC BRAIN INJURY FINDING 1:
A MEDICAID HOME AND COMMUNITY-BASED WAIVER IS THE PREFERRED APPROACH TO PROVIDE STATE-FUNDED SERVICES TO INDIVIDUALS WITH TRAUMATIC BRAIN INJURY (TBI)

The Joint Legislative Oversight Committee on Health and Human Services finds that there are currently underserved and unserved North Carolinians with TBI. The Department of Health and Human Services (DHHS), working in collaboration with interested stakeholders, has developed a waiver plan. (Details on the waiver plan may be found in the Appendix of the Traumatic Brain Injury Subcommittee report.) The Committee supports the DHHS plan and anticipates that DHHS will seek legislative authorization and funding for the waiver plan in the 2015 Session.

TRAUMATIC BRAIN INJURY RECOMMENDATION 1A:
DESIGN A STATE MEDICAID TBI WAIVER

The Joint Legislative Oversight Committee on Health and Human Services supports the Department of Health and Human Services efforts to develop a TBI home and community based Medicaid waiver and to seek legislative authority to submit the waiver to the federal Centers for Medicare and Medicaid Services (CMS), including the necessary funds appropriated for the purposes of waiver implementation.

TRAUMATIC BRAIN INJURY RECOMMENDATION 1B:
AUTHORIZE DHHS TO SUBMIT A STATE MEDICAID TBI WAIVER FOR APPROVAL BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation to authorize the Department of Health and Human Services to prepare and submit a TBI waiver application for approval by the federal Centers on Medicare and Medicaid Services.

TRAUMATIC BRAIN INJURY RECOMMENDATION 1C:
APPROPRIATE STATE GENERAL FUNDS TO BE USED AS THE STATE MATCH FOR A MEDICAID TBI WAIVER

The Joint Legislative Oversight Committee on Health and Human Services supports the enactment of legislation to appropriate $2.2 million beginning in Fiscal Year 2015-16 to be used as the State matching funds for a Medicaid TBI waiver.

TRAUMATIC BRAIN INJURY RECOMMENDATION 1D:
ESTABLISH A TRAUMATIC BRAIN INJURY SUBCOMMITTEE DURING THE INTERIM FOLLOWING THE 2015 SESSION

The Joint Legislative Oversight Committee on Health and Human Services may exercise its authority under G.S. 120-208.2(d) to establish a Subcommittee on Traumatic Brain Injury during the interim following the 2015 Regular Session for the purpose of continuing to monitor the development and implementation of a TBI Waiver for the State of North Carolina.

TRAUMATIC BRAIN INJURY FINDING 2:
NEED FOR ONGOING COORDINATION WITH THE U.S. DEPARTMENT OF VETERANS AFFAIRS

The Joint Legislative Oversight Committee on Health and Human Services finds that local management entities/managed care organizations (LME/MCOS) need to assess individuals who have been referred to them for mental health and/or behavioral health needs to determine if they are military veterans who may be eligible for federally funded TBI treatment and services of military service. The Traumatic Brain Injury Subcommittee heard presentations on the array of traumatic brain injury treatment and services provided by the U.S. Department of Defense and the U.S. Department of Veterans' Affairs.

TRAUMATIC BRAIN INJURY RECOMMENDATION 2:
DHHS NEEDS TO PROVIDE MORE SUPPORT FOR LME/MCO EFFORTS TO IDENTIFY VETERANS WHO ARE ELIGIBLE FOR FEDERALLY FUNDED TBI SERVICES

The Joint Legislative Oversight Committee on Health and Human Services directs the DHHS to provide needed supports to LME/MCOs to determine veterans' status, and connect veterans to the appropriate resources to address mental and/or behavioral health issues that may be the result of a TBI that occurred prior or subsequent to any type of discharge from the armed forces.

TRAUMATIC BRAIN INJURY FINDING 3:
NEED FOR VALID AND RELIABLE DATA ON THE INCIDENCE RATE OF TBI IN NC

The Joint Legislative Oversight Committee on Health and Human Services finds that there is a lack of accurate TBI incidence and prevalence rate data specific to the number of North Carolinians diagnosed with traumatic brain injury and in need of subsequent acute, rehabilitative, or long term care services. This data is needed to assess the need for and develop cost efficient and effective care options for this population. Staff from the DHHS Division of Mental Health/Developmental Disabilities/Substance Abuse Services and Alliance Behavioral Healthcare LME/MCO presented information to the Traumatic Brain Injury Subcommittee on the development and implementation of a screening tool which will be used by all LME/MCOs to screen, identify, and collect data on individuals with TBI. This effort is being funded by a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA).

TRAUMATIC BRAIN INJURY RECOMMENDATION 3:
DHHS SHOULD ENSURE THAT LME/MCOS SCREEN, IDENTIFY, AND COLLECT DATA ON INDIVIDUALS IN NEED OF TBI TREATMENT AND SERVICES

The Joint Legislative Oversight Committee on Health and Human Services directs DHHS to work with the Brain Injury Association of North Carolina, the Brain Injury Council of North Carolina, the LME/MCOs, and other interested stakeholders to gather valid and reliable data on the number of individuals per county (i) with TBI, (ii) the level of TBI, (iii) the acute, rehabilitation, or long term care needs, and (iv) veterans status.