GENERAL ASSEMBLY OF NORTH CAROLINA

SPECIAL PROVISIONS
APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
REPORT

APRIL 13, 2011

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H5**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

CHILD CARE SUBSIDY RATES

SECTION #.(a) The maximum gross annual income for initial eligibility, adjusted biennially, for subsidized child care services shall be seventy-five percent (75%) of the State median income, adjusted for family size.

SECTION #.(b) Fees for families who are required to share in the cost of care shall be established based on a percent of gross family income and adjusted for family size. Fees shall be determined as follows:

FAMILY SIZE	PERCENT OF GROSS FAMILY INCOME
1-3	10%
4-5	9%
6 or more	8%.

SECTION #.(c) Payments for the purchase of child care services for low-income children shall be in accordance with the following requirements:

(1) Religious-sponsored child care facilities operating pursuant to G.S. 110-106 and licensed child care centers and homes that meet the minimum licensing standards that are participating in the subsidized child care program shall be paid the one-star county market rate or the rate they charge privately paying parents, whichever is lower.

(2) Licensed child care centers and homes with two or more stars shall receive the market rate for that rated license level for that age group or the rate they charge privately paying parents, whichever is lower.

(3) Nonlicensed homes shall receive fifty percent (50%) of the county market rate or the rate they charge privately paying parents, whichever is lower.

(4) Maximum payment rates shall also be calculated periodically by the Division of Child Development for transportation to and from child care provided by the child care provider, individual transporter, or transportation agency, and for fees charged by providers to parents. These payment rates shall be based upon information collected by market rate surveys.

SECTION #.(d) Provisions of payment rates for child care providers in counties that do not have at least 50 children in each age group for center-based and home-based care are as follows:

(1) Except as applicable in subdivision (2) of this subsection, payment rates shall be set at the statewide or regional market rate for licensed child care centers and homes.

(2) If it can be demonstrated that the application of the statewide or regional market rate to a county with fewer than 50 children in each age group is lower than the county market rate and would inhibit the ability of the county to purchase child care for low-income children, then the county market rate may be applied.

SECTION #.(e) A market rate shall be calculated for child care centers and homes at each rated license level for each county and for each age group or age category of enrollees and shall be representative of fees charged to parents for each age group of enrollees within the county. The Division of Child Development shall also calculate a statewide rate and regional market rates for each rated license level for each age category.

SECTION #.(f) Facilities licensed pursuant to Article 7 of Chapter 110 of the General Statutes and facilities operated pursuant to G.S. 110-106 may participate in the program that provides for the purchase of care in child care facilities for minor children of needy families. No separate licensing requirements shall be used to select facilities to participate. In addition, child care facilities shall be required to meet any additional applicable requirements of federal law or regulations. Child care arrangements exempt from State regulation pursuant to Article 7 of Chapter 110 of the General Statutes shall meet the requirements established by other State law and by the Social Services Commission.

County departments of social services or other local contracting agencies shall not use a provider's failure to comply with requirements in addition to those specified in this subsection as a condition for reducing the provider's subsidized child care rate.

SECTION #.(g) Payment for subsidized child care services provided with Work First Block Grant funds shall comply with all regulations and policies issued by the Division of Child Development for the subsidized child care program.

SECTION #.(h) Noncitizen families who reside in this State legally shall be eligible for child care subsidies if all other conditions of eligibility are met. If all other conditions of eligibility are met, noncitizen families who reside in this State illegally shall be eligible for child care subsidies only if at least one of the following conditions is met:

(1) The child for whom a child care subsidy is sought is receiving child protective services or foster care services.

(2) The child for whom a child care subsidy is sought is developmentally delayed or at risk of being developmentally delayed.

(3) The child for whom a child care subsidy is sought is a citizen of the United States.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

CHILD CARE ALLOCATION FORMULA

SECTION #.(a) The Department of Health and Human Services shall allocate child care subsidy voucher funds to pay the costs of necessary child care for minor children of needy families. The mandatory thirty percent (30%) Smart Start subsidy allocation under G.S. 143B-168.15(g) shall constitute the base amount for each county's child care subsidy allocation. The Department of Health and Human Services shall use the following method when allocating federal and State child care funds, not including the aggregate mandatory thirty percent (30%) Smart Start subsidy allocation:

(1) Funds shall be allocated to a county based upon the projected cost of serving children under age 11 in families with all parents working who earn less than seventy-five percent (75%) of the State median income.

(2) No county's allocation shall be less than ninety percent (90%) of its State fiscal year 2001-2002 initial child care subsidy allocation.

SECTION #.(b) The Department of Health and Human Services may reallocate unused child care subsidy voucher funds in order to meet the child care needs of low-income families. Any reallocation of funds shall be based upon the expenditures of all child care subsidy voucher funding, including Smart Start funds, within a county.

SECTION #.(c) Notwithstanding subsection (a) of this section, the Department of Health and Human Services shall allocate up to twenty million dollars ($20,000,000) in federal block grant funds and State funds appropriated for fiscal years 2011-2012 and 2012-2013 for child care services. These funds shall be allocated to prevent termination of child care services. Funds appropriated for specific purposes, including targeted market rate adjustments given in the past, may also be allocated by the Department separately from the allocation formula described in subsection (a) of this section.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

CHILD CARE FUNDS MATCHING REQUIREMENT

SECTION #. No local matching funds may be required by the Department of Health and Human Services as a condition of any locality's receiving its initial allocation of child care funds appropriated by this act unless federal law requires a match. If the Department reallocates additional funds above twenty-five thousand dollars ($25,000) to local purchasing agencies beyond their initial allocation, local purchasing agencies must provide a twenty percent (20%) local match to receive the reallocated funds. Matching requirements shall not apply when funds are allocated because of a disaster as defined in G.S. 166A-4(1).

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

CHILD CARE REVOLVING LOAN

SECTION #. Notwithstanding any law to the contrary, funds budgeted for the Child Care Revolving Loan Fund may be transferred to and invested by the financial institution contracted to operate the Fund. The principal and any income to the Fund may be used to make loans, reduce loan interest to borrowers, serve as collateral for borrowers, pay the contractor's cost of operating the Fund, or pay the Department's cost of administering the program.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

EARLY CHILDHOOD EDUCATION AND DEVELOPMENT INITIATIVES ENHANCEMENTS

SECTION #.(a) Administrative costs shall be equivalent to, on an average statewide basis for all local partnerships, not more than eight percent (8%) of the total statewide allocation to all local partnerships. For purposes of this subsection, administrative costs shall include costs associated with partnership oversight, business and financial management, general accounting, human resources, budgeting, purchasing, contracting, and information systems management. The eight percent (8%) administrative cap shall not include the fifty-two million dollars ($52,000,000) local partnerships are required to spend on child care subsidies in accordance with subsection (h) of this section.

SECTION #.(b) The North Carolina Partnership for Children, Inc., shall not use more than eighty thousand dollars ($80,000) in funds from the General Fund for the salary of any individual employee. A local partnership shall not use more than sixty thousand dollars ($60,000) in funds from the General Fund for the salary of any individual employee. Nothing in this subsection shall be construed to prohibit the North Carolina Partnership for Children, Inc. or a local partnership from using non-State funds to supplement the salary of an employee employed by the North Carolina Partnership for Children, Inc. or the local partnership.

SECTION #.(c) The North Carolina Partnership for Children, Inc., and all local partnerships shall use competitive bidding practices in contracting for goods and services on contract amounts as follows:

(1) For amounts of five thousand dollars ($5,000) or less, the procedures specified by a written policy to be developed by the Board of Directors of the North Carolina Partnership for Children, Inc.

(2) For amounts greater than five thousand dollars ($5,000), but less than fifteen thousand dollars ($15,000), three written quotes.

(3) For amounts of fifteen thousand dollars ($15,000) or more, but less than forty thousand dollars ($40,000), a request for proposal process.

(4) For amounts of forty thousand dollars ($40,000) or more, a request for proposal process and advertising in a major newspaper.

SECTION #.(d) The North Carolina Partnership for Children, Inc., and all local partnerships shall, in the aggregate, be required to match one hundred percent (100%) of the total amount budgeted for the program in each fiscal year of the biennium. However, the one hundred percent (100%) match shall not include the fifty-two million dollars ($52,000,000) required for child care subsidies under subsection (h) of this section. Of the funds the North Carolina Partnership for Children, Inc. and the local partnerships are required to match, contributions shall be of cash equal to at least fifteen percent (15%) and in-kind donated resources equal to no more than five percent (5%) for a total match requirement of twenty percent (20%) for each fiscal year. The North Carolina Partnership for Children, Inc., may carry forward any amount in excess of the required match for a fiscal year in order to meet the

match requirement of the succeeding fiscal year. Only in-kind contributions that are quantifiable shall be applied to the in-kind match requirement. Volunteer services may be treated as an in-kind contribution for the purpose of the match requirement of this subsection. Volunteer services that qualify as professional services shall be valued at the fair market value of those services. All other volunteer service hours shall be valued at the statewide average wage rate as calculated from data compiled by the Employment Security Commission in the Employment and Wages in North Carolina Annual Report for the most recent period for which data are available. Expenses, including both those paid by cash and in-kind contributions, incurred by other participating non-State entities contracting with the North Carolina Partnership for Children, Inc., or the local partnerships, also may be considered resources available to meet the required private match. In order to qualify to meet the required private match, the expenses shall:

(1) Be verifiable from the contractor's records.

(2) If in-kind, other than volunteer services, be quantifiable in accordance with generally accepted accounting principles for nonprofit organizations.

(3) Not include expenses funded by State funds.

(4) Be supplemental to and not supplant preexisting resources for related program activities.

(5) Be incurred as a direct result of the Early Childhood Initiatives Program and be necessary and reasonable for the proper and efficient accomplishment of the Program's objectives.

(6) Be otherwise allowable under federal or State law.

(7) Be required and described in the contractual agreements approved by the North Carolina Partnership for Children, Inc., or the local partnership.

(8) Be reported to the North Carolina Partnership for Children, Inc., or the local partnership by the contractor in the same manner as reimbursable expenses.

Failure to obtain a twenty percent (20%) match by June 30 of each fiscal year shall result in a dollar-for-dollar reduction in the appropriation for the Program for a subsequent fiscal year. The North Carolina Partnership for Children, Inc., shall be responsible for compiling information on the private cash and in-kind contributions into a report that is submitted to the Joint Legislative Commission on Governmental Operations in a format that allows verification by the Department of Revenue. The same match requirements shall apply to any expansion funds appropriated by the General Assembly.

SECTION #.(e) The Department of Health and Human Services shall continue to implement the performance-based evaluation system.

SECTION #.(f) The Department of Health and Human Services and the North Carolina Partnership for Children, Inc., shall ensure that the allocation of funds for Early Childhood Education and Development Initiatives for State fiscal years 2011-2012 and 2012-2013 shall be administered and distributed in the following manner:

(1) Capital expenditures are prohibited for fiscal years 2011-2012 and 2012-2013. For the purposes of this section, "capital expenditures" means expenditures for capital improvements as defined in G.S. 143C-1-1(d)(5).

(2) Expenditures of State funds for advertising and promotional activities are prohibited for fiscal years 2011-2012 and 2012-2013.

SECTION #.(g) A county may use the county's allocation of State and federal child care funds to subsidize child care according to the county's Early Childhood Education and Development Initiatives Plan as approved by the North Carolina Partnership for Children, Inc. The use of federal funds shall be consistent with the appropriate federal regulations. Child care providers shall, at a minimum, comply with the applicable requirements for State licensure pursuant to Article 7 of Chapter 110 of the General Statutes.

SECTION #.(h) For fiscal years 2011-2012 and 2012-2013, the local partnerships shall spend an amount for child care subsidies that provides at least fifty-two million dollars ($52,000,000) for the TANF maintenance of effort requirement and the Child Care Development Fund and Block Grant match requirement.

SECTION #.(i) For fiscal years 2011-2012 and 2012-2012, local partnerships shall not spend any State funds on marketing campaigns, advertising, or any associated materials. Local partnerships may spend any private funds the local partnerships receive on those activities.

SECTION #.(j) The North Carolina Partnership for Children, Inc. and its Board shall establish policies that focus the North Carolina Partnership for Children, Inc.'s mission on improving child care quality in North Carolina for children from birth to five years of age. The focus shall include assisting centers and homes with the implementation of curriculum required by the Child Care Commission and helping one- and two-star rated facilities improve quality. State funding for local partnerships shall be used for the purpose of helping to improve the quality of child care for children from birth to five years of age. State funds shall not be spent on other activities currently funded through local partnerships.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

ADMINISTRATIVE ALLOWANCE FOR COUNTY DEPARTMENTS OF SOCIAL SERVICES

SECTION #. The Division of Child Development of the Department of Health and Human Services shall fund the allowance that county departments of social services may use for administrative costs at four percent (4%) of the county's total child care subsidy funds allocated in the Child Care Development Fund Block Grant plan.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

CONSOLIDATE MORE AT FOUR PROGRAM INTO DIVISION OF CHILD DEVELOPMENT

SECTION #.(a) The Department of Public Instruction, Office of Early Learning, and Department of Health and Human Services are directed to consolidate the "More At Four" program into the Division of Child Development. The Division of Child Development is renamed the Division of Child Development and Early Education (DCDEE). The DCDEE is directed to maintain "More At Four" program's high programmatic standards. The Department of Health and Human Services shall assume the functions of the regulation and monitoring system and payment and reimbursement system for the "More At Four" program.

All regulation and monitoring functions shall begin July 1, 2011. The "More At Four" program shall be designated as "pre-kindergarten" on the five-star rating scale.

The Office of State Budget and Management shall transfer positions to the Department of Health and Human Services to assume the regulation, monitoring, and accounting functions within the Division of Child Development's Regulatory Services Section. This transfer shall have all the elements of a Type I transfer as defined in G.S. 143A-6. All funds transferred pursuant to this section shall be used for the funding of pre-kindergarten slots for four-year olds and the management of the program. The Department of Health and Human Services shall incorporate eight consultant positions into the regulation and accounting sections of Division of Child Development and Early Education, eliminate the remaining positions, and use position elimination savings for the purpose of funding pre-kindergarten students.

SECTION #.(b) The Childcare Commission shall adopt rules for programmatic standards for regulation of pre-kindergarten classrooms. The Commission shall review and approve a comprehensive, evidenced-based early childhood curricula with a reading component. These curricula shall be added to the currently approved "More At Four" curricula.

SECTION #.(c) G.S. 143B-168.4(a) reads as rewritten:

"(a) The Child Care Commission of the Department of Health and Human Services shall consist of ~~15~~ 17 members. Seven of the members shall be appointed by the Governor and ~~eight~~ 10 by the General Assembly, ~~four~~ five upon the recommendation of the President Pro Tempore of the Senate, and ~~four~~ five upon the recommendation of the Speaker of the House of Representatives. Four of the members appointed by the Governor, two by the General Assembly on the recommendation of the President Pro Tempore of the Senate, and two by the General Assembly on the recommendation of the Speaker of the House of Representatives, shall be members of the public who are not employed in, or providing, child care and who have no financial interest in a child care facility. Two of the foregoing public members appointed by the Governor, one of the foregoing public members recommended by the President Pro Tempore of the Senate, and one of the foregoing public members recommended by the Speaker of the House of Representatives shall be parents of children receiving child care services. Of the remaining two public members appointed by the Governor, one shall be a pediatrician currently licensed to practice in North Carolina. Three of the members appointed by the

Governor shall be child care providers, one of whom shall be affiliated with a for profit child care center, one of whom shall be affiliated with a for profit family child care home, and one of whom shall be affiliated with a nonprofit facility. Two of the members appointed by the General Assembly on the recommendation of the President Pro Tempore of the Senate, and two by the General Assembly on recommendation of the Speaker of the House of Representatives, shall be child care providers, one affiliated with a for profit child care facility, and one affiliated with a nonprofit child care facility. The General Assembly on the recommendation of the President Pro Tempore of the Senate, and the General Assembly on recommendation of the Speaker of the House of Representatives, shall appoint two early childhood education specialists. None may be employees of the State."

SECTION #.(d) The curricula approved and taught in pre-kindergarten classrooms shall also be taught in four- and five-star rated facilities in the non pre-kindergarten classrooms. The Child Care Commission shall increase standards in the four- and five-star rated facilities for the purpose of placing an emphasis on early reading. The Commission shall require the four- and five-star rated facilities to teach from the Commission's approved curricula. The Division of Child Development shall use funds from the Child Care Development Fund Block Grant to assist with the purchase of curricula.

SECTION #.(e) The Division of Child Development and Early Education shall adopt a policy to encourage all pre-kindergarten classrooms to blend private pay families with pre-kindergarten subsidized children in the same manner that regular subsidy children are blended with private pay children.

SECTION #.(f) The pre-kindergarten program may continue to serve at-risk children identified through existing "child find" methods in the same manner as the current at-risk children are served within the Division of Child of Development.

SECTION #.(g) The Division of Child Development and Early Education (DCDEE) shall adopt policies that improve the quality of childcare for subsidized children. The DCDEE shall phase-in a new policy in which child care subsidies will be paid, to the extent possible, for child care in the higher quality centers and homes only. The DCDEE shall define the higher quality and subsidy funds shall not be paid for one- or two-star rated facilities. For those counties with an inadequate number of four- and five-star rated facilities, the DCDEE shall establish a transition period that allows the facilities to continue to receive subsidy while the facilities work on the increased star ratings. The DCDEE shall allow for exemptions in non-star rated programs, such as religious programs or other currently allowed arrangements, and continue to pay for child care in these situations.

SECTION #.(h) The Division of Child Development and Early Education shall implement a parent copayment requirement for pre-kindergarten classrooms similar to what is required of parents subject to regular child care subsidy payments.

Fees for families who are required to share in the cost of care shall be established based on a percent of gross family income and adjusted for family size. Fees shall be determined as follows:

FAMILY SIZE	PERCENT OF GROSS FAMILY INCOME
1-3	10%
4-5	9%
6 or more	8%.

SECTION #.(i) All pre-kindergarten classrooms shall be required to participate in the Subsidized Early Education for Kids (SEEK) accounting system to streamline the payment function for these classrooms with a goal of eliminating duplicative systems and streamlining the accounting and payment processes among the subsidy reimbursement systems.

SECTION #.(j) Based on market analysis, the Division of Child Development and Early Education shall establish reimbursement rates based on newly increased requirements of

four- and five- star rated facilities and the higher teacher standards within the pre-kindergarten classrooms, specifically "More At Four" teacher standards, when establishing the rates of reimbursements. Additionally, the pre-kindergarten curriculum day shall cover the same number of hours as regular subsidy covers for 12 months throughout the year.

DRAFT
SPECIAL PROVISION

2011-DHHS-H10

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

MENTAL HEALTH CHANGES

SECTION #.(a) For the purpose of mitigating cash flow problems that many non-single-stream local management entities (LMEs) experience at the beginning of each fiscal year, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall adjust the timing and method by which allocations of service dollars are distributed to each non-single-stream LME. To this end, the allocations shall be adjusted such that at the beginning of the fiscal year the Department shall distribute not less than one-twelfth of the LME's continuation allocation and subtract the amount of the adjusted distribution from the LME's total reimbursements for the fiscal year.

SECTION #.(b) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of twenty-nine million one hundred twenty-one thousand six hundred forty-four dollars ($29,121,644) for the 2011-2012 fiscal year and the sum of twenty-nine million one hundred twenty-one thousand six hundred forty-four dollars ($29,121,644) for the 2012-2013 fiscal year shall be allocated for the purchase of local inpatient psychiatric beds or bed days. These beds or bed days shall be distributed across the State in LME catchment areas and according to need as determined by the Department. The Department shall enter into contracts with the LMEs and community hospitals for the management of these beds or bed days. The Department shall work to ensure that these contracts are awarded equitably around all regions of the State. Local inpatient psychiatric beds or bed days shall be managed and controlled by the LME, including the determination of which local or State hospital the individual should be admitted to pursuant to an involuntary commitment order. Funds shall not be allocated to LMEs but shall be held in a statewide reserve at the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to pay for services authorized by the LMEs and billed by the hospitals through the LMEs. LMEs shall remit claims for payment to the Division within 15 working days of receipt of a clean claim from the hospital and shall pay the hospital within 30 working days of receipt of payment from the Division. If the Department determines (i) that an LME is not effectively managing the beds or bed days for which it has responsibility, as evidenced by beds or bed days in the local hospital not being utilized while demand for services at the State psychiatric hospitals has not reduced, or (ii) the LME has failed to comply with the prompt payment provisions of this subsection, the Department may contract with another LME to manage the beds or bed days, or, notwithstanding any other provision of law to the contrary, may pay the hospital directly. The Department shall develop reporting requirements for LMEs regarding the utilization of the beds or bed days. Funds appropriated in this section for the purchase of local inpatient psychiatric beds or bed days shall be used to purchase additional beds or bed days not currently funded by or through LMEs and shall not be used to supplant other funds available or otherwise appropriated for the purchase of psychiatric inpatient services under contract with community

hospitals, including beds or bed days being purchased through Hospital Utilization Pilot funds appropriated in S.L. 2007-323. Not later than March 1, 2011, the Department shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on a uniform system for beds or bed days purchased (i) with local funds, (ii) from existing State appropriations, (iii) under the Hospital Utilization Pilot, and (iv) purchased using funds appropriated under this subsection.

SECTION #.(c) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for mobile crisis teams, the sum of five million seven hundred thousand dollars ($5,700,000) shall be distributed to LMEs to support 30 mobile crisis teams. The new mobile crisis units shall be distributed over the State according to need as determined by the Department.

SECTION #.(d) The Department of Health and Human Services may create a midyear process by which it can reallocate State service dollars away from LMEs that do not appear to be on track to spend the LMEs' full appropriation and toward LMEs that appear able to spend the additional funds.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H12**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

MH/DD/SAS HEALTHCARE INFORMATION SYSTEM PROJECT

SECTION #. Of the funds appropriated to the Department of Health and Human Services for the 2011-2013 fiscal biennium, the Department may use a portion of these funds to continue to develop and implement a health care information system for State institutions operated by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. G.S. 143C-6-5 does not apply to this section.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

LME FUNDS FOR SUBSTANCE ABUSE SERVICES

SECTION #.(a) Consistent with G.S. 122C-2, the General Assembly strongly encourages Local Management Entities (LMEs) to use a portion of the funds appropriated for substance abuse treatment services to support prevention and education activities.

SECTION #.(b) An LME may use up to one percent (1%) of funds allocated to it for substance abuse treatment services to provide nominal incentives for consumers who achieve specified treatment benchmarks, in accordance with the federal substance abuse and mental health services administration best practice model entitled Contingency Management.

SECTION #.(c) In providing treatment and services for adult offenders and increasing the number of Treatment Accountability for Safer Communities (TASC) case managers, local management entities shall consult with TASC to improve offender access to substance abuse treatment and match evidence-based interventions to individual needs at each stage of substance abuse treatment. Special emphasis should be placed on intermediate punishment offenders, community punishment offenders at risk for revocation, and Department of Correction (DOC) releasees who have completed substance abuse treatment while in custody.

In addition to the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to provide substance abuse services for adult offenders and to increase the number of TASC case managers, the Department shall allocate up to three hundred thousand dollars ($300,000) to TASC. These funds shall be allocated to TASC before funds are allocated to LMEs for mental health services, substance abuse services, and crisis services.

SECTION #.(d) In providing drug treatment court services, LMEs shall consult with the local drug treatment court team and shall select a treatment provider that meets all provider qualification requirements and the drug treatment court's needs. A single treatment provider may be chosen for non-Medicaid-eligible participants only. A single provider may be chosen who can work with all of the non-Medicaid-eligible drug treatment court participants in a single group. During the 52-week drug treatment court program, participants shall receive an array of treatment and aftercare services that meets the participant's level of need, including step-down services that support continued recovery.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

MHDDSAS COMMUNITY SERVICE FUNDS

SECTION #. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (as used in this section "The Division") is directed to reduce the Community Service Fund by twenty million dollars ($20,000,000).

SECTION #. The Division shall prohibit Local Management Entities (LME) from using Community Service funds for Medicaid recipients' services, except for residential support services. The Division is directed, through consultation with LME representatives, to develop a set of standardized covered benefits for recipients of LME Service Funds and shall become the only services paid for by community service funds through LMEs. These services shall be nationally recognized best practices for developmental disabilities, mental illness, and substance abuse.

SECTION #. Effective January 1, 2012, the Division shall implement a copayment for all mental health, developmental disabilities, and substance abuse services based upon the Medicaid copayment rates.

SECTION #. The Division is directed to reduce the Community Service Fund by twenty-five million dollars ($25,000,000) for the 2011-2012 fiscal year based on available fund balance reported by the LMEs' 2010 fiscal audit. The Division is directed to allocate the reduction among LME's based on unreserved, undesignated fund balance totals, as of June 30, 2010. The LMEs are required to backfill the reduction with fund balance availability and not further reduce services beyond the amount identified in subsection #.1 of this section.

SECTION #. LME's are directed to spend their unreserved, undesignated fund balance on services, commensurate with the reduction directed by the Division. Quarterly reports shall be submitted to the Division by LME's to ensure expenditures from fund balance occurs at the level required by this law. Additionally, the Division shall review the designation of reserved or designated fund balance accounts to determine whether accounts may be moved to unreserved, undesignated, in essence increasing the unreserved, undesignated fund balance available for purchase of services. If categories of funds are moved into the unreserved/undesignated categories, the affected LMEs are required to spend these funds to minimize their share of the twenty million dollar ($20,000,000) in reductions to services as required in subsection #.1 of this section.

SECTION #. The Department of Health and Human Services shall report to the House and Senate Appropriations subcommittees by Dec. 12, 2011 on the status of implementing this section.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

CONSOLIDATION OF FORENSIC HEALTH CARE AT DOROTHEA DIX COMPLEX

SECTION #. The Department of Health and Human Services, Division of State Operated Facilities, shall issue a Request for Proposal for the consolidation of forensic hospital care. The operation shall initially be located at the Dorothea Dix complex. The Secretary of Health and Human Services is authorized to proceed with contracting with a private entity if the Secretary can justify savings through the contract. The Secretary shall compare the Department's total cost to provide forensic care to proposals received and determine whether it is cost-effective to contract for this service. The Secretary may only proceed if the Secretary estimates the Department will save money.

The Secretary shall report to the Joint Appropriations Subcommittee for Health and Human Services (or other interim oversight committees) by October 30, 2011 with cost detail and savings identified from the proposals.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION

2011-DHHS-H53

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

DHHS POSITION ELIMINATIONS

SECTION #. The Secretary of the Department of Health and Human Services is directed to eliminate 250 full-time equivalent positions, but may eliminate fewer positions as long as the number of positions eliminated results in a savings of six million five hundred thousand dollars ($6,500,000) in State funds. By September 30, 2011, the Secretary shall submit a report to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on the positions eliminated pursuant to this section. The report shall include the total number of positions eliminated, savings generated by each eliminated position, and the impact on any federal funds previously received for the eliminated positions.

DRAFT
SPECIAL PROVISION

2011-DHHS-H55

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

STUDY DHHS REGULATORY FUNCTIONS

SECTION #.(a) The Department of Health and Human Services shall examine all regulatory functions performed by each of the divisions within the Department. By January 30, 2012, the Department shall make a report of its findings to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division. The report shall include all of the following:

(1) A summary of each division's regulatory functions.

(2) The purpose of each of the identified regulatory functions.

(3) The amount of any fee charged for the identified regulatory functions, along with the date and amount of the most recent fee increase.

(4) The number of full-time equivalent positions dedicated to the identified regulatory functions, broken down by division.

(5) Whether there is a federal requirement for, or a federal component to, any of the identified regulatory functions.

(6) Identification of overlap among the divisions within the Department, and with other State agencies, with respect to the regulation of providers. For each area of overlap, the report shall specify all of the following:

a. The name of each division and State agency that performs the regulatory function.

b. How often each division or State agency performs the regulatory function.

c. The total amount of funds expended by each division or State agency to perform the regulatory function.

SECTION #.(b) The Department of Health and Human Services shall develop a plan to consolidate regulatory functions performed by the various divisions within the Department. The plan shall identify proposed position eliminations and anticipated savings as a result of the consolidation. The Department shall not implement the plan or consolidate any of its regulatory functions except as directed by an act of the General Assembly.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H28**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

REDUCE FUNDING FOR NONPROFIT ORGANIZATIONS

SECTION #. For fiscal years 2011-2012 and 2012-2013, the Department of Health and Human Services shall reduce the amount of funds allocated to nonprofit organizations by five million dollars ($5,000,000) on a recurring basis. In achieving the reductions required by this section, the Department (i) shall minimize reductions to funds allocated to nonprofit organizations for the provision of direct services and (ii) shall not reduce funds allocated to nonprofit organizations to pay for direct services to individuals with developmental disabilities.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H32**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

PROHIBIT USE OF ALL FUNDS FOR PLANNED PARENTHOOD ORGANIZATIONS

SECTION #. For fiscal years 2011-2012 and 2012-2013, the Department of Health and Human Services may not provide State funds or other funds administered by the Department for contracts or grants to Planned Parenthood, Inc. and affiliated organizations.

DRAFT
SPECIAL PROVISION

2011-DHHS-H34

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

CHANGES TO COMMUNITY-FOCUSED ELIMINATING HEALTH DISPARITIES INITIATIVE

SECTION #.(a) Funds appropriated in this act from the General Fund to the Department of Health and Human Services for the Community-Focused Eliminating Health Disparities Initiative (CFEHDI) shall be used to provide grants-in-aid to local public health departments to close the gap in the health status of African-Americans, Hispanics/Latinos, and American Indians as compared to the health status of white persons. These grants shall focus on the use of preventive measures to eliminate or reduce health disparities in infant mortality, heart disease, cardiovascular disease, asthma, cancer, diabetes, and other conditions that disproportionately affect minority populations in this State.

SECTION #.(b) In applying for the grants-in-aid available under subsection (a) of this section, local public health departments shall demonstrate the substantial involvement and role American Indian tribes, faith-based organizations, and community-based organizations will play in fulfilling the goals and activities of the grant.

SECTION #.(c) In implementing the grant-in-aid program authorized by subsection (a) of this section, the Department of Health and Human Services may consider the feasibility of a three-year grant period. If approved, the grantee shall be required at the end of the three-year grant period to demonstrate significant gains in addressing one or more of the health disparity focus areas identified in subsection (a) of this section.

SECTION #(d). Funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, for the CFEHDI shall be awarded as a grant-in-aid to honor the memory of the following recently deceased members of the General Assembly: Bernard Allen, John Hall, Robert Holloman, Howard Hunter, Jeanne Lucas, Vernon Malone, William Martin, and Pete Cunningham. These funds shall be used for concerted efforts to address large gaps in health status among North Carolinians who are African-American, as well as disparities among other minority populations in North Carolina.

SECTION #.(e) By October 1, 2012, and annually thereafter, the Department of Health and Human Services shall submit a report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on funds appropriated to the CFEHDI. The report shall include specific activities undertaken pursuant to subsection (a) of this section to address large gaps in health status among North Carolinians who are African-American and other minority populations in this State, and shall also address all of the following:

(1) Which local health departments received CFEHDI grants.
(2) The amount of funding awarded to each local health department grantee.
(3) Which of the minority populations were served by local health department grantees.

(4) Which American Indian tribes, faith-based organizations, or community-based organizations were involved in fulfilling the goals and activities of each grant awarded to a local health department.

(5) How the activities implemented by the local health departments fulfilled the goal of reducing health disparities among minority populations, and the specific success in reducing particular incidences.

DRAFT
SPECIAL PROVISION **2011-DHHS-H38**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

FUNDS FOR SCHOOL NURSES

SECTION #.(a) All funds appropriated for the School Nurse Funding Initiative shall be used to supplement and not supplant other State, local, or federal funds appropriated or allocated for this purpose. Communities shall maintain their current level of effort and funding for school nurses. These funds shall not be used to fund nurses for State agencies. These funds shall be distributed to local health departments according to a formula that includes all of the following:

(1) School nurse to student ratio.
(2) Percentage of students eligible for free or reduced meals.
(3) Percentage of children in poverty.
(4) Per capita income.
(5) Eligibility as a low wealth county.
(6) Mortality rates for children between 1 and 19 years of age.
(7) Percentage of students with chronic illnesses.
(8) Percentage of county population consisting of minority persons.

SECTION #.(b) The Division of Public Health shall ensure that school nurses funded with State funds (i) do not assist in any instructional or administrative duties associated with a school's curriculum and (ii) perform all of the following with respect to school health programs:

(1) Serve as the coordinator of the health services program and provide nursing care.
(2) Provide health education to students, staff, and parents.
(3) Identify health and safety concerns in the school environment and promote a nurturing school environment.
(4) Support health food services programs.
(5) Promote healthy physical education, sports policies, and practices.
(6) Provide health counseling, assess mental health needs, provide interventions, and refer students to appropriate school staff or community agencies.
(7) Promote community involvement in assuring a healthy school, and serve as school liaison to a health advisory committee.
(8) Provide health education and counseling, and promote healthy activities and a healthy environment for school staff.
(9) Be available to assist the county health department during a public health emergency.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H27**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

REPLACEMENT OF RECEIPTS FOR CHILD DEVELOPMENT SERVICE AGENCIES.

SECTION #. Receipts earned by the Child Development Service Agencies (CDSAs) from any public or private third-party payer shall be budgeted on a recurring basis to replace reductions in State appropriations to CDSAs.

DRAFT
SPECIAL PROVISION

2011-DHHS-H3

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

HEALTH INFORMATION TECHNOLOGY

SECTION #.(a) The Department of Health and Human Services, in cooperation with the State Chief Information Officer, shall coordinate health information technology (HIT) policies and programs within the State of North Carolina. The Department's goal in coordinating State HIT policy and programs shall be to avoid duplication of efforts and to ensure that each State agency, public entity, and private entity that undertakes health information technology activities does so within the area of its greatest expertise and technical capability and in a manner that supports coordinated State and national goals, which shall include at least all of the following:

(1) Ensuring that patient health information is secure and protected, in accordance with applicable law.

(2) Improving health care quality, reducing medical errors, reducing health disparities, and advancing the delivery of patient-centered medical care.

(3) Providing appropriate information to guide medical decisions at the time and place of care.

(4) Ensuring meaningful public input into HIT infrastructure development.

(5) Improving the coordination of information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information.

(6) Improving public health services and facilitating early identification and rapid response to public health threats and emergencies, including bioterrorist events and infectious disease outbreaks.

(7) Facilitating health and clinical research.

(8) Promoting early detection, prevention, and management of chronic diseases.

SECTION #.(b) The Department of Health and Human Services shall establish and direct a HIT management structure that is efficient and transparent and that is compatible with the Office of the National Health Coordinator for Information Technology (National Coordinator) governance mechanism. The HIT management structure shall be responsible for all of the following:

(1) Developing a State plan for implementing and ensuring compliance with national HIT standards and for the most efficient, effective, and widespread adoption of HIT.

(2) Ensuring that (i) specific populations are effectively integrated into the State plan, including aging populations, populations requiring mental health services, and populations utilizing the public health system; and (ii) unserved and underserved populations receive priority consideration for HIT support.

(3) Identifying all HIT stakeholders and soliciting feedback and participation from each stakeholder in the development of the State plan.

(4) Ensuring that existing HIT capabilities are considered and incorporated into the State plan.

(5) Identifying and eliminating conflicting HIT efforts where necessary.

(6) Identifying available resources for the implementation, operation, and maintenance of health information technology, including identifying resources and available opportunities for North Carolina institutions of higher education.

(7) Ensuring that potential State plan participants are aware of HIT policies and programs and the opportunity for improved health information technology.

(8) Monitoring HIT efforts and initiatives in other States and replicating successful efforts and initiatives in North Carolina.

(9) Monitoring the development of the National Coordinator's strategic plan and ensuring that all stakeholders are aware of and in compliance with its requirements.

(10) Monitoring the progress and recommendations of the HIT Policy and Standards Committees and ensuring that all stakeholders remain informed of the Committee's recommendations.

(11) Monitoring all studies and reports provided to the United States Congress and reporting to the Joint Legislative Oversight Committee on Information Technology and the Fiscal Research Division on the impact of report recommendations on State efforts to implement coordinated HIT.

SECTION #.(c) Beginning October 1, 2011, the Department of Health and Human Services shall provide quarterly written reports on the status of HIT efforts to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division. The report shall include the following:

(1) Current status of federal HIT initiatives.

(2) Current status of State HIT efforts and initiatives among both public and private entities.

(3) A breakdown of current public and private funding sources and dollar amounts for State HIT initiatives.

(4) Department efforts to coordinate HIT initiatives within the State and any obstacles or impediments to coordination.

(5) HIT research efforts being conducted within the State and sources of funding for research efforts.

(6) Opportunities for stakeholders to participate in HIT funding and other efforts and initiatives during the next quarter.

(7) Issues associated with the implementation of HIT in North Carolina and recommended solutions to these issues.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

FUNDS FOR STROKE PREVENTION

SECTION #.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, the sum of four hundred thousand dollars ($400,000) in nonrecurring funds for the 2011-2012 fiscal year and the sum of four hundred thousand dollars ($400,000) in nonrecurring funds for the 2012-2013 fiscal year is allocated to the Heart Disease and Stroke Prevention Branch for continuation of community education campaigns and communication strategies, in partnership with the American Heart Association/American Stroke Association, on stroke signs and symptoms and the importance of immediate response.

SECTION #.(b) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, the sum of fifty thousand dollars ($50,000) in nonrecurring funds for the 2011-2012 fiscal year and the sum of fifty thousand dollars ($50,000) in nonrecurring funds for the 2012-2013 fiscal year is allocated for continued operations of the Stroke Advisory Council.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

PERMIT FEES FOR FOOD AND LODGING ESTABLISHMENTS

SECTION #. Subsection (d) of G.S. 130A-248 reads as rewritten:

"(d) The Department shall charge each establishment subject to this section, except nutrition programs for the elderly administered by the Division of Aging and Adult Services of the Department of Health and Human Services, establishments that prepare and sell meat food products or poultry products, and public school cafeterias, a fee of ~~seventy-five dollars ($75.00) for each permit issued. This fee shall be reassessed annually for permits that do not expire.~~two hundred fifty dollars ($250.00) for each non-expiring permit issued and a reduced fee of fifty dollars ($50.00) for each temporary permit issued. The Department shall reassess the fee for non-expiring permits annually. The Commission shall adopt rules to implement this subsection. Fees collected under this subsection shall be used for State and local food, lodging, and institution sanitation programs and activities. No more than ~~thirty-three and one-third percent (33 1/3%)~~eleven percent (11%) of the fees collected under this subsection may be used to support State health programs and activities."

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

NC HEALTH CHOICE MEDICAL POLICY

SECTION #. Unless required for compliance with federal law, the Department shall not change medical policy affecting the amount, sufficiency, duration, and scope of NC Health Choice health care services and who may provide services until the Division of Medical Assistance has prepared a five-year fiscal analysis documenting the increased cost of the proposed change in medical policy and submitted it for Departmental review. If the fiscal impact indicated by the fiscal analysis for any proposed medical policy change exceeds one million dollars ($1,000,000) in total requirements for a given fiscal year, then the Department shall submit the proposed medical policy change with the fiscal analysis to the Office of State Budget and Management and the Fiscal Research Division. The Department shall not implement any proposed medical policy change exceeding one million dollars ($1,000,000) in total requirements for a given fiscal year unless the source of State funding is identified and approved by the Office of State Budget and Management. For medical policy changes exceeding one million dollars ($1,000,000) in total requirements for a given fiscal year that are required for compliance with federal law, the Department shall submit the proposed medical policy or policy interpretation change with a five-year fiscal analysis to the Office of State Budget and Management prior to implementing the change. The Department shall provide the Office of State Budget and Management and the Fiscal Research Division a quarterly report itemizing all medical policy changes with total requirements of less than one million dollars ($1,000,000).

DRAFT
SPECIAL PROVISION

2011-DHHS-H42

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

COMMUNITY CARE OF NORTH CAROLINA

SECTION #. The Department of Health and Human Services (Department) shall submit a report annually from a qualified entity with proven experience in conducting actuarial and health care studies on the Medicaid cost-savings achieved by the CCNC networks, which shall include children, adults, and the aged, blind, and disabled, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION #.(b) The Department and the Division of Medical Assistance (DMA) shall enter into a three-party contract between North Carolina Community Care Networks, Inc., (NCCCN, Inc.) and each of the 14 participating local CCNC networks and shall require NCCCN, Inc., to provide standardized clinical and budgetary coordination, oversight, and reporting for a statewide Enhanced Primary Care Case Management System for Medicaid enrollees. The contracts shall require NCCCN, Inc., to build upon and expand the existing successful CCNC primary care case management model to include comprehensive statewide quantitative performance goals and deliverables which shall include all of the following areas: (i) service utilization management, (ii) budget analytics, (iii) budget forecasting methodologies, (iv) quality of care analytics, (v) participant access measures, and (vi) predictable cost containment methodologies.

SECTION #.(c) NCCCN, Inc., shall report quarterly to the Department and to the Office of State Budget and Management (OSBM) on the development of the statewide Enhanced Primary Care Case Management System and its defined goals and deliverables as agreed upon in the contract. NCCCN, Inc., shall submit biannual reports to the Secretary of Health and Human Services, OSBM, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on the progress and results of implementing the quantitative, analytical, utilization, quality, cost containment, and access goals and deliverables set out in the contract. NCCCN, Inc., shall conduct its own analysis of the CCNC system to identify any variations from the development plan for the Enhanced Primary Care Case Management System and its defined goals and deliverables set out in the contract between DMA and NCCCN, Inc. Upon identifying any variations, NCCCN, Inc., shall develop and implement a plan to address the variations. NCCCN, Inc., shall report the plan to DMA within 30 days after taking any action to implement the plan.

SECTION #.(d) By January 1, 2012, the Department and OSBM shall assess the performance of NCCCN, Inc., and CCNC regarding the goals and deliverables established in the contract. Based on this assessment, the Department and DMA shall expand, cancel, or alter the contract with NCCCN, Inc., and CCNC effective April 1, 2012. Expansion or alteration of the contract may reflect refinements based on clearly identified goals and deliverables in the areas of quality of care, participant access, cost containment, and service delivery.

SECTION #.(e) By July 1, 2012, the Department, DMA, and NCCCN, Inc., shall finalize a comprehensive plan that establishes management methodologies which include all of the following: (i) quality of care measures, (ii) utilization measures, (iii) recipient access measures, (iv) performance incentive models in which past experience indicates a benefit from financial incentives, (v) accountable budget models, (vi) shared savings budget models, and (vii) budget forecasting analytics as agreed upon by the Department, DMA, and NCCCN, Inc. In the development of these methodologies, the Department, DMA, and NCCCN, Inc., shall consider options for shared risk. The Department and DMA shall provide assistance to NCCCN, Inc., in meeting the objectives of this section.

DRAFT
SPECIAL PROVISION

2011-DHHS-H43

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) FUNDS/IMPLEMENTATION OF MMIS

SECTION #.(a) The Secretary of the Department of Health and Human Services may utilize prior year earned revenue received for the new Medicaid Management Information System (MMIS) in the amount of three million two hundred thirty-two thousand three hundred four dollars ($3,232,304) in fiscal year 2011-2012 and twelve million dollars ($12,000,000) in fiscal year 2012-2013. The Department shall utilize prior year earned revenues received for the procurement, design, development, and implementation of the new MMIS. In the event that the Department does not receive prior year earned revenues in the amounts authorized by this section, the Department is authorized, with approval of the Office of State Budget and Management, to utilize other overrealized receipts and funds appropriated to the Department to achieve the level of funding specified in this section for the MMIS.

SECTION #.(b) The Department shall make full development of the replacement MMIS a top priority. During the development and implementation of MMIS, the Department shall develop plans to ensure the timely and effective implementation of enhancements to the system to provide the following capabilities:

(1) Receiving and tracking premiums or other payments required by law.

(2) Compatibility with the administration of the Health Information System.

The Department shall make every effort to expedite the implementation of the enhancements. The Office of Information Technology Services shall work in cooperation with the Department to ensure the timely and effective implementation of the MMIS and enhancements. The contract between the Department and the contract vendor shall contain an explicit provision requiring that the MMIS have the capability to fully implement the administration of NC Health Choice, NC Kids' Care, Ticket to Work, Families Pay Part of the Cost of Services under the CAP-MR/DD, CAP Children's Program, and all relevant Medicaid waivers and the Medicare 646 waiver as it applies to Medicaid eligibles. The Department must have detailed cost information for each requirement before signing the contract. Any contract between the Department and a vendor for the MMIS that does not contain the explicit provision required under this subsection is void on its face. Notwithstanding any other provision of law to the contrary, the Secretary of the Department does not have the authority to sign a contract for the MMIS if the contract does not contain the explicit provision required under this section.

SECTION #.(c) Notwithstanding G.S. 114-2.3, the Department shall engage the services of private counsel with the pertinent information technology and computer law expertise to review requests for proposals and to negotiate and review contracts associated with MMIS. The counsel engaged by the Department shall review the MMIS contracts and change requests between the Department and the vendor to ensure that the requirements of subsection (b) of this section are met in their entirety.

SECTION #.(d) The Department shall develop a revised comprehensive schedule for the development and implementation of the MMIS that fully incorporates federal and State

project management and review requirements. The Department shall ensure that the schedule is as accurate as possible. Any changes to the design, development, and implementation schedule shall be reported as part of the Department's quarterly MMIS reporting requirements. The Department shall submit the schedule to the Chairs of the House of Representatives Committee on Appropriations and the House of Representatives Subcommittee on Health and Human Services, the Chairs of the Senate Committee on Appropriations and the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division. This submission shall include a detailed explanation of schedule changes that have occurred since the initiation of the project. Any change to key milestones in either schedule shall be immediately reported to the Chairs of the House of Representatives Committee on Appropriations and the House of Representatives Subcommittee on Health and Human Services, the Chairs of the Senate Committee on Appropriations and the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, and the Fiscal Research Division with a full explanation of the reason for the change.

SECTION #.(e) Beginning July 1, 2011, the Department shall make quarterly reports on changes in the functionality and projected costs of the MMIS. This report shall include any changes to MMIS vendor contracts and shall provide a detailed explanation for any cost increases. Each report shall be made to the Chairs of the House of Representatives Committee on Appropriations and the House of Representatives Subcommittee on Health and Human Services, the Chairs of the Senate Committee on Appropriations and the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division. A copy of the final report on the contract award also shall be submitted to the Joint Legislative Commission on Governmental Operations.

SECTION #.(f) Upon initiation of the NC MMIS Program Reporting and Analytics Project and the Division of Health Services Regulation Project, the Department shall submit all reports regarding functionality, schedule, and cost in the next regular cycle of reporting identified in subsections (d) and (e) of this section. The Department shall ensure that the solution developed in the Reporting and Analytics Project supports the capability, in its initial implementation, to interface with the North Carolina Teachers' and State Employees' Health Plan. The costs for this capability shall be negotiated prior to the award of the Reporting and Analytics Project contract. The Reporting and Analytics Project solution must be completed simultaneously with the replacement MMIS.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

NORTH CAROLINA FAMILIES ACCESSING SERVICES THROUGH TECHNOLOGY (NC FAST) FUNDS

SECTION 10.27. Of the funds appropriated in this act to the Department of Health and Human Services (Department), the nonrecurring sum of nine million five hundred ninety-two thousand three hundred thirty-two dollars ($9,592,332) for fiscal year 2011-2012 and the nonrecurring sum of nine million five hundred ninety-two thousand three hundred thirty-two dollars ($9,592,332) for fiscal year 2012-2013 shall be used to support the NC FAST project. These funds shall be (i) deposited to the Department's information technology budget code and (ii) used to match federal funds for the project. In addition, the Department shall utilize prior year earned revenues received in the amount of eight million seven hundred sixty-seven thousand six hundred ninety-six dollars ($8,767,696) in fiscal year 2011-2012 for the NC FAST project. Funds appropriated to the Department by this act shall be used to expedite the development and implementation of the Global Case Management and Food and Nutrition Services and the Eligibility Information System (EIS) components of the North Carolina Families Accessing Services through Technology (NC FAST) project. In the event that the Department does not receive prior year earned revenues in the amount authorized by this section, the Department is authorized, with approval of the Office of State Budget and Management, to utilize other overrealized receipts and funds appropriated to the Department to achieve the level of funding specified in this section for the NC FAST project. The Department shall not obligate any of its overrealized receipts or funds for this purpose without (i) prior written approval from the United States Department of Agriculture Food and Nutrition Service, the United States Department of Health and Human Services Administration for Children and Families, the Centers for Medicare and Medicaid Services, and any other federal partner responsible for approving changes to the annual Advance Planning Document update (APDu) for the NC FAST Program and (ii) prior review and approval from the Office of Information Technology Services (ITS) and the Office of State Budget and Management (OSBM). The Department shall report any changes to the NC FAST Program to the Joint Legislative Oversight Committee on Information Technology, the Joint Legislative Commission on Governmental Operations, the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division not later than 30 days after receiving all the approvals required by this section.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

MEDICAID

SECTION #.(a) Use of Funds, Allocation of Costs, Other Authorizations. –

(1) Use of funds. – Funds appropriated in this act for services provided in accordance with Title XIX of the Social Security Act (Medicaid) are for both the categorically needy and the medically needy.

(2) Allocation of nonfederal cost of Medicaid. – The State shall pay one hundred percent (100%) of the nonfederal costs of all applicable services listed in this section. In addition, the State shall pay one hundred percent (100%) of the federal Medicare Part D clawback payments under the Medicare Modernization Act of 2004.

(3) Use of funds for development and acquisition of equipment and software. – If first approved by the Office of State Budget and Management, the Division of Medical Assistance, Department of Health and Human Services, may use funds that are identified to support the cost of development and acquisition of equipment and software and related operational costs through contractual means to improve and enhance information systems that provide management information and claims processing. The Department of Health and Human Services shall identify adequate funds to support the implementation and first year's operational costs that exceed funds allocated for the new contract for the fiscal agent for the Medicaid Management Information System.

(4) Reports. – Unless otherwise provided, whenever the Department of Health and Human Services is required by this section to report to the General Assembly, the report shall be submitted to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division of the Legislative Services Office. Reports shall be submitted on the date provided in the reporting requirement.

SECTION #.(b) Policy.

(1) Volume purchase plans and single source procurement. – The Department of Health and Human Services, Division of Medical Assistance, may, subject to the approval of a change in the State Medicaid Plan, contract for services, medical equipment, supplies, and appliances by implementation of volume purchase plans, single source procurement, or other contracting processes in order to improve cost containment.

(2) Cost containment programs. – The Department of Health and Human Services, Division of Medical Assistance, may undertake cost containment programs, including contracting for services, preadmissions to hospitals, and

prior approval for certain outpatient surgeries before they may be performed in an inpatient setting.

(3) Fraud and abuse. – The Division of Medical Assistance, Department of Health and Human Services, shall provide incentives to counties that successfully recover fraudulently spent Medicaid funds by sharing State savings with counties responsible for the recovery of the fraudulently spent funds.

(4) Medical policy. – Unless required for compliance with federal law, the Department shall not change medical policy affecting the amount, sufficiency, duration, and scope of health care services and who may provide services until the Division of Medical Assistance has prepared a five-year fiscal analysis documenting the increased cost of the proposed change in medical policy and submitted it for Departmental review. If the fiscal impact indicated by the fiscal analysis for any proposed medical policy change exceeds three million dollars ($3,000,000) in total requirements for a given fiscal year, then the Department shall submit the proposed medical policy change with the fiscal analysis to the Office of State Budget and Management and the Fiscal Research Division. The Department shall not implement any proposed medical policy change exceeding three million dollars ($3,000,000) in total requirements for a given fiscal year unless the source of State funding is identified and approved by the Office of State Budget and Management. For medical policy changes exceeding three million dollars ($3,000,000) in total requirements for a given fiscal year that are required for compliance with federal law, the Department shall submit the proposed medical policy or policy interpretation change with the five-year fiscal analysis to the Office of State Budget and Management prior to implementing the change. The Department shall provide the Office of State Budget and Management and the Fiscal Research Division a quarterly report itemizing all medical policy changes with total requirements of less than three million dollars ($3,000,000).

(5) Posting of notices of changes on department web site. – For any public notice of change required pursuant to the provisions of 42 C.F.R. § 447.205, the Department shall, no later than five days after the date of publication, publish the same notice on its web site on the same web page as it publishes State Plan amendments, and the notice shall remain on the web site continuously for 90 days.

(6) Electronic transactions. – Medicaid providers shall follow the Department's established procedures for securing electronic payments and the Department shall not provide routine provider payments by check. Medicaid providers shall file claims electronically, except that Nonelectronic claims submission may be required when it is in the best interest of the Department. Medicaid providers shall submit Preadmission Screening and Annual Resident Reviews (PASARR) through the Department's Web-based tool or thorugh a vendor with interface capability to submit data into the Web-based PASARR.

SECTION #.(c) Eligibility. – Eligibility for Medicaid shall be determined in accordance with the following:

(1) Medicaid and Work First Family Assistance. –

a. Income eligibility standards. – The maximum net family annual income eligibility standards for Medicaid and Work First Family

Assistance and the Standard of Need for Work First Family Assistance shall be as follows:

	CATEGORICALLY NEEDY – WFFA*		MEDICALLY NEEDY
Family Size	Standard of Need & Families and Children Income Level	WFFA* Payment Level	Children & AA, AB, AD* Income Level
1	$4,344	$2,172	$2,900
2	5,664	2,832	3,800
3	6,528	3,264	4,400
4	7,128	3,564	4,800
5	7,776	3,888	5,200
6	8,376	4,188	5,600
7	8,952	4,476	6,000
8	9,256	4,680	6,300

*Work First Family Assistance (WFFA); Aid to the Aged (AA); Aid to the Blind (AB); and Aid to the Disabled (AD).

b. The payment level for Work First Family Assistance shall be fifty percent (50%) of the standard of need. These standards may be changed with the approval of the Director of the Budget.

c. The Department of Health and Human Services shall provide Medicaid coverage to 19- and 20-year-olds in accordance with federal rules and regulations.

d. Medicaid enrollment of categorically needy families with children shall be continuous for one year without regard to changes in income or assets.

(2) For the following Medicaid eligibility classifications for which the federal poverty guidelines are used as income limits for eligibility determinations, the income limits will be updated each April 1 immediately following publication of federal poverty guidelines. The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to the following:

a. All elderly, blind, and disabled people who have incomes equal to or less than one hundred percent (100%) of the federal poverty guidelines.

b. Pregnant women with incomes equal to or less than one hundred eighty-five percent (185%) of the federal poverty guidelines and without regard to resources. Services to pregnant women eligible under this subsection continue throughout the pregnancy but include only those related to pregnancy and to those other conditions determined by the Department as conditions that may complicate pregnancy.

c. Infants under the age of one with family incomes equal to or less than two hundred percent (200%) of the federal poverty guidelines and without regard to resources.

d. Children aged one through five with family incomes equal to or less than two hundred percent (200%) of the federal poverty guidelines and without regard to resources.

e. Children aged six through 18 with family incomes equal to or less than one hundred percent (100%) of the federal poverty guidelines and without regard to resources.

f. Family planning services to men and women of childbearing age with family incomes equal to or less than one hundred eighty-five percent (185%) of the federal poverty guidelines and without regard to resources.

g. Workers with disabilities described in G.S. 108A-54.1 with unearned income equal to or less than one hundred fifty percent (150%) of the federal poverty guidelines.

(3) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to adoptive children with special or rehabilitative needs regardless of the adoptive family's income.

(4) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to "independent foster care adolescents," ages 18, 19, and 20, as defined in section 1905(w)(1) of the Social Security Act [42 U.S.C. § 1396d(w)(1)], without regard to the adolescent's assets, resources, or income levels.

(5) ICF and ICF/MR work incentive allowances. – The Department of Health and Human Services may provide an incentive allowance to Medicaid-eligible recipients of ICF and ICF/MR services, who are regularly engaged in work activities as part of their developmental plan, and for whom retention of additional income contributes to their achievement of independence. The State funds required to match the federal funds that are required by these allowances shall be provided from savings within the Medicaid budget or from other unbudgeted funds available to the Department. The incentive allowances may be as follows:

Monthly Net Wages	**Monthly Incentive Allowance**
$1.00 to $100.99	Up to $50.00
$101.00 to $200.99	$80.00
$201.00 to $300.99	$130.00
$301.00 and greater	$212.00

(6) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to women who need treatment for breast or cervical cancer and who are defined in 42 U.S.C. § 1396a.(a)(10)(A)(ii)(XVIII).

SECTION #.(d) Services and Payment Bases. – The Department shall spend funds appropriated for Medicaid services in accordance with the following schedule of services and payment bases. All services and payments are subject to the language at the end of this subsection. Unless otherwise provided, services and payment bases will be as prescribed in the State Plan as established by the Department of Health and Human Services and may be changed with the approval of the Director of the Budget.

The Department of Health and Human Services (DHHS) shall operate and manage the Medicaid program within the annual State appropriation. DHHS shall establish policies,

practices, rates, and expenditure procedures that are in compliance with CMS regulations and approved State Plans, State laws, and regulations.

Additionally, the Department shall be required to use the Physician's Advisory Group for review and will collaborate with other stakeholder groups in the adoption and implementation of all clinical and payment policies, including all public notice and posting provisions in use as of the effective date of this provision.

(1) **Mandatory Services** – In order to manage the Medicaid program within the annual State appropriation, the Secretary shall have the authority to submit State Plan amendments and establish temporary rules affecting the amount of service and payment rate for the following mandatory services:

a. Hospital inpatient. – Payment for hospital inpatient services will be prescribed by the State Plan as established by the Department of Health and Human Services.

b. Hospital outpatient. – Eighty percent (80%) of allowable costs or a prospective reimbursement plan as established by the Department of Health and Human Services.

c. Nursing facilities. – Nursing facilities providing services to Medicaid recipients who also qualify for Medicare must be enrolled in the Medicare program as a condition of participation in the Medicaid program. State facilities are not subject to the requirement to enroll in the Medicare program. Residents of nursing facilities who are eligible for Medicare coverage of nursing facility services must be placed in a Medicare-certified bed. Medicaid shall cover facility services only after the appropriate services have been billed to Medicare.

d. Physicians, certified nurse midwife services, nurse practitioners, physician assistants. – Fee schedules as developed by the Department of Health and Human Services.

e. EPSDT Screens. – Payments in accordance with rate schedule developed by the Department of Health and Human Services.

f. Home health and related services, durable medical equipment. – Payments according to reimbursement plans developed by the Department of Health and Human Services.

g. Rural health clinical services. – Provider-based, reasonable cost, nonprovider-based, single-cost reimbursement rate per clinic visit.

h. Family planning. – Negotiated rate for local health departments. For other providers see specific services, e.g., hospitals, physicians.

i. Independent laboratory and X-ray services. – Uniform fee schedules as developed by the Department of Health and Human Services.

j. Medicare Buy-In. – Social Security Administration premium.

k. Ambulance services. – Uniform fee schedules as developed by the Department of Health and Human Services. Public ambulance providers will be reimbursed at cost.

l. Medicare crossover claims. – The Department shall apply Medicaid medical policy to Medicare claims for dually eligible recipients. The Department shall pay an amount up to the actual coinsurance or deductible or both, in accordance with the State Plan, as approved by the Department of Health and Human Services. The Department may disregard application of this policy in cases where application of the policy would adversely affect patient care.

m. Pregnancy-related services. – Covered services for pregnant women shall include nutritional counseling, psychosocial counseling, and predelivery and postpartum home visits as described in clinical policy.

n. Mental health services. – Coverage is limited to children eligible for EPSDT services provided by:

1. Licensed or certified psychologists, licensed clinical social workers, certified clinical nurse specialists in psychiatric mental health advanced practice, nurse practitioners certified as clinical nurse specialists in psychiatric mental health advanced practice, licensed psychological associates, licensed professional counselors, licensed marriage and family therapists, licensed clinical addictions specialists, and certified clinical supervisors, when Medicaid-eligible children are referred by the Community Care of North Carolina primary care physician, a Medicaid-enrolled psychiatrist, or the area mental health program or local management entity, and

2. Institutional providers of residential services as defined by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and approved by the Centers for Medicare and Medicaid Services (CMS) for children and Psychiatric Residential Treatment Facility services that meet federal and State requirements as defined by the Department.

(2) **Optional Services –** In order to manage the Medicaid program within the annual State appropriation, the Secretary shall have the authority to submit State Plan amendments and establish temporary rules affecting the amount of service, payment rate, or elimination of the following optional services:

a. Certified registered nurse anesthetists.

b. Community Alternative Programs.

c. Hearing aids. – Wholesale cost plus dispensing fee to provider.

d. Ambulatory surgical centers.

e. Private duty nursing, clinic services, prepaid health plans.

f. Intermediate care facilities for the mentally retarded.

g. Chiropractors, podiatrists, optometrists, dentists.

h. Dental coverage. – Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.

i. Optical supplies. – Payment for materials is made to a contractor in accordance with 42 C.F.R. § 431.54(d). Fees paid to dispensing providers are negotiated fees established by the State agency based on industry charges.

j. Physical therapy, occupational therapy, and speech therapy. – Services for adults. Payments are to be made only to qualified providers at rates negotiated by the Department of Health and Human Services.

k. Personal care services. – Payment in accordance with the State Plan developed by the Department of Health and Human Services.

l. Case management services. – Reimbursement in accordance with the availability of funds to be transferred within the Department of Health and Human Services.

m. Hospice and palliative care.

n. Medically necessary prosthetics or orthotics. – In order to be eligible for reimbursement, providers must be licensed or certified by the occupational licensing board or the certification authority having authority over the provider's license or certification. Medically necessary prosthetics and orthotics are subject to prior approval and utilization review.

o. Health insurance premiums.

p. Medical care/other remedial care. – Services not covered elsewhere in this section include related services in schools; health professional services provided outside the clinic setting to meet maternal and infant health goals.

q. Bariatric surgeries. – Covered as described in clinical policy 1A-15, Surgery for Clinically Severe Obesity. In order to raise the standard of bariatric care in North Carolina, approval for these procedures shall only be granted to those providers (facilities and surgeons) who are designated as a Bariatric Surgery Center of Excellence (BSCOE) by the American Society for Metabolic and Bariatric Surgery (ASMBS). Providers must then submit to NC Medicaid documentation of their designation as a BSCOE as well as verify their continued annual participation.

r. Drugs. –

1. Reimbursements. – Reimbursements shall be available for prescription drugs as allowed by federal regulations plus a professional services fee per month, excluding refills for the same drug or generic equivalent during the same month. Payments for drugs are subject to the provisions of this subdivision or in accordance with the State Plan adopted by the Department of Health and Human Services, consistent with federal reimbursement regulations. Payment of the professional services fee shall be made in accordance with the State Plan adopted by the Department of Health and Human Services, consistent with federal reimbursement regulations. The professional services fee shall be established by the Department. In addition to the professional services fee, the Department may pay an enhanced fee for pharmacy services.

2. Limitations on quantity. – The Department of Health and Human Services may establish authorizations, limitations, and reviews for specific drugs, drug classes, brands, or quantities in order to manage effectively the Medicaid program. The Department may impose prior authorization requirements on brand-name drugs for which the phrase "medically necessary" is written on the prescription.

3. Dispensing of generic drugs. – Notwithstanding G.S. 90-85.27 through G.S. 90-85.31, or any other law to the contrary, under the Medical Assistance Program (Title XIX of the Social Security Act), and except as otherwise provided

in this subsection for drugs listed in the narrow therapeutic index, a prescription order for a drug designated by a trade or brand name shall be considered to be an order for the drug by its established or generic name, except when the prescriber has determined, at the time the drug is prescribed, that the brand-name drug is medically necessary and has written on the prescription order the phrase "medically necessary." An initial prescription order for a drug listed in the narrow therapeutic drug index that does not contain the phrase "medically necessary" shall be considered an order for the drug by its established or generic name, except that a pharmacy shall not substitute a generic or established name prescription drug for subsequent brand or trade name prescription orders of the same prescription drug without explicit oral or written approval of the prescriber given at the time the order is filled. Generic drugs shall be dispensed at a lower cost to the Medical Assistance Program rather than trade or brand-name drugs. Notwithstanding this subdivision to the contrary, the Secretary of Health and Human Services may prevent substitution of a generic equivalent drug, including a generic equivalent that is on the State maximum allowable cost list, when the net cost to the State of the brand-name drug, after consideration of all rebates, is less than the cost of the generic equivalent. As used in this subsection, "brand name" means the proprietary name the manufacturer places upon a drug product or on its container, label, or wrapping at the time of packaging; and "established name" has the same meaning as in section 502(e)(3) of the Federal Food, Drug, and Cosmetic Act, as amended, 21 U.S.C. § 352(e)(3).

4. Specialty Drug Provider Network. – The Department of Health and Human Services shall work with specialty drug providers, manufacturers of specialty drugs, Medicaid recipients who are prescribed specialty drugs, and the medical professionals that treat Medicaid recipients who are prescribed specialty drugs to develop ways to ensure that best practices and the prevention of overutilization are maintained in the delivery and utilization of specialty drugs.

5. Lock Controlled Substances Prescriptions into Single Pharmacy/Provider. – The Department of Health and Human Services, Division of Medical Assistance, shall lock Medicaid enrollees into a single pharmacy and provider when the Medicaid enrollee's utilization of selected controlled substance medications meets the lock-in criteria approved by the NC Physicians Advisory Group, as follows:

   i. Enrollees may be prescribed selected controlled substance medications by only one prescribing physician and may not change the prescribing physician at any time without prior approval or authorization by the Division.

ii. Enrollees may have prescriptions for selected controlled substance medications filled at only one pharmacy and may not change to another pharmacy at any time without prior approval or authorization by the Division.

6. Preferred Drug List. – The Department of Health and Human Services shall establish and implement a preferred drug list program under the Division of Medical Assistance. Medications prescribed for the treatment of mental illness shall be included on the Preferred Drug List (PDL).

The pharmaceutical and therapeutics committee of the Physician's Advisory Group (PAG) shall provide ongoing review of the preferred drug list including the implementation of prior authorization on identified drugs. Members of the committee shall submit conflict of interest disclosure statements to the Department and shall have an ongoing duty to disclose conflicts of interest not included in the original disclosure.

The Department, in consultation with the PAG, shall adopt and publish policies and procedures relating to the preferred drug list, including:

i. Guidelines for the presentation and review of drugs for inclusion on the preferred drug list,

ii. The manner and frequency of audits of the preferred drug list for appropriateness of patient care and cost-effectiveness,

iii. An appeals process for the resolution of disputes, and

iv. Such other policies and procedures as the Department deems necessary and appropriate.

The Department and the pharmaceutical and therapeutics committee shall consider all therapeutic classes of prescription drugs for inclusion on the preferred drug list.

The Department shall maintain an updated preferred drug list in electronic format and shall make the list available to the public on the Department's Internet Web site.

The Department shall: (i) enter into a multistate purchasing pool; (ii) negotiate directly with manufacturers or labelers; (iii) contract with a pharmacy benefit manager for negotiated discounts or rebates for all prescription drugs under the medical assistance program; or (iv) effectuate any combination of these options in order to achieve the lowest available price for such drugs under such program.

The Department may negotiate supplemental rebates from manufacturers that are in addition to those required by Title XIX of the federal Social Security Act. The committee shall consider a product for inclusion on the preferred drug list if the manufacturer provides a supplemental rebate. The Department may procure a sole source contract with an outside entity or contractor to conduct negotiations for supplemental rebates.

The Secretary of the Department of Health and Human Services shall establish a Preferred Drug List (PDL) Policy Review Panel within 60 days after the effective date of this section. The purpose of the PDL Policy Review Panel is to review the Medicaid PDL recommendations from the Department of Health and Human Services, Division of Medical Assistance, and the Physician Advisory Group Pharmacy and Therapeutics (PAG P&T) Committee.

The Secretary shall appoint the following individuals to the review panel:

i. The Director of Pharmacy for the Division of Medical Assistance.
ii. A representative from the PAG P&T Committee.
iii. A representative from the Old North State Medical Society.
iv. A representative from the North Carolina Association of Pharmacists.
v. A representative from Community Care of North Carolina.
vi. A representative from the North Carolina Psychiatric Association.
vii. A representative from the North Carolina Pediatric Society.
viii. A representative from the North Carolina Academy of Family Physicians.
ix. A representative from the North Carolina Chapter of the American College of Physicians.
x. A representative from a research-based pharmaceutical company.
xi. A representative from hospital-based pharmacy.

Individuals appointed to the Review Panel, except for the Division's Director of Pharmacy, shall only serve a two-year term.

After the Department, in consultation with the PAG P&T Committee, publishes a proposed policy or procedure related to the Medicaid PDL, the Review Panel shall hold an open meeting to review the recommended policy or procedure along with any written public comments received as a result of the posting. The Review Panel shall provide an opportunity for public comment at the meeting. After the conclusion of the meeting, the Review Panel shall submit policy recommendations about the proposed Medicaid PDL policy or procedure to the Secretary.

The Department may establish a Preferred Drug List for the North Carolina Health Choice for Children program and pursue negotiated discounts or rebates for all prescription drugs under the program in order to achieve the lowest available price for such drugs under such program. The Department may procure a sole source contract with an outside entity or contractor to conduct negotiations for these

discounts or rebates. The PAG P&T Committee and Preferred Drug List Policy Review Panel will provide recommendations on policies and procedures for the NC Health Choice Preferred Drug List.

s. Incentive Payments as outlined in the State Medicaid Health Information Plan for Electronic Health Records.

t. Other mental health services. – Unless otherwise covered by this section, coverage is limited to the following:

1. Services as established by the Division of Medical Assistance in consultation with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and approved by the Centers for Medicare and Medicaid Services (CMS) when provided in agencies meeting the requirements and reimbursement is made in accordance with a State Plan developed by the Department of Health and Human Services not to exceed the upper limits established in federal regulations, and

2. For Medicaid-eligible adults, services provided by licensed or certified psychologists, licensed clinical social workers, certified clinical nurse specialists in psychiatric mental health advanced practice, and nurse practitioners certified as clinical nurse specialists in psychiatric mental health advanced practice, licensed psychological associates, licensed professional counselors, licensed marriage and family therapists, certified clinical addictions specialists, and licensed clinical supervisors, Medicaid-eligible adults may be self-referred.

3. Payments made for services rendered in accordance with this subdivision shall be to qualified providers in accordance with approved policies and the State Plan. Nothing in sub-subdivision b. or c. of this subdivision shall be interpreted to modify the scope of practice of any service provider, practitioner, or licensee, nor to modify or attenuate any collaboration or supervision requirement related to the professional activities of any service provider, practitioner, or licensee. Nothing in sub-subdivision b. or c. of this subdivision shall be interpreted to require any private health insurer or health plan to make direct third-party reimbursements or payments to any service provider, practitioner, or licensee.

Notwithstanding G.S. 150B-21.1(a), the Department of Health and Human Services may adopt temporary rules in accordance with Chapter 150B of the General Statutes further defining the qualifications of providers and referral procedures in order to implement this subdivision. Coverage policy for services established by the Division of Medical Assistance in consultation with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services under sub-subdivisions a. and b.2. of this subdivision shall be established by the Division of Medical Assistance.

u. Experimental/investigational medical procedures. – Coverage is limited to services, supplies, drugs, or devices recognized as standard medical care for the condition, disease, illness, or injury being treated as determined by nationally recognized scientific professional organizations or scientifically based federal organizations such as the Food and Drug Administration, the National Institutes of Health, the Centers for Disease Control, or the Agency for Health Care Research and Quality.

v. Clinical trials. – The Division of Medical Assistance shall develop clinical policy for the coverage of routine costs in clinical trial services for life-threatening conditions using resources such as coverage criteria from Medicare, NC State Health Plan, and the input of the Physician Advisory Group.

w. Organ transplants.

(3) Never Events and Hospital Acquired Conditions (HACs) shall not be reimbursed. Medicaid will adhere to Medicare requirements for definition of events and conditions.

SECTION #.(e) Provider Performance Bonds and Visits. –

(1) Subject to the provisions of this subdivision, the Department may require Medicaid-enrolled providers to purchase a performance bond in an amount not to exceed one hundred thousand dollars ($100,000) naming as beneficiary the Department of Health and Human Services, Division of Medical Assistance, or provide to the Department a validly executed letter of credit or other financial instrument issued by a financial institution or agency honoring a demand for payment in an equivalent amount. The Department may require the purchase of a performance bond or the submission of an executed letter of credit or financial instrument as a condition of initial enrollment, reenrollment, or reinstatement if:

a. The provider fails to demonstrate financial viability.

b. The Department determines there is significant potential for fraud and abuse.

c. The Department otherwise finds it is in the best interest of the Medicaid program to do so.

The Department shall specify the circumstances under which a performance bond or executed letter of credit will be required.

(1a) The Department may waive or limit the requirements of this subsection for individual Medicaid-enrolled providers or for one or more classes of Medicaid-enrolled providers based on the following:

a. The provider's or provider class's dollar amount of monthly billings to Medicaid.

b. The length of time an individual provider has been licensed, endorsed, certified, or accredited in this State to provide services.

c. The length of time an individual provider has been enrolled to provide Medicaid services in this State.

d. The provider's demonstrated ability to ensure adequate record keeping, staffing, and services.

e. The need to ensure adequate access to care.

In waiving or limiting requirements of this subsection, the Department shall take into consideration the potential fiscal impact of the waiver or limitation on the State Medicaid Program. The Department shall provide to the affected

provider written notice of the findings upon which its action is based and shall include the performance bond requirements and the conditions under which a waiver or limitation apply. The Department may adopt temporary rules in accordance with G.S. 150B-21.1 as necessary to implement this provision.

(2) Reimbursement is available for up to 30 visits per recipient per fiscal year for the following professional services: physicians, nurse practitioners, nurse midwives, physician assistants, clinics, health departments, optometrists, chiropractors, and podiatrists. The Department of Health and Human Services shall adopt medical policies in accordance with G.S. 108A-54.2 to distribute the allowable number of visits for each service or each group of services consistent with federal law. In addition, the Department shall establish a threshold of some number of visits for these services. The Department shall ensure that primary care providers or the appropriate CCNC network are notified when a patient is nearing the established threshold to facilitate care coordination and intervention as needed.

Prenatal services, all EPSDT children, emergency room visits, and mental health visits subject to independent utilization review are exempt from the visit limitations contained in this subdivision. Subject to appropriate medical review, the Department may authorize exceptions when additional care is medically necessary. Routine or maintenance visits above the established visit limit will not be covered unless necessary to actively manage a life threatening disorder or as an alternative to more costly care options.

SECTION #.(f) Exceptions and Limitations on Services; Authorization of Co-Payments and Other Services. –

(1) Exceptions to service limitations, eligibility requirements, and payments. – Service limitations, eligibility requirements, and payment bases in this section may be waived by the Department of Health and Human Services, with the approval of the Director of the Budget, to allow the Department to carry out pilot programs for prepaid health plans, contracting for services, managed care plans, or community-based services programs in accordance with plans approved by the United States Department of Health and Human Services or when the Department determines that such a waiver or innovation projects will result in a reduction in the total Medicaid costs.

(2) Co-payment for Medicaid services. – The Department of Health and Human Services may establish co-payments up to the maximum permitted by federal law and regulation.

(3) Provider enrollment fee. – Effective September 1, 2009, the Department of Health and Human Services, Division of Medical Assistance, shall charge an enrollment fee of one hundred dollars ($100.00), or the amount federally required, to each provider enrolling in the Medicaid program for the first time. The fee shall be charged to all providers at recredentialling every three years.

SECTION #.(g) Rules, Reports, and Other Matters. –

Rules. – The Department of Health and Human Services may adopt temporary or emergency rules according to the procedures established in G.S. 150B-21.1 and G.S. 150B-21.1A when it finds that these rules are necessary to maximize receipt of federal funds within existing State appropriations, to reduce Medicaid expenditures, and to reduce fraud and abuse. The Department of Health and Human Services shall adopt rules requiring

providers to attend training as a condition of enrollment and may adopt temporary or emergency rules to implement the training requirement.

Prior to the filing of the temporary or emergency rules authorized under this subsection with the Rules Review Commission and the Office of Administrative Hearings, the Department shall consult with the Office of State Budget and Management on the possible fiscal impact of the temporary or emergency rule and its effect on State appropriations and local governments.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

DMA CONTRACT SHORTFALL

SECTION #.(a) Budget approval is required by the Office of State Budget and Management prior to the Department of Health and Human Services, Division of Medical Assistance, entering into any new contract or the renewal or amendment of existing contracts that exceed the current contract amounts.

SECTION #.(b) The Division of Medical Assistance shall make every effort to effect savings within its operational budget and use those savings to offset its contract shortfall. Notwithstanding G.S. 143C-6-4(b)(3), the Department may use funds appropriated in this act to cover the contract shortfall in the Division of Medical Assistance if insufficient funds exist within the Division.

DRAFT
SPECIAL PROVISION

2011-DHHS-H46

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

MEDICAID COST CONTAINMENT ACTIVITIES

SECTION #.(a) The Department of Health and Human Services may use up to five million dollars ($5,000,000) in the 2011-2012 fiscal year and up to five million dollars ($5,000,000) in the 2012-2013 fiscal year in Medicaid funds budgeted for program services to support the cost of administrative activities when cost-effectiveness and savings are demonstrated. The funds shall be used to support activities that will contain the cost of the Medicaid Program, including contracting for services, hiring additional staff, funding pilot programs, Health Information Exchange and Health Information Technology (HIE/HIT) administrative activities, or providing grants through the Office of Rural Health and Community Care to plan, develop, and implement cost containment programs.

Medicaid cost containment activities may include prospective reimbursement methods, incentive-based reimbursement methods, service limits, prior authorization of services, periodic medical necessity reviews, revised medical necessity criteria, service provision in the least costly settings, plastic magnetic stripped Medicaid identification cards for issuance to Medicaid enrollees, fraud detection software or other fraud detection activities, technology that improves clinical decision making, credit balance recovery and data mining services, and other cost containment activities. Funds may be expended under this section only after the Office of State Budget and Management has approved a proposal for the expenditure submitted by the Department. Proposals for expenditure of funds under this section shall include the cost of implementing the cost containment activity and documentation of the amount of savings expected to be realized from the cost containment activity.

SECTION #.(b) The Department shall report annually on the expenditures under this section to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division. The report shall include the methods used to achieve savings and the amount saved by these methods. The report is due to the House and Senate Appropriations Subcommittees on Health and Human Services and the Fiscal Research Division of the General Assembly not later than December 1 of each year for the activities of the previous State fiscal year.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H18**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

MEDICAID SPECIAL FUND TRANSFER

SECTION #. Of the funds transferred to the Department of Health and Human Services for Medicaid programs pursuant to G.S. 143C-9-1, there is appropriated from the Medicaid Special Fund to the Department of Health and Human Services the sum of forty-three million dollars ($43,000,000) for the 2011-2012 fiscal year and the sum of forty-three million dollars ($43,000,000) for the 2012-2013 fiscal year. These funds shall be allocated as prescribed by G.S. 143C-9-1(b) for Medicaid programs. Notwithstanding the prescription in G.S. 143C-9-1(b) that these funds not reduce State general revenue funding, these funds shall replace the reduction in general revenue funding effected in this act. The Department may also use funds in the Medicaid Special Fund to fund the settlement of the Disproportionate Share Hospital payment audit issues between the Department of Health and Human Services and the federal government related to fiscal years 1997-2002, and funds are appropriated from the Fund for the 2011-2012 fiscal year for this purpose.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

ACCOUNTING FOR MEDICAID RECEIVABLES AS NONTAX REVENUE

SECTION #.(a) Receivables reserved at the end of the 2011-2012 and 2012-2013 fiscal years shall, when received, be accounted for as nontax revenue for each of those fiscal years.

SECTION #.(b) For the 2011-2012 fiscal year, the Department of Health and Human Services shall deposit from its revenues one hundred fifteen million dollars ($115,000,000) with the Department of State Treasurer to be accounted for as nontax revenue. For the 2012-2013 fiscal year, the Department of Health and Human Services shall deposit from its revenues one hundred fifteen million dollars ($115,000,000) with the Department of State Treasurer to be accounted for as nontax revenue. These deposits shall represent the return of General Fund appropriations provided to hospitals that are owned and operated by the State to provide indigent and nonindigent care services and shall be returned to the DHHS. The treatment of any revenue derived from federal programs shall be in accordance with the requirements specified in the Code of Federal Regulations, Volume 2, Part 225.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

FAMILIES PAY PART OF THE COST OF SERVICES UNDER THE CAP-MR/DD PROGRAM AND THE CAP-CHILDREN'S PROGRAM BASED ON FAMILY INCOME

SECTION #.(a) Subject to approval from the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services, Division of Medical Assistance, shall, in consultation with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and Community Alternatives Program (CAP) stakeholders, develop a schedule of cost-sharing requirements for families of children with incomes above the Medicaid allowable limit to share in the costs of their child's Medicaid expenses under the CAP-MR/DD (Community Alternatives Program for Mental Retardation and Developmentally Disabled) and the CAP-C (Community Alternatives Program for Children). The cost-sharing amounts shall be based on a sliding scale of family income and shall take into account the impact on families with more than one child in the CAP programs. In developing the schedule, the Department shall also take into consideration how other states have implemented cost-sharing in their CAP programs. The Division of Medical Assistance may establish monthly deductibles as a means of implementing this cost-sharing. The Department shall provide for at least one public hearing and other opportunities for individuals to comment on the imposition of cost-sharing under the CAP program schedule.

SECTION #.(b) The Division of Medical Assistance shall also, in collaboration with the Controller's Office of the Department of Health and Human Services, the Division of Information Resource Management (DIRM), and the new vendor of the replacement Medicaid Management Information System, develop business rules, program policies and procedures, and define relevant technical requirements.

SECTION #.(c) Implementation of this provision shall be delayed until the implementation of the new Medicaid Management Information System.

DRAFT
SPECIAL PROVISION

2011-DHHS-H33

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

AUTHORIZE THE DIVISION OF MEDICAL ASSISTANCE TO TAKE CERTAIN STEPS TO EFFECTUATE COMPLIANCE WITH BUDGET REDUCTIONS IN THE MEDICAID PROGRAM

SECTION #.(a) The Department of Health and Human Services, Division of Medical Assistance, may take the following actions, notwithstanding any other provision of this act or other State law or rule to the contrary:

(1) In-Home Care provision. – In order to enhance in-home aide services to Medicaid recipients, the Department of Health and Human Services, Division of Medical Assistance, shall:

a. No longer provide services under PCS and PCS-Plus the later of January 1, 2013, or whenever CMS approves the elimination of the PCS and PCS-Plus programs and the implementation of the following two new services:

1. In-Home Care for Children (IHCC). – Services to assist families to meet the in-home care needs of children, including those individuals under the age of 21 receiving comprehensive and preventive child health services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

2. In-Home Care for Adults (IHCA). – Services to meet the eating, dressing, bathing, toileting, and mobility needs of individuals 21 years of age or older who, because of a medical condition, disability, or cognitive impairment, demonstrate unmet needs for, at a minimum: (i) three of the five qualifying activities of daily living (ADLs) with limited hands-on assistance; (ii) two ADLs, one of which requires extensive assistance; or (iii) two ADLs, one of which requires assistance at the full dependence level. The five qualifying ADLs are eating, dressing, bathing, toileting, and mobility. IHCA shall serve individuals at the highest level of need for in-home care who are able to remain safely in the home.

b. Establish, in accordance with G.S. 108A-54.2, a Medical Coverage Policy for each of these programs to include:

1. For IHCC, up to 60 hours per month in accordance with an assessment conducted by DMA or its designee and a plan of care developed by the service provider and approved by DMA or its designee. Additional hours may be authorized when the services are required to correct or ameliorate defects and physical and mental illnesses and conditions in this age

group, as defined in 42 U.S.C. § 1396d(r)(5), in accordance with a plan of care approved by DMA or its designee.

2. For IHCA, up to 80 hours per month in accordance with an assessment conducted by DMA or its designee and a plan of care developed by the service provider and approved by DMA or its designee.

c. Implement the following program limitations and restrictions to apply to both IHCC and IHCA:

1. Additional services to children required under federal EPSDT requirements shall be provided to qualified recipients in the IHCC Program.

2. Services shall be provided in a manner that supplements, rather than supplants, family roles and responsibilities.

3. Services shall be authorized in amounts based on assessed need of each recipient, taking into account care and services provided by the family, other public and private agencies, and other informal caregivers who may be available to assist the family. All available resources shall be utilized fully, and services provided by such agencies and individuals shall be disclosed to the DMA assessor.

4. Services shall be directly related to the hands-on assistance and related tasks to complete each qualifying ADL in accordance with the IHCC or IHCA assessment and plan of care, as applicable.

5. Services provided under IHCC and IHCA shall not include household chores not directly related to the qualifying ADLs, nonmedical transportation, financial management, and non-hands-on assistance such as cueing, prompting, guiding, coaching, or babysitting.

6. Essential errands that are critical to maintaining the health and welfare of the recipient may be approved on a case-by-case basis by the DMA assessor when there is no family member, other individual, program, or service available to meet this need. Approval, including the amount of time required to perform this task, shall be documented on the recipient's assessment form and plan of care.

d. Utilize the following process for admission to the IHCC and IHCA programs:

1. The recipient shall be seen by his or her primary or attending physician, who shall provide written authorization for referral for the service and written attestation to the medical necessity for the service.

2. All assessments for admission to IHCC and IHCA, continuation of these services, and change of status reviews for these services shall be performed by DMA or its designee. The DMA designee may not be an owner of a provider business, or provider of in-home or personal care services of any type.

3. DMA or its designee shall determine and authorize the amount of service to be provided on a "needs basis," as

determined by its review and findings of each recipient's degree of functional disability and level of unmet needs for hands-on personal assistance in the five qualifying ADLs.

e. Take all appropriate actions to manage the cost, quality, program compliance, and utilization of services provided under the IHCC and IHCA programs, including, but not limited to:

1. Priority independent reassessment of recipients before the anniversary date of their initial admission or reassessment for those recipients likely to qualify for the restructured IHCC and IHCA programs;
2. Priority independent reassessment of recipients requesting a change of service provider;
3. Targeted reassessments of recipient prior to their anniversary dates when the current provider assessment indicates they may not qualify for the program or for the amount of services they are currently receiving;
4. Targeted reassessment of recipients receiving services from providers with a history of program noncompliance;
5. Provider desk and on-site reviews and recoupment of all identified overpayments or improper payments;
6. Recipient reviews, interviews, and surveys;
7. The use of mandated electronic transmission of referral forms, plans of care, and reporting forms;
8. The use of mandated electronic transmission of uniform reporting forms for recipient complaints and critical incidents;
9. The use of automated systems to monitor, evaluate, and profile provider performance against established performance indicators; and
10. Establishment of rules that implement the requirements of 42 C.F.R. § 441.16.

f. Timeline for implementation of new IHCC and IHCA programs.

1. Subject to approvals from CMS, DMA shall make every effort to implement the new IHCC and IHCA programs by January 1, 2013.
2. DMA shall ensure that individuals who qualify for the IHCC and IHCA programs shall not experience a lapse in service and, if necessary, shall be admitted on the basis of their current provider assessment when an independent reassessment has not yet been performed and the current assessment documents that the medical necessity requirements for the IHCC or IHCA program, as applicable, have been met.
3. Prior to the implementation date of the new IHCC and IHCA programs, all recipients in the PCS and PCS-Plus programs shall be notified pursuant to 42 C.F.R. § 431.220(b) and discharged, and the Department shall no longer provide services under the PCS and PCS-Plus programs, which shall terminate. Recipients who qualify for the new IHCC and

IHCA programs shall be admitted and shall be eligible to receive services immediately.

(2) Medicaid Personal Care Services (PCS) studies:

a. The Department of Health and Human Services shall conduct a study determining the cost effectiveness, efficiencies gained, and challenges associated with transitioning the performance of independent assessments for PCS, IHCC, or IHCA services to CCNC and shall report its findings to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Commission on Health and Human Services, and the Fiscal Research Division on or before January 1, 2013.

b. The Division of Medical Assistance shall study the incidence of fraud, waste, or abuse by Medicaid PCS providers and recipients and by Medicaid IHCC or IHCA providers and recipients, after the implementation of those programs, and shall report its findings on or before January 1, 2013, and annually thereafter, to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

(3) MH/DD/SA Personal Care and Personal Assistance Services Provision. – A denial, reduction, or termination of Medicaid-funded personal care services shall result in a similar denial, reduction, or termination of State-funded MH/DD/SA personal care and personal assistance services.

(4) Community Support and other MH/DD/SA services. – The Department of Health and Human Services shall transition community support child and adult, individual and group services to other defined services on or before June 30, 2012. The Division of Medical Assistance and the Division of MH/DD/SA shall take the steps necessary for the Medicaid and the State-funded community support program to provide for transition and discharge planning to recipients currently receiving community support services. The following shall occur:

a. The Department shall submit to CMS: (i) revised service definitions that separate case management functions from the Community Support definition and (ii) a new service definition for peer support services for adults with mental illness and/or substance abuse disorders, for implementation no sooner than January 1, 2013.

b. No new admissions for community support individual or group shall be allowed during this transition period unless the Department determines appropriate alternative services are not available, in which case limited community support services may be provided during the transition period. LMEs will be responsible for referring eligible consumers to appropriate alternative services.

c. Authorizations currently in effect as of the date of enactment of this act remain valid. Any new authorization or subsequent reauthorization is subject to the provisions of this act.

d. No community support services shall be provided in conjunction with other enhanced services. Until CMS approves the new case management definition, professional level community support may be provided in conjunction with residential Level III and IV to assist in recipient discharge planning. Up to a maximum of 24 hours of

case management (professional level) functions may be provided over a 90-day authorization period as approved by the prior authorization vendor.

e. The current moratorium on community support provider endorsement shall remain in effect.

f. A provider of community support services whose endorsement has been withdrawn or whose Medicaid participation has been terminated is not entitled to payment during the period the appeal is pending, and the Department shall make no payment to the provider during that period. If the final agency decision is in favor of the provider, the Department shall remove the suspension, commence payment for valid claims, and reimburse the provider for payments withheld during the period of appeal.

g. Effective 60 days from the enactment of this act, the paraprofessional level of community support shall be eliminated, and from this date the Department shall not use any Medicaid or State funds to pay for this level of service.

h. Thirty days after the enactment of this act, any concurrent request shall be accompanied with a discharge plan. Submission of the discharge plan will be a required document for a request to be considered complete. Failure to submit the discharge plan will result in the request being returned as "unable to process." Discharge from the service must occur within 90 days after the submission of the discharge plan.

i. Any community support provider that ceases to function as a provider shall provide written notification to DMA, the Local Management Entity, recipients, and the prior authorization vendor 30 days prior to closing of the business.

j. Medical and financial record retention is the responsibility of the provider and shall be in compliance with the record retention requirements of their Medicaid provider agreement or State-funded services contract. Records shall also be available to State, federal, and local agencies.

k. Failure to comply with notification, recipient transition planning, or record maintenance shall result in suspension of further payment until such failure is corrected. In addition, failure to comply shall result in denial of enrollment as a provider for any Medicaid or State-funded service. A provider (including its officers, directors, agents, or managing employees or individuals or entities having a direct or indirect ownership interest or control interest of five percent (5%) or more as set forth in Title XI of the Social Security Act) that fails to comply with the required record retention may be subject to sanctions, including exclusion from further participation in the Medicaid program, as set forth in Title XI.

(5) Community Support Team. – Authorization for a Community Support Team shall be based upon medical necessity as defined by the Department and shall not exceed 18 hours per week. The Division of Medical Assistance shall do an immediate rate study of the Community Support Team to bring the average cost of service per recipient in line with Assertive Community Treatment Team (ACTT) services. The Division shall also revise provider

qualifications and tighten the service definition to contain costs in this line item. Not later than December 1, 2011, the Division of Medical Assistance shall report its findings on the rate study and any actions it has taken to conform with this subdivision to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(6) MH Residential. – The Department of Health and Human Services shall restructure the Medicaid child mental health, developmental disabilities, and substance abuse residential services to ensure that total expenditures are within budgeted levels. All restructuring activities shall be in compliance with federal and State law or rule. The Divisions of Medical Assistance and Mental Health, Developmental Disabilities, and Substance Abuse Services shall establish a team inclusive of providers, LMEs, and other stakeholders to assure effective transition of recipients to appropriate treatment options. The restructuring shall address all of the following:

a. Submission of the therapeutic family service definition to CMS.

b. The Department shall reexamine the entrance and continued stay criteria for all residential services. The revised criteria shall promote least restrictive services in the home prior to residential placement. During treatment, there must be inclusion in community activities and parent or legal guardian participation in treatment.

c. Require all existing residential providers or agencies to be nationally accredited within one year of enactment of this act. Any providers enrolled after the enactment of this act shall be subject to existing endorsement and nationally accrediting requirements. In the interim, providers who are nationally accredited will be preferred providers for placement considerations.

d. Before a child can be admitted to Level III or Level IV placement, an assessment shall be completed to ensure the appropriateness of placement, and one or more of the following shall apply:

1. Placement shall be a step down from a higher level placement such as a psychiatric residential treatment facility or inpatient; or

2. Multisystemic therapy or intensive in-home therapy services have been unsuccessful; or

3. The Child and Family Team has reviewed all other alternatives and recommendations and recommends Level III or IV placement due to maintaining health and safety; or

4. Transition or discharge plan shall be submitted as part of the initial or concurrent request.

e. Length of stay is limited to no more than 180 days. Any exceptions granted will require for non-CABHAs an independent psychological or psychiatric assessment, for CABHAs, a psychological or psychiatric assessment that may be completed by the CABHA, and for both Child and Family Team review of goals and treatment progress, family or discharge placement setting are actively engaged in treatment goals and objectives and active participation of the prior authorization of vendor.

f. Submission of discharge plan is required in order for the request to be considered complete, but the authorization approval is not

conditional upon all signatures. The LME will designate appropriate individuals who can sign the discharge plan within 24 hours of receipt. Failure to submit a complete discharge plan will result in the request being returned as unable to process.

g. Any residential provider that ceases to function as a provider shall provide written notification to DMA, the Local Management Entity, recipients, and the prior authorization vendor 30 days prior to closing of the business.

h. Record maintenance is the responsibility of the provider and must be in compliance with record retention requirements. Records shall also be available to State, federal, and local agencies.

i. Failure to comply with notification, recipient transition planning, or record maintenance shall be grounds for withholding payment until such activity is concluded. In addition, failure to comply shall be conditions that prevent enrollment for any Medicaid or State-funded service. A provider (including its officers, directors, agents, or managing employees or individuals or entities having a direct or indirect ownership interest or control interest of five percent (5%) or more as set forth in Title XI of the Social Security Act) that fails to comply with the required record retention may be subject to sanctions, including exclusion from further participation in the Medicaid program, as set forth in Title XI.

j. On or before October 1, 2011, the Department shall report on its plan for transitioning children out of Level III and Level IV group homes. The Department shall submit the reports to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(7) Reduce Medicaid rates. – Subject to the prior approval of the Office of State Budget and Management, the Secretary shall reduce Medicaid provider rates to accomplish the reduction in funds for this purpose enacted in this act. The Secretary shall consider the impact on access to care through primary care providers and critical access hospitals and may adjust the rates accordingly. Medicaid rates predicated upon Medicare fee schedules shall follow Medicare reductions but not Medicare increases unless federally required. The reductions authorized by this subdivision are subject to the following additional limitations:

a. Additional Limitation on Reductions for Adult Care Home Services. – Provider rates for adult home care services shall not be reduced below current levels.

b. Exceptions for Certain Providers. – The rate reduction applies to all Medicaid private and public providers with the following exceptions:

1. Federally qualified health clinics.
2. Rural health centers.
3. State institutions.
4. Hospital outpatient.
5. Perscriptions.
6. The noninflationary components of the case-mix reimbursement system for nursing facilities.

(8) Medicaid identification cards. – The Department shall issue Medicaid identification cards to recipients on an annual basis with quarterly updates.

(9) The Department of Health and Human Services shall develop a plan for the consolidation of case management services utilizing CCNC. The plan shall address the time line and process for implementation, the identification of savings, and the Medicaid recipients affected by the consolidation. Consolidation under this subdivision does not apply to HIV case management. By December 1, 2012, the Department shall report on the plan to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

(10) For the purpose of promoting cost-effective utilization of outpatient mental health services for children, DMA shall require prior authorization for services following the sixteenth visit.

(11) Provision of Medicaid Private Duty Nursing (PDN). – DMA shall change the Medicaid Private Duty Nursing program provided under the State Medicaid Plan, as follows:

a. Restructure the current PDN program to provide services that are:

1. Provided only to qualified recipients under the age of 21.
2. Authorized by the recipient's primary care or attending physician.
3. Limited to 16 hours of service per day, unless additional services are required to correct or ameliorate defects and physical and mental illnesses and conditions as defined in 42 U.S.C. § 1396d(r)(5).
4. Approved based on an initial assessment and continuing need reassessments performed by an Independent Assessment Entity (IAE) that does not provide PDN services and authorized in amounts that are medically necessary based on the recipient's medical condition, amount of family assistance available, and other relevant conditions and circumstances, as defined by the Medicaid Clinical Coverage Policy for this service.
5. Provided in accordance with a plan of care approved by DMA or its designee.

b. Develop and submit to CMS a 1915(c) Home and Community Based Services Waiver for individuals dependent on technology to substitute for a vital body function.

c. Once approved by CMS and upon approval of the Medicaid Clinical Coverage Policy, transition all qualified recipients age 21 and older currently receiving PDN to waiver services provided under the Technology Dependent Waiver.

(12) Medicaid service modifications and eliminations. – Subject to the prior approval of the Centers for Medicare and Medicaid Services where required, the Division of Medical Assistance shall make the following eliminations of or modifications to Medicaid services:

a. Optical. – Eliminate adult routine eye exams. Eye exams shall be restricted to cases in which a specific optical problem exists.

b. Durable Medical Equipment. – Negotiate a single source contract with a manufacturer for incontinence supply procurement, notwithstanding any other provision of law. The contract shall

provide that suppliers may use the contract but are also free to take advantage of better prices available elsewhere.

c. Specialized Therapies. – For evaluations, re-evaluations, as well as physical, occupational, speech, respiratory, and audiological services, reduce the maximum number of allowable services by 1 per year.

d. Home Health. – Restrict usage of the miscellaneous T199 code. All billing must be for a specific service.

e. Pregnancy Home Model Initiative. – Eliminate tocolatic therapy.

f. Dental. –

1. Eliminate composite fillings for back teeth fillings.
2. Limit the number of surfaces that can be filled to four per tooth.
3. Limit frequency of scaling and replaning to once every two years.
4. Raise the threshold for eligibility for replaning to 5mm to 4mm.
5. Eliminate cast dentures for partial dentures only and replace with acrylic dentures. Change the frequency frequency of replacement from every 10 years to every eight years.
6. Require prior authorization for oral excision of gum tissue.

g. Miscellaneous. –

1. Restrict usage of evaluation and management billing as well as of unlisted codes and strengthen supporting documentation requirements. Billing shall use specific service codes for specific services as a prerequisite to reimbursement.
2. Restrict circumcision coverage to medically necessary procedures.
3. Utilize Bloodhound, Inc. software, or comparable software, to examine billing codes that are duplicative or inconsistent with evidence-based practices.
4. Require prior authorization for back surgery for selective diagnoses and require that all other therapies have been exhausted prior to granting authorization.
5. Require prior authorization for capsule endoscopy but not traditional endoscopy.
6. Require prior authorization for selected medical procedures and services, including elective cardiac procedures, chronic pain management, and related procedures.
7. Negotiate a single source contract for genetic testing, notwithstanding any other provision of law.

SECTION #.(b) At least 30 days prior to the adoption of new or amended medical coverage policies necessitated by the reductions to the Medicaid program enacted in this act, the Department shall:

(1) Publish the proposed new or amended medical coverage policies via the Medicaid Bulletin published on the Department's Web site, which shall include an invitation to readers to send written comments on the proposed new or amended policies to the Department's mailing address, including e-mail.

(2) Notify via direct mail the members of the Physician Advisory Group (PAG) of the proposed policies.

(3) Update the policies published on the Web site to reflect any changes made as a result of written comments received from the PAG and others.

(4) Provide written notice to recipients about changes in policy.

SECTION #.(c) The Department of Health and Human Services shall not implement any actions directed by this act if the Department determines that such actions would jeopardize the receipt of ARRA funds appropriated or allocated to the Department.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H48**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

MEDICAID WAIVER FOR ASSISTED LIVING

SECTION #.(a) The Department of Health and Human Services, Division of Medical Assistance (Division) shall develop and implement a home and community-based services program under Medicaid State Plan 1915(i) authority in order to continue Medicaid funding of personal care services to individuals living in adult care homes.

SECTION #.(b) The Division shall implement the program upon approval of the application by the Centers for Medicare and Medicaid Services.

SECTION #.(c) On or before April 1, 2012, the Division shall provide a report on the status of approval and implementation of the program to the Joint Legislative Commission on Governmental Operations, the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H26B**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

PROGRAM INTEGRITY

SECTION #.(a) In order to ensure all claims presented by a provider for payment by the Department of Health and Human Services meet the Department's medical necessity criteria and all other applicable Medicaid, Health Choice, or other federal or state documentation requirements, a provider may be required to undergo prepayment claims review by DHHS. Claims reviews conducted pursuant to this section shall be in accordance with the provisions of the Patient Protect and Affordable Care Act, P.L. 111-148, and any implementing regulations.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H35**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

TRANSFER TO OFFICE OF ADMINISTRATIVE HEARINGS

SECTION #. From funds available to the Department of Health and Human Services (Department) for the 2011-2012 fiscal year, the sum of one million dollars ($1,000,000) and for the 2012-2013 fiscal year, the sum one million dollars ($1,000,000) shall be transferred by the Department of Health and Human Services to the Office of Administrative Hearings (OAH). These funds shall be allocated by the OAH for mediation services provided for Medicaid applicant and recipient appeals and to contract for other services necessary to conduct the appeals process. OAH shall continue the Memorandum of Agreement (MOA) with the Department for mediation services provided for Medicaid recipient appeals and contracted services necessary to conduct the appeals process. The MOA will facilitate the Department's ability to draw down federal Medicaid funds to support this administrative function. Upon receipt of invoices from OAH for covered services rendered in accordance with the MOA, the Department shall transfer the federal share of Medicaid funds drawn down for this purpose.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

NC HEALTH CHOICE

SECTION #.(a) G.S. 108A-54.3 is amended by adding a new subdivision to read:

"**§ 108A-54.3. Procedures for changing medical policy.**

The Department shall develop, amend, and adopt medical coverage policy in accordance with the following:

…

(5) Any changes in medical policy that require an amendment to the Health Choice State Plan will be submitted by the Department upon approval of the proposed policy."

SECTION #.(b) G.S. 108A-70.21(b) reads as rewritten:

"(b) Benefits. – Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided ~~for dependents~~ under the ~~Predecessor Plan.~~ North Carolina Medicaid Program except for the following:

(1) No services for long-term care.

(2) No nonemergency medical transportation.

(3) No EPSDT.

(4) Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.

In addition to the benefits provided under the ~~Predecessor Plan,~~ North Carolina Medicaid Program, the following services and supplies are covered under the Health Insurance Program for Children established under this Part:

~~(1) Oral examinations, teeth cleaning, and topical fluoride treatments twice during a 12-month period, full mouth X-rays once every 60 months, supplemental bitewing X-rays showing the back of the teeth once during a 12-month period, sealants, extractions, other than impacted teeth or wisdom teeth, therapeutic pulpotomies, space maintainers, root canal therapy for permanent anterior teeth and permanent first molars, prefabricated stainless steel crowns, and routine fillings of amalgam or other tooth colored filling material to restore diseased teeth.~~

~~(1a) Orthognathic surgery to correct functionally impairing malocclusions when orthodontics was approved and initiated while the child was covered by Medicaid and the need for orthognathic surgery was documented in the orthodontic treatment plan.~~

(2) Vision: Scheduled routine eye examinations once every 12 months, eyeglass lenses or contact lenses once every 12 months, routine replacement of eyeglass frames once every 24 months, and optical supplies and solutions when needed. ~~Optical~~ NCHC recipients must obtain optical services, supplies, and solutions ~~must be obtained~~ from NCHC enrolled, licensed or

certified ophthalmologists, optometrists, or ~~optical dispensing laboratories.~~ opticians. In accordance with G.S. 148-134, NCHC providers must order complete eyeglasses, eyeglass lenses, and ophthalmic frames through Nash Optical Plant. Eyeglass lenses are limited to NCHC-approved single vision, bifocal, trifocal, or other complex lenses necessary for a Plan enrollee's visual welfare. Coverage for oversized lenses and frames, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated lenses, and laminated lenses is limited to the coverage for single vision, bifocal, trifocal, or other complex lenses provided by this subsection. Eyeglass frames are limited to ~~those~~ NCHC-approved frames made of zylonite, metal, or a combination of zylonite and metal. All visual aids covered by this subsection require prior approval. Requests for medically necessary complete eyeglasses, eyeglass lenses, and ophthalmic frames outside of the NCHC-approved selection require prior approval. Requests for medically necessary fabrication of complete eyeglasses or eyeglass lenses outside of Nash Optical Plan require prior approval. Upon prior approval refractions may be covered more often than once every 12 months.

(3) ~~Hearing: Auditory diagnostic testing services and hearing aids and accessories when provided by a licensed or certified audiologist, otolaryngologist, or other approved hearing aid specialist. Prior approval is required for hearing aids, accessories, earmolds, repairs, loaners, and rental aids.~~Under the North Carolina Health Choice Program for Children, the co-payment for nonemergency visits to the emergency room for children whose family income is at or below one hundred fifty percent (150%) of the federal poverty level is ten dollars ($10.00). The co-payment for children whose family income is between one hundred fifty-one percent (151%) and two hundred percent (200%) of the federal poverty level is twenty-five dollars ($25.00).

(4) Over the counter medications: Selected over the counter medications provided the medication is covered under the State Medical Assistance Plan. Coverage shall be subject to the same policies and approvals as required under the Medicaid program.

(5) Routine diagnostic examinations and tests: annual routine diagnostic examinations and tests, including x-rays, blood and blood pressure checks, urine tests, tuberculosis tests, and general health check-ups that are medically necessary for the maintenance and improvement of individual health are covered.

No benefits are to be provided for services and materials under this subsection that do not meet the standards accepted by the American Dental Association.

The Department shall provide services to children enrolled in the NC Health Choice Program through Community Care of North Carolina (CCNC) and shall pay Community Care of North Carolina providers ~~for these services~~ the per member, per month fees as allowed under Medicaid. ~~The Department shall pay for these services only if sufficient information is available to the Department for utilization management of the services provided through CCNC.~~"

SECTION #.(c) G.S. 108A-70.23 is repealed.

SECTION #.(d) G.S. 108A-70.27(c) reads as rewritten:

"(c) ~~The Executive Administrator and Board of Trustees of the North Carolina Teachers' and State Employees' Major Medical Plan ("Plan")~~ DMA shall provide to the Department data

required under this section that are collected by the Plan. Data shall be reported by the Plan in sufficient detail to meet federal reporting requirements under Title XXI. The Plan shall report periodically to the Joint Legislative Health Care Oversight Committee claims processing data for the Program and any other information the Plan or the Committee deems appropriate and relevant to assist the Committee in its review of the Program."

SECTION #.(e) G.S. 108A-70.29 reads as rewritten:

"**§ 108A-70.29. Program review process.**

…

(e) Rule-Making authority. – The Department shall have the authority to adopt rules for the implementation and operation of the Program review process.

(f) Rulemaking authority. – The Department of Health and Human Services shall have the authority to adopt rules for the transition and operation of the North Carolina Health Choice Program. Notwithstanding G.S. 150B-21.1(a), the Department of Health and Human Services may adopt temporary rules in accordance with Chapter 150B of the General Statutes for enrolling providers to participate in the NC Health Choice program, for regulating provider participation in the NC Health Choice program, and for other operational issues regarding the NC Health Choice Program."

DRAFT
SPECIAL PROVISION

2011-DHHS-H51

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

MEDICATION THERAPY MANAGEMENT PILOT

SECTION #.(a) The Department of Health and Human Services shall develop a two-year medication therapy management pilot program to be administered through Community Care of North Carolina (CCNC) in order to determine (i) the best method of adapting the ChecKmedsNC program to the Medicaid program and CCNC's Medical Homes and (ii) the most effective and efficient role for community-based pharmacists as active members of CCNC's care management teams. The pilot program created pursuant to this section shall consist of the following components:

(1) Identification of at least 20 community-based pharmacies that employ a pharmacist who has been given dedicated time to work with patients, their care team members, and their Medical Home practices to improve patient outcomes. To the extent that available resources allow, other types of community-based pharmacists may be involved, including those working with long-term care residents or their attending physicians.

(2) Targeting of Medicaid recipients with co-occurring illnesses or conditions that are especially susceptible to poor patient outcomes when medication is underused, misused, or poorly coordinated.

(3) Allowing pharmacists identified pursuant to subdivision (1) of this section to have access to CCNC's web based Pharmacy Portal, which allows CCNC to establish and monitor patients' prescriptions and to communicate with other care team members.

SECTION #.(b) On January 1, 2012, and every six months thereafter, CCNC shall report to the Department of Health and Human Services, the House and Senate Appropriations Subcommittees on Health and Human Services, and the Fiscal Research Division of the General Assembly, on the development and implementation of this pilot program. This reporting requirement shall terminate with the filing of the third report on January 1, 2013. In addition to any other information, the reports required by this section shall include the following additional information:

(1) The July 1, 2012 report shall include an interim evaluation of the pharmacists' demonstrated use of the CCNC Pharmacy Home Model and the pharmacists' role in intervening and successfully managing the medication therapy of Medicaid recipients with chronic illnesses.

(2) The January 1, 2013 report shall include an evaluation of the pharmacists' role in CCNC's management of Medicaid recipients with mental health diagnoses, or who receive Home Health or Nursing Home care; and a determination of the appropriate per member/per month pharmacists should receive for participating in the Medical Home Model of CCNC.

SECTION #.(c) Funding for this pilot program shall be made available through the Enhanced Federal Funding for Health Homes for the Chronically Ill.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

NO INFLATIONARY MEDICAID PROVIDER RATE INCREASES

SECTION #. Notwithstanding any other provision of law, the Secretary of the Department of Health and Human Services shall not authorize any inflationary increases to Medicaid provider rates during the 2011-2013 fiscal biennium, except that inflationary increases for private ICF-MRs paying provider fees and nursing facilities paying provider fees may occur if the State share of the increases can be funded with provider fees.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

MEDICAID RECIPIENT APPEALS

SECTION #.(a) G.S. 108A-70.9A reads as rewritten:

"**§ 108A-70.9A. Appeals by Medicaid recipients.**

(a) Definitions. – The following definitions apply in this Part, unless the context clearly requires otherwise.

(1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid service.

(2) OAH. – The Office of Administrative Hearings.

(3) Recipient. – A recipient ~~and~~ or the recipient's ~~parent, guardian, or legal representative,~~ parent or legal guardian, unless otherwise specified.

(b) General Rule. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the Department.

(c) Adverse Notice. – Except as otherwise provided by federal law or regulation, at least 10 days before the effective date of an adverse determination, the Department shall notify the recipient, and the provider, if applicable, in writing of the adverse determination and of the recipient's right to appeal the adverse determination. The Department shall not be required to notify a recipient's ~~parent, guardian, or legal representative~~ parent or legal guardian unless the recipient's ~~parent, guardian, or legal representative~~ parent or legal guardian has requested in writing to receive the notice. The notice shall be mailed on the date indicated on the notice as the date of the determination. The notice shall include:

(1) An identification of the recipient whose services are being affected by the adverse determination, including the recipient's full name and Medicaid identification number.

(2) An explanation of what service is being denied, terminated, suspended, or reduced and the reason for the determination.

(3) The specific regulation, statute, or medical policy that supports or requires the adverse determination.

(4) The effective date of the adverse determination.

(5) An explanation of the recipient's right to appeal the Department's adverse determination in an evidentiary hearing before an administrative law judge.

(6) An explanation of how the recipient can request a hearing and a statement that the recipient may represent himself or herself or use legal counsel, a relative, or other spokesperson.

(7) A statement that the recipient will continue to receive Medicaid services at the level provided on the day immediately preceding the Department's adverse determination or the amount requested by the recipient, whichever is less, if the recipient requests a hearing before the effective date of the

adverse determination. The services shall continue until the hearing is completed and a final decision is rendered.

(8) The ~~name and~~ telephone number of ~~a contact person at the Department~~ the Department's Medicaid Appeals Section and the CARE-LINE to respond in a timely fashion to the recipient's questions.

(9) The telephone number by which the recipient may contact a Legal Aid/Legal Services office.

(10) The individualized Departmental appeal request form described in subsection (e) of this section that the recipient may use to request a hearing.

(d) Appeals. – Except as provided by this section and G.S. 108A-70.9B, a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The recipient shall request a hearing within 30 days of the mailing of the notice required by subsection (c) of this section by ~~sending an~~ properly filing a completed appeal request form ~~to OAH and the Department.~~with OAH. Where a request for hearing concerns the reduction, modification, or termination of Medicaid services, including the failure to act upon a timely request for reauthorization with reasonable promptness, upon the receipt of ~~a timely appeal,~~ an appeal filed within 10 days of the date of the adverse notice, the Department shall reinstate or continue the services ~~to~~ at the level or manner prior to action by the Department as permitted by federal law or ~~regulation.~~ regulation and as required by subdivision (c)(7) of this section. If the hearing request is submitted more than 10 days from the date of the adverse notice, and regardless of whether OAH accepts the appeal and schedules the case for hearing, the Department shall not authorize payment for services at the level provided on the day immediately preceding the Department's adverse determination or the amount requested by the recipient pending the outcome of the appeal. The Department shall immediately forward a copy of the notice to OAH electronically. The information contained in the notice is confidential unless the recipient appeals. OAH may dispose of the records after one year. The Department may not influence, limit, or interfere with the recipient's decision to request a hearing.

(e) Appeal Request Form. – Along with the notice required by subsection (c) of this section, the Department shall also provide the recipient with an appeal request form which shall be no more than one side of one page. Only a completed individualized hearing request form provided by the Department shall be accepted for hearing by OAH. Appeal request forms filed more than 30 days from the date of the adverse notice shall not be accepted for hearing by OAH under any circumstances. Within 24 hours of receipt of a properly filed individualized Departmental appeal request form, OAH shall notify the Department by facsimile or electronic messaging. The form shall include the following:

(1) A statement that in order to request an appeal, the recipient must send the completed individualized Departmental appeal request form by mail or fax to the address or fax number listed on the form within 30 days of ~~mailing of the notice.~~ the date of the adverse notice, which is the date the notice was mailed.

(2) A statement that the completed individualized Departmental request form must be properly filed with OAH on or before the effective date of the adverse notice for maintenance of services to continue during the pendency of the appeal,

~~(2)~~(3) The recipient's name, address, ~~telephone number,~~ and Medicaid identification number.

~~(3)~~(4) A preprinted statement that indicates that the recipient would like to appeal the specific adverse determination of which the recipient was notified in the notice.

~~(4)~~(5) A statement informing the recipient that he or she may choose to be represented by a lawyer, a relative, a friend, or other spokesperson.

~~(5)~~(6) A space for the recipient's signature and ~~date.~~date, telephone number and current address.

(7) If the recipient designates a personal representative, a space for the personal representative's name, telephone number and current address.

(f) Final Decision. – After a hearing before an administrative law judge, the judge shall return the decision and record to the Department in accordance with G.S. 108A-70.9B. The Department shall make a final decision in the case within 20 days of receipt of the decision and record from the administrative law judge and promptly notify the recipient of the final decision and of the right to judicial review of the decision pursuant to Article 4 of Chapter 150B of the General Statutes."

SECTION #.(b) G.S. 108A-70.9B reads as rewritten:

"**§ 108A-70.9A. Appeals by Medicaid recipients.**

(a) Definitions. – The following definitions apply in this Part, unless the context clearly requires otherwise.

(1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid service.

(2) OAH. – The Office of Administrative Hearings.

(3) Recipient. – A recipient and the recipient's parent, guardian, or legal representative, unless otherwise specified.

(b) General Rule. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the Department.

(c) Notice. – Except as otherwise provided by federal law or regulation, at least 10 days before the effective date of an adverse determination, the Department shall notify the recipient, and the provider, if applicable, in writing of the adverse determination and of the recipient's right to appeal the adverse determination. The Department shall not be required to notify a recipient's parent, guardian, or legal representative unless the recipient's parent, guardian, or legal representative has requested in writing to receive the notice. The notice shall be mailed on the date indicated on the notice as the date of the determination. The notice shall include:

(1) An identification of the recipient whose services are being affected by the adverse determination, including the recipient's full name and Medicaid identification number.

(2) An explanation of what service is being denied, terminated, suspended, or reduced and the reason for the determination.

(3) The specific regulation, statute, or medical policy that supports or requires the adverse determination.

(4) The effective date of the adverse determination.

(5) An explanation of the recipient's right to appeal the Department's adverse determination in an evidentiary hearing before an administrative law judge.

(6) An explanation of how the recipient can request a hearing and a statement that the recipient may represent himself or herself or use legal counsel, a relative, or other spokesperson.

(7) A statement that the recipient will continue to receive Medicaid services at the level provided on the day immediately preceding the Department's adverse determination or the amount requested by the recipient, whichever is less, if the recipient requests a hearing before the effective date of the

adverse determination. The services shall continue until the hearing is completed and a final decision is rendered.

(8) The name and telephone number of a contact person at the Department to respond in a timely fashion to the recipient's questions.

(9) The telephone number by which the recipient may contact a Legal Aid/Legal Services office.

(10) The appeal request form described in subsection (e) of this section that the recipient may use to request a hearing.

(d) Appeals. – Except as provided by this section and G.S. 108A-70.9B, a request for a hearing to appeal an adverse determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The recipient shall request a hearing within 30 days of the mailing of the notice required by subsection (c) of this section by sending an appeal request form to OAH and the Department. Where a request for hearing concerns the reduction, modification, or termination of Medicaid services, including the failure to act upon a timely request for reauthorization with reasonable promptness, upon the receipt of a timely appeal, the Department shall reinstate the services to the level or manner prior to action by the Department as permitted by federal law or regulation. The Department shall immediately forward a copy of the notice to OAH electronically. The information contained in the notice is confidential unless the recipient appeals. OAH may dispose of the records after one year. The Department may not influence, limit, or interfere with the recipient's decision to request a hearing.

(e) Appeal Request Form. – Along with the notice required by subsection (c) of this section, the Department shall also provide the recipient with an appeal request form which shall be no more than one side of one page. The form shall include the following:

(1) A statement that in order to request an appeal, the recipient must send the form by mail or fax to the address or fax number listed on the form within 30 days of mailing of the notice.

(2) The recipient's name, address, telephone number, and Medicaid identification number.

(3) A preprinted statement that indicates that the recipient would like to appeal the specific adverse determination of which the recipient was notified in the notice.

(4) A statement informing the recipient that he or she may choose to be represented by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the recipient's signature and date.

(f) Final Decision. – After a hearing before an administrative law judge, the judge shall return the decision and record to the Department in accordance with G.S. 108A-70.9B. The Department shall make a final decision in the case within 20 days of receipt of the decision and record from the administrative law judge and promptly notify the recipient of the final decision and of the right to judicial review of the decision pursuant to Article 4 of Chapter 150B of the General Statutes."

SECTION #.(b) G.S. 108A-70.9B reads as rewritten:

"**§ 108A-70.9B. Contested Medicaid cases.**

(a) Application. – This section applies only to contested Medicaid cases commenced by Medicaid recipients under G.S. 108A-70.9A. Except as otherwise provided by G.S. 108A-70.9A and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid recipient is subject to the provisions of Article 3 of Chapter 150B of the General Statutes. To the extent any provision in this section or G.S. 108A-70.9A conflicts with another provision in Article 3 of Chapter 150B of the General Statutes, this section and G.S. 108A-70.9A control.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid recipient in order to complete the case as quickly as possible.

(1) To the extent possible, OAH shall schedule and hear contested Medicaid cases within 55 days of submission of a ~~request for appeal.~~timely filed completed individualized Departmental appeal request form.

(2) Hearings shall be conducted telephonically or by video technology with all parties, however the recipient may request that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in Wake County, however, for good cause shown, the in-person hearing may be conducted in the county of residence of the recipient or a nearby county. Good cause shall ~~include, but is not limited to,~~ be limited to the recipient's impairments limiting ~~travel or the unavailability of the recipient's treating professional witnesses. The Department shall provide written notice to the recipient of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, and how to request a hearing in the recipient's county of residence.~~travel.

(3) The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing.

(4) The administrative law judge may allow brief extensions of the time limits contained in this section for good cause and to ensure that the record is complete. Good cause includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances. Continuances shall only be granted in accordance with rules adopted by OAH and shall not be granted on the day of the hearing, except for good cause shown. If a petitioner fails to make an appearance at a hearing that has been properly noticed via certified mail by OAH, OAH shall immediately dismiss the contested case, unless the recipient moves to show good cause within three business days of the date of dismissal. Good cause to reopen a contested Medicaid case under these circumstances shall be limited to medical or other documented emergencies involving the recipient or his or her witnesses. A failure to answer the telephone for a properly noticed telephone hearing shall not constitute good cause sufficient to continue the case on the date of the hearing or reopen a previously dismissed contested Medicaid case.

(5) The notice of hearing provided by OAH to the recipient shall include the following information:

a. The recipient's right to examine at a reasonable time before the hearing and during the hearing the contents of the recipient's case file and documents to be used by the Department in the hearing before the administrative law judge.

b. The recipient's right to an interpreter during the appeals process.

c. Circumstances in which a medical assessment may be obtained at agency expense and be made part of the record. Qualifying

circumstances include those in which (i) a hearing involves medical issues, such as a diagnosis, an examining physician's report, or a medical review team's decision; and (ii) the administrative law judge considers it necessary to have a medical assessment other than that performed by the individual involved in making the original decision.

(c) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108A-70.9A(e) or other clear request for a hearing by a Medicaid recipient, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the Department within 24 hours of the resolution by facsimile or electronic messaging. In cases where the mediator only informs OAH of the mediation results, OAH shall transmit the mediation decision to the Department within 24 hours of receipt from the mediator. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested Medicaid case until it has received notice from the mediator assigned that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. Nothing in this subsection shall restrict the right to a contested case hearing.

(d) Burden of Proof. – The recipient has the burden of proof ~~to show entitlement to a requested benefit or the propriety of requested agency action when the agency has denied the benefit or refused to take the particular action. The agency has the burden of proof when the appeal is from an agency determination to impose a penalty or to reduce, terminate, or suspend a previously granted benefit.~~ in all cases heard pursuant to G.S. 108A-70.9A. The party with the burden of proof on any issue has the burden of going forward, and the administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

(e) New Evidence. – The recipient shall be permitted to submit evidence regardless of whether obtained prior to or subsequent to the Department's actions and regardless of whether the Department had an opportunity to consider the evidence in making its adverse determination. When the evidence is received, at the request of the Department, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days to allow for the Department's review of the evidence. Subsequent to review of the evidence, if the Department reverses its original decision, it shall immediately inform the administrative law judge.

(f) Issue for Hearing. – For each adverse determination, the hearing shall determine whether the Department substantially prejudiced the rights of the recipient and if the Department, based upon evidence at the hearing:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(g) Decision. – The administrative law judge assigned to a contested Medicaid case shall hear and decide the case without unnecessary delay. OAH shall send a copy of the audiotape or diskette of the hearing to the agency within five days of completion of the hearing. The judge shall prepare a written decision and send it to the parties. The decision shall be sent together with the record to the agency within 20 days of the conclusion of the hearing."

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

DEPARTMENT TO DETERMINE COST SAVINGS FOR MEDICAID THAT WOULD RESULT FROM PROVISION OF MUSCULOSKELETAL HEALTH SERVICES

SECTION #.(a) The Department of Health and Human Services shall study and determine the cost savings that would result for Medicaid if the following measures were implemented:

(1) Healthcare providers who have expertise in musculoskeletal conditions and who are willing to assist emergency departments were identified.

(2) Evidence-based medical criteria were developed, implemented, and supported for high cost/high risk elective musculoskeletal procedures.

(3) Patient management services were provided to primary care and emergency department physicians who provided musculoskeletal services.

SECTION #.(b) The Department shall report its findings to the House and Senate Appropriations Subcommittees on Health and Human Services and to the Fiscal Research Division of the General Assembly on or before October 1, 2011.

DRAFT
SPECIAL PROVISION

2011-DHHS-H64

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

MEDICAID PROVIDER RATE ADJUSTMENTS

SECTION #.(a) Subject to the limitations contained in Section #(a)(7) a. and b. of this act, the Secretary of Health and Human Services shall reduce Medicaid provider rates for all Medicaid providers by two percent (2%) except as follows:

(1) Physician Services. – The provider rate for physicians shall not be reduced.

(2) Hospital Inpatient Services. – The provider rate for inpatient hospital services shall be reduced by a percentage equal to two percent (2%) plus a percentage sufficient to achieve the amount of savings that would have resulted if provider rates for physicians had been reduced by two percent (2%). The provider rate for inpatient hospital services shall be further reduced to offset any reduction or inflationary freeze attributable to outpatient hospital services or to critical access hospitals.

SECTION #.(b) The rate reductions required by this section shall take effect in accordance with the following schedule:

(1) October 1, 2011. – The provider rate reductions required by subsection (a) of this section shall take effect on October 1, 2011. However, the reductions shall be adjusted by a percentage sufficient to yield savings as if the reductions had taken effect on July 1, 2011.

(2) July 1, 2012. – On July 1, 2012, the provider rate reductions required by subsection (a) of this section shall be adjusted to the level at which they would have been without the adjustment required by subdivision (1) of this subsection.

SECTION #.(c) No other adjustments to the provider rates for hospital outpatient or critical access hospital rates shall be made.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION

2011-DHHS-H65

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

DHHS SAVINGS THROUGH CCNC

SECTION #.(a) The Department of Health and Human Services, in conjunction with Community Care of North Carolina Networks and North Carolina Community Care, Inc., shall obtain savings totaling eighty million dollars ($80,000,000) through cooperation and effective cost savings on the part of various health care providers.

SECTION #.(b) The Department of Health and Human Services shall monitor the performance of the CCNC Networks and the expenditures of various healthcare providers to determine the extent to which the savings required by subsection (a) of this section are being achieved.

SECTION #.(c) On or before October 1, 2011, and quarterly thereafter, the Department shall report to the House and Senate Appropriations Subcommittees on Health and Human Services and to the Fiscal Research Division of the General Assembly on the savings being achieved pursuant to this section.

SECTION #.(d) If by October 1, 2011, savings are not being achieved at a rate sufficient to yield savings in the amount required by subsection (a) of this section, the Secretary of Health and Human Services shall to the extent required in order to achieve savings at the required rate take whatever actions are necessary, including the following, in the following order, to be effective January 1, 2012:

(1) Reduce Medicaid provider rates by up to two percent (2%). This reduction shall be in addition to other provider rate reductions in this act.

(2) Eliminate or reduce the level or duration of optional Medicaid services.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H41**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

ELIMINATE ADOPTION ASSISTANCE VENDOR PAYMENTS

SECTION #.(a) The Department of Health and Human Services, Division of Social Services, is authorized to eliminate the Adoption Assistance Vendor payments for all adoptions finalized on or after July 1, 2011. All agreements entered into prior to July 1, 2011, shall remain in effect.

SECTION #.(b) Eligibility for Adoption Assistance is clarified to mean that only children who have been in foster care are eligible for Adoption Assistance.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION

2011-DHHS-H39

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

REPEAL STATE ABORTION FUND

SECTION #. Section 93 of Chapter 479 of the 1985 Session Laws, as amended by Section 75 of Chapter 738 of the 1987 Session Laws, Section 72 of Chapter 500 of the 1989 Session Laws, Section 79 of Chapter 1066 of the 1989 Session Laws, Section 106 of Chapter 689 of the 1991 Session Laws, Section 259.1 of Chapter 321 of the 1993 Session Laws, Section 23.27 of Chapter 324 of the 1995 Session Laws, and Section 23.8A of Chapter 507 of the 1995 Session Laws, is repealed.

DRAFT
SPECIAL PROVISION

2011-DHHS-H56

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

CHILD WELFARE POSTSECONDARY SUPPORT PROGRAM

SECTION #.(a) Of the funds appropriated from the General Fund to the Department of Health and Human Services, the sum of one million five hundred eighty-four thousand one hundred twenty-five dollars ($1,584,125) for the 2011-2012 fiscal year and one million five hundred eighty-four thousand one hundred twenty-five dollars ($1,584,125) for the 2012-2013 fiscal year shall be used to support the child welfare postsecondary support program for the educational needs of foster youth aging out of the foster care system and special needs children adopted from foster care after age 12 by providing assistance with the "cost of attendance" as that term is defined in 20 U.S.C. § 1087ll.

Funds appropriated by this subsection shall be allocated by the State Education Assistance Authority.

SECTION #.(b) Of the funds appropriated from the General Fund to the Department of Health and Human Services the sum of fifty thousand dollars ($50,000) for the 2011-2012 fiscal year and the sum of fifty thousand dollars ($50,000) for the 2012-2013 fiscal year shall be allocated to the North Carolina State Education Assistance Authority (SEAA). The SEAA shall use these funds only to perform administrative functions necessary to manage and distribute scholarship funds under the child welfare postsecondary support program.

SECTION #.(c) Of the funds appropriated from the General Fund to the Department of Health and Human Services the sum of three hundred thirty-nine thousand four hundred ninety-three dollars ($339,493) for the 2011-2012 fiscal year and the sum of three hundred thirty-nine thousand four hundred ninety-three dollars ($339,493) for the 2012-2013 fiscal year shall be used to contract with an entity to administer the child welfare postsecondary support program described under subsection (a) of this section, which development and administration shall include the performance of case management services.

SECTION #.(d) Funds appropriated to the Department of Health and Human Services for the child welfare postsecondary support program shall be used only for students attending public institutions of higher education in this State.

DRAFT
SPECIAL PROVISION

2011-DHHS-H57

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

TANF BENEFIT IMPLEMENTATION

SECTION #.(a) The General Assembly approves the plan titled "North Carolina Temporary Assistance for Needy Families State Plan FY 2010-2012," prepared by the Department of Health and Human Services and presented to the General Assembly. The North Carolina Temporary Assistance for Needy Families State Plan covers the period October 1, 2010, through September 30, 2012. The Department shall submit the State Plan, as revised in accordance with subsection (b) of this section, to the United States Department of Health and Human Services, as amended by this act or any other act of the 2009 General Assembly.

SECTION #.(b) The counties approved as Electing Counties in the North Carolina Temporary Assistance for Needy Families State Plan FY 2010-2012, as approved by this section are: Beaufort, Caldwell, Catawba, Lenoir, Lincoln, Macon, and Wilson.

SECTION #.(c) Counties that submitted the letter of intent to remain as an Electing County or to be redesignated as an Electing County and the accompanying county plan for fiscal years 2009 through 2011, pursuant to G.S. 108A-27(e), shall operate under the Electing County budget requirements effective July 1, 2009. For programmatic purposes, all counties referred to in this subsection shall remain under their current county designation through September 30, 2012.

SECTION #.(d) For the 2011-2012 fiscal year, Electing Counties shall be held harmless to their Work First Family Assistance allocations for the 2008-2009 fiscal year, provided that remaining funds allocated for Work First Family Assistance and Work First Diversion Assistance are sufficient for payments made by the Department on behalf of Standard Counties pursuant to G.S. 108A-27.11(b).

SECTION #.(e) In the event that Departmental projections of Work First Family Assistance and Work First Diversion Assistance for the 2010-2011 fiscal year indicate that remaining funds are insufficient for Work First Family Assistance and Work First Diversion Assistance payments to be made on behalf of Standard Counties, the Department is authorized to deallocate funds, of those allocated to Electing Counties for Work First Family Assistance in excess of the sums set forth in G.S. 108A-27.11, up to the requisite amount for payments in Standard Counties. Prior to deallocation, the Department shall obtain approval by the Office of State Budget and Management. If the Department adjusts the allocation set forth in subsection (d) of this section, then a report shall be made to the Joint Legislative Commission on Governmental Operations, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: **Representative**

PAYMENTS FOR LIEAP/CIP/UTILITY PAYMENTS ONLY

SECTION #. Part 1 of Article 2 of Chapter 108A of the General Statutes is amended by adding the following new section to read:

"**§ 108A-25.4. Use of payments under the Low-Income Energy Assistance Program and Crisis Intervention Program.**

Any payments a recipient is eligible to receive from the Low-Income Energy Assistance Program or the Crisis Intervention Program shall be used for the payment of utility services only. The county department of social services shall make payments on behalf of the recipient directly to the utility services vendor designated by the recipient. A recipient who uses payments in violation of this section shall be subject to action by the county department of social services in accordance with rules adopted by the Commission. For purposes of this section, 'utility services' means services provided for the purpose of heating or cooling a residential dwelling."

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2011

DRAFT
SPECIAL PROVISION **2011-DHHS-H58**

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

CONSOLIDATE BLIND, DEAF, AND VOCATIONAL REHABILITATION DIVISIONS

SECTION #. On or before January 1, 2012, the Department of Health and Human Services shall consolidate the Division of Services for the Blind, the Division of Services for the Deaf and the Hard of Hearing, and the Division of Vocational Rehabilitation into one division within the Department for the provision of these services.

Department of Health and Human Services
Appropriations Subcommittee on Health and Human Services

Requested by: Representative

DHHS BLOCK GRANTS

SECTION #.(a) Appropriations from federal block grant funds are made for the fiscal year ending June 30, 2012, according to the following schedule:

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) FUNDS

Local Program Expenditures

Division of Social Services

01.	Work First Family Assistance	$ 80,840,356
02.	Work First County Block Grants	94,453,315
03.	Work First Electing Counties	2,378,213
04	Adoption Services – Special Children's Adoption Fund	3,609,355
05.	Family Violence Prevention	2,200,000
06.	Child Protective Services – Child Welfare Workers for Local DSS	14,452,391
07.	Child Welfare Collaborative	754,115
08.	Child Advocacy Centers	375,000

Division of Child Development

09.	Subsidized Child Care Program	67,439,721

Division of Public Health

10.	Teen Pregnancy Initiatives	450,000

DHHS Administration

11.	Division of Social Services	1,093,176

12.	Office of the Secretary	75,392

Transfers to Other Block Grants

Division of Child Development

13.	Transfer to the Child Care and Development Fund	82,210,675
14.	Transfer to Social Services Block Grant for Child Protective Services – Child Welfare Training in Counties	1,300,000
15.	Transfer to Social Services Block Grant for Foster Care Services	650,829
16.	Transfer to Social Services Block Grant for Child Protective Services	5,040,000
17.	Transfer to Social Services Block Grant for Adult Protective Services	1,191,925

TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) FUNDS $358,514,463

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS

Local Program Expenditures

Division of Social Services

01.	NC FAST	$ 1,664,936
02.	Work First – Boys and Girls Clubs	2,500,000
03.	Maternity Homes	943,002

Division of Public Health

04.	Teen Pregnancy Initiatives	2,500,000

DHHS Administration

05.	Division of Social Services	1,389,084

TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS $8,997,022

SOCIAL SERVICES BLOCK GRANT

Local Program Expenditures

Divisions of Social Services and Aging and Adult Services

01.	County Departments of Social Services	$ 30,710,585
02.	Child Protective Services (Transfer from TANF)	5,040,000
03.	Adult Protective Services (Transfer from TANF)	1,191,925
04.	State In-Home Services Fund	2,101,113
05.	State Adult Day Care Fund	2,155,301
06.	Child Protective Services/CPS Investigative Services-Child Medical Evaluation Program	609,455
07.	Foster Care Services (Transfer from TANF $650,829)	2,147,967
08.	Special Children Adoption Incentive Fund	78,198
09.	Child Protective Services-Child Welfare Training for Counties (Transfer from TANF)	1,300,000
10.	Home and Community Care Block Grant (HCCBG)	1,834,077

Division of Central Management and Support

11.	ALS Association Jim Catfish Hunter Chapter	400,000

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

12.	Mental Health Services Program	422,003
13.	Developmental Disabilities Services Program	5,000,000
14.	Mental Health Services-Adult and Child/Developmental Disabilities Program/ Substance Abuse Services-Adult	3,234,601

Division of Public Health

15.	Prevent Blindness	150,000

Division of Vocational Rehabilitation

16.	Vocational Rehabilitation Services – Easter Seal Society/UCP Community Health Program	188,263
	DHHS Program Expenditures	
	Division of Aging and Adult Services	
17.	UNC-CARES Training Contract	247,920
	Division of Services for the Blind	
18.	Independent Living Program	3,633,077
19.	Accessible Electronic Information for Blind and Disabled Persons	75,000
	Division of Health Service Regulation	
20.	Adult Care Licensure Program	411,897
21.	Mental Health Licensure and Certification Program	205,668
	DHHS Administration	
22.	Division of Aging and Adult Services	688,436
23.	Division of Social Services	892,624
24.	Office of the Secretary/Controller's Office	138,058
25.	Office of the Secretary/DIRM	87,483
26.	Division of Child Development	15,000
27.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	29,665
28.	Division of Health Service Regulation	235,625
29.	Office of the Secretary-NC Interagency Council for Coordinating Homeless Programs	250,000
30.	Office of the Secretary	48,053
	Transfers to Other Block Grants	
	Division of Public Health	
31.	Transfer to Preventive Health Services Block Grant for HIV/STD Prevention and Community Planning	145,819

TOTAL SOCIAL SERVICES BLOCK GRANT		$ 63,667,813
LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT		
Local Program Expenditures		
Division of Social Services		
01.	Low-Income Energy Assistance Program (LIEAP)	$ 46,677,488
02.	Crisis Intervention Program (CIP)	18,905,645
Local Administration		
Division of Social Services		
03.	County DSS Administration	5,296,962
DHHS Administration		
04.	Office of the Secretary/DIRM	276,784
05.	Office of the Secretary/Controller's Office	12,332
Transfers to Other State Agencies		
Department of Commerce		
06.	Weatherization Program	500,000
07.	Heating Air Repair and Replacement Program (HARRP)	4,744,344
08.	Local Residential Energy Efficiency Service Providers – Weatherization	25,000
09.	Local Residential Energy Efficiency Service Providers – HARRP	227,038
10.	Department of Commerce Administration – Weatherization	25,000
11.	Department of Commerce Administration – HARRP	227,038
TOTAL LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT		$ 76,917,631
CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT		

Local Program Expenditures		
Division of Child Development		
01.	Subsidized Child Care Services (CCDF)	$151,534,624
02.	Electronic Tracking System	3,336,345
03.	Subsidized Child Care Services (Transfer from TANF)	82,210,675
04.	Quality and Availability Initiatives (TEACH Program $3,800,000)	25,948,434
Division of Social Services		
05.	Local Subsidized Child Care Services Support (4% Administrative Allowance)	16,471,587
DHHS Administration		
Division of Child Development		
06.	DCD Administrative Expenses	6,539,277
Division of Central Administration		
07.	DHHS Central Administration – DIRM Technical Services	774,317
TOTAL CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT		$ 286,815,255

MENTAL HEALTH SERVICES BLOCK GRANT

Local Program Expenditures		
01.	Mental Health Services – Adult	$ 6,656,212
02.	Mental Health Services – Child	5,121,991
03.	Administration	100,000
TOTAL MENTAL HEALTH SERVICES BLOCK GRANT		$ 11,878,203

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

Local Program Expenditures		
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services		
01.	Substance Abuse Services – Adult	$ 20,008,541

02.	Substance Abuse Treatment Alternative for Women	8,107,303
03.	Substance Abuse – HIV and IV Drug	5,116,378
04.	Substance Abuse Prevention – Child	7,186,857
05.	Substance Abuse Services – Child	4,940,500
06.	Institute of Medicine	250,000
07.	Administration	250,000
	Division of Public Health	
08.	Risk Reduction Projects	633,980
09.	Aid-to-Counties	209,576
TOTAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT		$ 46,703,135

MATERNAL AND CHILD HEALTH BLOCK GRANT

Local Program Expenditures

	Division of Public Health	
01.	Children's Health Services	8,528,156
02.	Women's Health	8,510,783
03.	Oral Health	42,268

DHHS Program Expenditures

	Division of Public Health	
04.	Children's Health Services	1,417,087
05.	Women's Health	136,628
06.	State Center for Health Statistics	164,318
07.	Quality Improvement in Public Health	1,636
08.	Health Promotion	89,374
09.	Office of Minority Health	40,141

DHHS Administration		
Division of Public Health		
10.	Division of Public Health Administration	631,966
TOTAL MATERNAL AND CHILD HEALTH BLOCK GRANT		$ 19,562,357

PREVENTIVE HEALTH SERVICES BLOCK GRANT

Local Program Expenditures		
Division of Public Health		
01.	NC Statewide Health Promotion	$1,730,653
02.	Services to Rape Victims	89,152
03.	HIV/STD Prevention and Community Planning (Transfer from Social Services Block Grant)	145,819
DHHS Program Expenditures		
Division of Public Health		
04.	State Center for Health Statistics	55,040
05.	NC Statewide Health Promotion	947,056
06.	Oral Health	70,000
07.	State Laboratory of Public Health	16,600
08.	Services to Rape Victims	107,960
TOTAL PREVENTIVE HEALTH SERVICES BLOCK GRANT		$3,162,280

COMMUNITY SERVICES BLOCK GRANT

Local Program Expenditures		
Office of Economic Opportunity		
01.	Community Action Agencies	$ 18,075,488
02.	Limited Purpose Agencies	1,004,194
DHHS Administration		

03.	Office of Economic Opportunity	1,004,194
TOTAL COMMUNITY SERVICES BLOCK GRANT		$ 20,083,876

GENERAL PROVISIONS

SECTION #.(b) Information to Be Included in Block Grant Plans. – The Department of Health and Human Services shall submit a separate plan for each Block Grant received and administered by the Department, and each plan shall include the following:

(1) A delineation of the proposed allocations by program or activity, including State and federal match requirements.

(2) A delineation of the proposed State and local administrative expenditures.

(3) An identification of all new positions to be established through the Block Grant, including permanent, temporary, and time-limited positions.

(4) A comparison of the proposed allocations by program or activity with two prior years' program and activity budgets and two prior years' actual program or activity expenditures.

(5) A projection of current year expenditures by program or activity.

(6) A projection of federal Block Grant funds available, including unspent federal funds from the current and prior fiscal years.

SECTION #.(c) Changes in Federal Fund Availability. – If the Congress of the United States increases the federal fund availability for any of the Block Grants or contingency funds and other grants related to existing Block Grants administered by the Department of Health and Human Services from the amounts appropriated in this section, the Department shall allocate the increase proportionally across the program and activity appropriations identified for that Block Grant in this section. In allocating an increase in federal fund availability, the Office of State Budget and Management shall not approve funding for new programs or activities not appropriated in this section.

If the Congress of the United States decreases the federal fund availability for any of the Block Grants or contingency funds and other grants related to existing Block Grants administered by the Department of Health and Human Services from the amounts appropriated in this section, the Department shall reduce State administration by at least the percentage of the reduction in federal funds. After determining the State administration, the remaining reductions shall be allocated proportionately across the program and activity appropriations identified for that Block Grant in this section. The Office of State Budget and Management shall report on these changes.

Prior to allocating the change in federal fund availability, the proposed allocation must be approved by the Office of State Budget and Management. If the Department adjusts the allocation of any Block Grant due to changes in federal fund availability, then a report shall be made to the Joint Legislative Commission on Governmental Operations, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION #.(d) Appropriations from federal Block Grant funds are made for the fiscal year ending June 30, 2012, according to the schedule enacted for State fiscal year 2011-2012 or until a new schedule is enacted by the General Assembly.

SECTION #.(e) All changes to the budgeted allocations to the Block Grants or contingency funds and other grants related to existing Block Grants administered by the Department of Health and Human Services that are not specifically addressed in this section shall be approved by the Office of State Budget and Management, and the Office of State Budget and Management shall consult with the Joint Legislative Commission on Governmental Operations for review prior to implementing the changes. The report shall include an itemized

listing of affected programs, including associated changes in budgeted allocations. All changes to the budgeted allocations to the Block Grants shall be reported immediately to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division. This subsection does not apply to Block Grant changes caused by legislative salary increases and benefit adjustments.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) FUNDS

SECTION #.(f) The sum of one million ninety-three thousand one hundred seventy-six dollars ($1,093,176) appropriated in this section in TANF funds to the Department of Health and Human Services, Division of Social Services, for the 2011-2012 fiscal year shall be used to support administration of TANF-funded programs.

SECTION #.(g) The sum of two million two hundred thousand dollars ($2,200,000) appropriated under this section in TANF funds to the Department of Health and Human Services, Division of Social Services, for the 2011-2012 fiscal year shall be used to provide domestic violence services to Work First recipients. These funds shall be used to provide domestic violence counseling, support, and other direct services to clients. These funds shall not be used to establish new domestic violence shelters or to facilitate lobbying efforts. The Division of Social Services may use up to seventy-five thousand dollars ($75,000) in TANF funds to support one administrative position within the Division of Social Services to implement this subsection.

Each county department of social services and the local domestic violence shelter program serving the county shall develop jointly a plan for utilizing these funds. The plan shall include the services to be provided and the manner in which the services shall be delivered. The county plan shall be signed by the county social services director or the director's designee and the domestic violence program director or the director's designee and submitted to the Division of Social Services by December 1, 2011. The Division of Social Services, in consultation with the Council for Women, shall review the county plans and shall provide consultation and technical assistance to the departments of social services and local domestic violence shelter programs, if needed.

The Division of Social Services shall allocate these funds to county departments of social services according to the following formula: (i) each county shall receive a base allocation of five thousand dollars ($5,000); and (ii) each county shall receive an allocation of the remaining funds based on the county's proportion of the statewide total of the Work First caseload as of July 1, 2011, and the county's proportion of the statewide total of the individuals receiving domestic violence services from programs funded by the Council for Women as of July 1, 2011. The Division of Social Services may reallocate unspent funds to counties that submit a written request for additional funds.

SECTION #.(h) The sum of fourteen million four hundred fifty-two thousand three hundred ninety-one dollars ($14,452,391) appropriated in this section to the Department of Health and Human Services, Division of Social Services, in TANF funds for the 2011-2012 fiscal year for child welfare improvements shall be allocated to the county departments of social services for hiring or contracting staff to investigate and provide services in Child Protective Services cases; to provide foster care and support services; to recruit, train, license, and support prospective foster and adoptive families; and to provide interstate and postadoption services for eligible families.

SECTION #.(i) The sum of three million six hundred nine thousand three hundred fifty-five dollars ($3,609,355) appropriated in this section in TANF funds to the Department of Health and Human Services, Special Children Adoption Fund, for the 2011-2012 fiscal year shall be used in accordance with G.S. 108A-50.2, as enacted in Section 10.48 of S.L. 2009-451.

The Division of Social Services, in consultation with the North Carolina Association of County Directors of Social Services and representatives of licensed private adoption agencies, shall develop guidelines for the awarding of funds to licensed public and private adoption agencies upon the adoption of children described in G.S. 108A-50 and in foster care. Payments received from the Special Children Adoption Fund by participating agencies shall be used exclusively to enhance the adoption services program. No local match shall be required as a condition for receipt of these funds.

SECTION #.(j) The sum of seven hundred fifty-four thousand one hundred fifteen dollars ($754,115) appropriated in this section to the Department of Health and Human Services in TANF funds for the 2011-2012 fiscal year shall be used to continue support for the Child Welfare Collaborative.

SECTION #.(k) The sum of three hundred seventy-five thousand dollars ($375,000) appropriated in this section to the Department of Health and Human Services in TANF funds for the 2011-2012 fiscal year shall be used to continue support for the Child Advocacy Centers.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) CONTINGENCY FUNDS

SECTION #.(l) The sum of two million five hundred thousand dollars ($2,500,000) appropriated in this section to the Department in TANF funds for Boys and Girls Clubs for the 2011-2012 fiscal year shall be used to make grants for approved programs. The Department of Health and Human Services, in accordance with federal regulations for the use of TANF Contingency funds, shall administer a grant program to award funds to the Boys and Girls Clubs across the State in order to implement programs that improve the motivation, performance, and self-esteem of youths and to implement other initiatives that would be expected to reduce gang participation, school dropout, and teen pregnancy rates. The Department shall facilitate collaboration between the Boys and Girls Clubs and Support Our Students, Communities in Schools, and similar programs and encourage them to submit joint applications for the funds if appropriate.

SECTION #.(m) The sum of one million three hundred eighty-nine thousand eighty-four dollars ($1,389,084) appropriated in this section in TANF Contingency funds to the Department of Health and Human Services, Division of Social Services, for the 2011-2012 fiscal year shall be used to support administration of TANF-funded programs.

SOCIAL SERVICES BLOCK GRANT

SECTION #.(n) The sum of one million three hundred thousand dollars ($1,300,000) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2011-2012 fiscal year shall be used to support various child welfare training projects as follows:

(1) Provide a regional training center in southeastern North Carolina.

(2) Provide training for residential child caring facilities.

(3) Provide for various other child welfare training initiatives.

SECTION #.(o) The sum of two million one hundred forty-seven thousand nine hundred sixty-seven dollars ($2,147,967) appropriated in this section in the Social Services Block Grant for child caring agencies for the 2011-2012 fiscal year shall be allocated in support of State foster home children.

SECTION #.(p) The Department of Health and Human Services is authorized, subject to the approval of the Office of State Budget and Management, to transfer Social Services Block Grant funding allocated for departmental administration between divisions that have received administrative allocations from the Social Services Block Grant.

SECTION #.(q) Social Services Block Grant funds appropriated for the Special Children's Adoption Incentive Fund will require a fifty percent (50%) local match.

SECTION #.(r) The sum of four hundred twenty-two thousand three dollars ($422,003) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2011-2012 fiscal year shall be used to continue a Mental Health Services Program for children.

SECTION #.(s) The sum of five million forty thousand dollars ($5,040,000) appropriated in this section in the Social Services Block Grant for the 2011-2012 fiscal year shall be allocated to the Department of Health and Human Services, Division of Social Services. The Division shall allocate these funds to local departments of social services to replace the loss of Child Protective Services State funds that are currently used by county government to pay for Child Protective Services staff at the local level. These funds shall be used to maintain the number of Child Protective Services workers throughout the State. These SSBG funds shall be used to pay for salaries and related expenses only and are exempt from 10A NCAC 71R .0201(3) requiring a local match of twenty-five percent (25%).

SECTION #.(t) The sum of four hundred thousand dollars ($400,000) appropriated in this section in the Social Service Block Grant for the 2011-2012 fiscal year to the Department of Health and Human Services, Division of Central Management and Support, shall be allocated to the ALS Association, Jim "Catfish" Hunter Chapter, to be used to provide patient care and community services to persons with ALS and their families.

SECTION #.(u) The sum of one hundred fifty thousand dollars ($150,000) appropriated in this section in the Social Service Block Grant for the 2011-2012 fiscal year to the Department of Health and Human Services, Division of Public Health, shall be allocated to Prevent Blindness North Carolina to be used for direct service programs.

SECTION #.(v) The sum of seventy-five thousand dollars ($75,000) appropriated in this section in the Social Service Block Grant for the 2011-2012 fiscal year to the Department of Health and Human Services, Division of Services for the Blind, shall be used to provide accessible electronic information for blind and disabled persons.

LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT

SECTION #.(w) Additional emergency contingency funds received may be allocated for Energy Assistance Payments or Crisis Intervention Payments without prior consultation with the Joint Legislative Commission on Governmental Operations. Additional funds received shall be reported to the Joint Legislative Commission on Governmental Operations and the Fiscal Research Division upon notification of the award. The Department of Health and Human Services shall not allocate funds for any activities, including increasing administration, other than assistance payments, without prior consultation with the Joint Legislative Commission on Governmental Operations.

SECTION #.(x) The sum of five million one hundred sixty thousand five hundred ten dollars ($5,160,510) appropriated in this section in the Low-Income Home Energy Assistance Block Grant for the 2011-2012 fiscal year to the Department of Health and Human Services, Division of Social Services, shall be used for energy assistance payments for the households of (i) elderly persons age 60 and above with income up to one hundred thirty percent (130%) of the federal poverty level and (ii) disabled persons eligible for services funded by the Home and Community Care Block Grant.

CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT

SECTION #.(y) Payment for subsidized child care services provided with federal TANF funds shall comply with all regulations and policies issued by the Division of Child Development for the subsidized child care program.

SECTION #.(z) If funds appropriated through the Child Care and Development Fund Block Grant for any program cannot be obligated or spent in that program within the obligation or liquidation periods allowed by the federal grants, the Department may move funds to child care subsidies, unless otherwise prohibited by federal requirements of the grant, in order to use the federal funds fully.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

SECTION #.(aa) The sum of two hundred fifty thousand dollars ($250,000) appropriated in this section in the Substance Abuse Prevention and Treatment Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2011-2012 fiscal year for the North Carolina Institute of Medicine (NCIOM) shall be used to continue its Task Force on the mental health, social, and emotional needs of young children and their families. In addition to the issues identified in Section 16.1 of S.L. 2010-152, the Task Force shall study the impact of parents' substance use problems on the mental health and social and emotional well-being of children from conception through age five. The NCIOM shall make an interim report to the General Assembly no later than January 15, 2012, which may include legislative and other recommendations, and shall issue its final report with findings, recommendations, and any proposed legislation to the 2013 General Assembly upon its convening.

MATERNAL AND CHILD HEALTH BLOCK GRANT

SECTION #.(bb) The sum of one million four hundred ninety-seven thousand dollars ($1,497,000) appropriated in this section in the Maternal and Child Health Block Grant for the 2011-2012 fiscal year to the Department of Health and Human Services, Division of Public Health, shall be used to fund the following activities as indicated:

(1) Folic acid for uninsured pregnant women, the sum of three hundred fifty thousand dollars ($350,000).

(2) Teen Pregnancy Prevention, the sum of six hundred fifty thousand dollars ($650,000).

(3) Healthy Start/Safe Sleep, the sum of two hundred forty-seven thousand dollars ($247,000).

(4) Perinatal Quality Collaborative of North Carolina, the sum of two hundred fifty thousand dollars ($250,000).

SECTION #.(cc) If federal funds are received under the Maternal and Child Health Block Grant for abstinence education, pursuant to section 912 of Public Law 104-193 (42 U.S.C. § 710), for the 2011-2012 fiscal year, then those funds shall be transferred to the State Board of Education to be administered by the Department of Public Instruction. The Department of Public Instruction shall use the funds to establish an abstinence until marriage education program and shall delegate to one or more persons the responsibility of implementing the program and G.S. 115C-81(e1)(4) and (4a). The Department of Public Instruction shall carefully and strictly follow federal guidelines in implementing and administering the abstinence education grant funds.

SECTION #.(dd) The Department of Health and Human Services shall ensure that there will be follow-up testing in the Newborn Screening Program.