2013

SENATE APPROPRIATIONS – HEALTH & HUMAN SERVICES (JOINT)

MINUTES

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

February 14, 2013
Legislative Office Building - Room 643
8:30 a.m.

Senator Ralph Hise, Presiding Chair

State Auditor Audit Division of Medical Assistance Session Law 2012-142, Section 10.9A; Session Law 2012-145, Section 3.3	Susan Jacobs Committee Staff Fiscal Research Division
Beth A. Wood State Auditor	Performance Audit Department of Health and Human Services- Medicaid Program
Adjourn	
Next Meeting:	February 19, 2013- 8:30 a.m.

Senate Committee on Appropriations on Health and Human Services
Thursday, February 14, 2013 at 8:30 a.m.
Room 643

MINUTES

The Senate Committee on Appropriations on Health and Human Services met at 8:30 a.m. on February 14, 2013, in Room 643. Representatives Verla Insko, Jean Farmer-Butterfield, Carl Ford, Jim Fulghum, Susan Martin, Donny Lambeth, Marilyn Avila, William Brisson and 5 Senate members were present.

Senator Ralph Hise presided.

Senator Hise recognized the following Sergeants-at-Arms: Young Bae, Martha Gadison and Martha Parrish for the House; Steve Wilson and Leslie Wright assisted the Senate. He also recognized the following Pages for the House: Claire Ledford – Yancey County, TyKayla Martin – Vance County, Zyniah Ryan – Bertie County and Cameron Suddreth – Wilson County. Jessica White from Mocksville assisted for the Senate.

Senator Hise then welcomed everyone and recognized Susan Jacobs with the Fiscal Research Division for comments explaining Session Law 2012-142, Section 10.9A and Session Law 2012-145, Section 3.3 which is "An Act to Modify the Current Operations and Capital Improvements Appropriations Act of 2011 and for Other Purposes." This law states that the State Auditor shall audit the Department of Health and Human Services, the Division of Medical Assistance, and the State Medicaid Program operated within the Department.

Senator Hise welcomed State Auditor Beth Wood and Secretary Aldona Wos and her staff to the meeting. Ms. Wood gave a detailed presentation regarding the performance audit of the Department of Health and Human Resources (see attachments) and explained her findings. Senator Hise opened the floor for members to ask Ms. Wood, which she answered. After a brief question and answer session, Senator Hise asked Secretary Wos if she would like to respond to Ms. Wood's findings. Secretary Wos said that her Department is working tirelessly to correct the issues that were found in the audit, and pledged that the Department of Health and Human Resources would NEVER receive an audit like this one again.

The meeting adjourned at 9:50 a.m.

Senator Ralph Hise
Presiding

Edna Pearce, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 07, 2013 11:01 AM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Thursday, February 14, 2013 at 8:30 AM

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Thursday	February 14, 2013	8:30 AM	643 LOB

State Auditor Wood to discuss Medicaid Audit

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

SESSION LAW 2012-142
(as amended by Section 3.3 of S.L. 2012-145)
HOUSE BILL 950

AN ACT TO MODIFY THE CURRENT OPERATIONS AND CAPITAL IMPROVEMENTS APPROPRIATIONS ACT OF 2011 AND FOR OTHER PURPOSES.

The General Assembly of North Carolina enacts:

PART X. DEPARTMENT OF HEALTH AND HUMAN SERVICES

...

STATE AUDITOR AUDIT DIVISION OF MEDICAL ASSISTANCE

SECTION 10.9A.(a) [As amended by Section 3.3 of S.L. 2012-145] The State Auditor shall audit the Department of Health and Human Services, Division of Medical Assistance, and the State Medicaid Program operated within the Department. The audit shall include the State Auditor's examination of at least all of the following:

(1) The administrative functions and responsibilities of permanent Division staff.

(2) The administrative functions that are performed either partially or entirely through contracts, cooperative agreements, Memorandums of Understanding (MOUs) with external entities, such as independent contractors, private vendors, universities, county governments, and other State or federal agencies. To identify these administrative functions, the State Auditor shall develop an inventory of all administrative contracts for purchased services, including a brief description of the scope of work, cost, and the period of performance for each contract.

(3) The amount of funds, staff, and other resources dedicated to the performance of each administrative function of the Division.

(4) The timeliness and compliance with State and federal mandates when carrying out the functions of the Division, including all of the following:

a. The production of accurate, multiyear projections of Medicaid recipient participation, consumption of services, and costs.

b. The oversight of the Medicaid program to ensure that program participation by Medicaid eligible recipients, consumption of services, and expenditures are within the budget authorized by the General Assembly for each fiscal year, including early detection of expenditure trends that indicate potential budget shortfalls.

c. The timeliness of preparing and submitting Medicaid State Plan amendments to obtain approval from the Centers for Medicare and Medicaid Services to comply with State and federal laws and regulations.

d. The collection, distribution, and maintenance of statistical data and other information on the Medicaid eligible population, eligible recipient participation, consumption of services, Medicaid patient health outcomes, provider participation and related issues, and costs.

e. The timeliness of distribution and the presentation of complete and accurate information with supportive documentation to the Secretary of the Department of Health and Human Services, the Governor's

Office, and the General Assembly regarding funding needs and policy issues.

SECTION 10.9A.(b) The State Auditor shall give a preliminary report on the audit required by this section to the Joint Legislative Commission on Governmental Operations and to the Fiscal Research Division by November 1, 2012, and shall complete the audit by February 1, 2013.

SECTION 10.9A.(c) Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, from the General Fund for the 2012-2013 fiscal year to fund contracts, the Department shall transfer to the North Carolina Office of the State Auditor the amount of funds necessary to complete the audit required by this section."

...

EFFECTIVE DATE

SECTION 27.8. Except as otherwise provided, this act becomes effective July 1, 2012.

In the General Assembly read three times and ratified this the 21st day of June, 2012.

s/ Richard Y. Stevens
Presiding Officer of the Senate

s/ Thom Tillis
Speaker of the House of Representatives

VETO Beverly E. Perdue
Governor

Became law notwithstanding the objections of the Governor at 10:41 p.m. this 2nd day of July, 2012.

s/ Sarah Clapp
Senate Principal Clerk

Medicaid Performance Audit Overview

Presentation to Joint Health and Human Services Appropriation Committee

February 14, 2013

Medicaid Performance Audit Overview
February 14, 2013

Authorization

- This audit was authorized by the General Assembly under Section 10.9A of House Bill 950 titled Modify Appropriations Act.

Medicaid Performance Audit Overview
February 14, 2013

Objectives

- To determine if the division's administrative functions complied with State and federal requirements, and allowed for efficient use of funds
- To evaluate the division's processes for preparing annual budgets and monitoring expenditures to determine if it accurately predicted and assessed program costs
- To review the process for State Plan Amendments
- To assess the flow of budget and expenditure information from the division to other stakeholders

Medicaid Performance Audit Overview
February 14, 2013

Administrative Expenses

- Compared to other states with similar medical assistance payment spending, NC administrative costs are significantly higher.

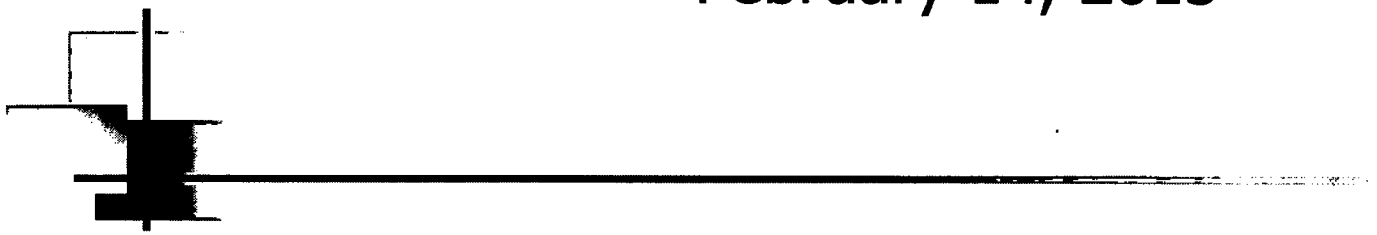
- $180 million above average spending for our nine-state peer group.

Medicaid Performance Audit Overview
February 14, 2013

- The Division of Medical Assistance (DMA) consistently exceeds budgeted amounts for contracted administrative costs.

- DMA only controls about 33% ($256.7 million) of the total administrative expenses for the NC Medicaid program. Other Department of Health and Human Services (DHHS) divisions spend the remaining 67% ($524.3 million), and there is little internal oversight of these expenses.

Medicaid Performance Audit Overview
February 14, 2013



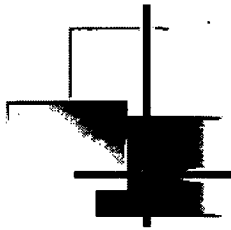
- DHHS does not have a comprehensive Public Assistance Cost Allocation Plan, and DMA does not have a cost allocation plan. Having comprehensive cost allocation plans would allow better management of administrative costs.

Medicaid Performance Audit Overview
February 14, 2013

Budget and Financial Projections

- DMA's budget has significantly exceeded Certified Budget and incurred State General Fund shortfalls of $418.2 million in 2012, $403.6 million in 2011, and $316.7 million in 2010.

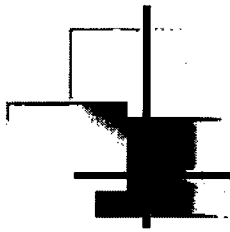
Medicaid Performance Audit Overview
February 14, 2013



- Contrary to state statute, DMA retained $131.8 million of federal funds owed in FY12. Most of this was drug rebate money.

- Directives to achieve budgeted savings were not followed. For example, DMA failed to comply with a legislative mandate to eliminate inflationary increases for nursing facilities.

Medicaid Performance Audit Overview
February 14, 2013



- DMA focuses on forecasts just for medical payments, not all relevant expenses. Known expenditures for personal care services ($41.7 million) and a partial repayment for the 2009 overdraw ($40.9 million), were not included in the 2012 budget. DMA began the year with an $82.6 million shortfall.

Medicaid Performance Audit Overview
February 14, 2013

- DMA does not follow best practices for its forecasting methodology by comparing forecasts to actual budget performance.

- Financial projections do not extend beyond the current biennium. Best practices recommend multi-year forecasts to allow long-term planning.

Medicaid Performance Audit Overview
February 14, 2013

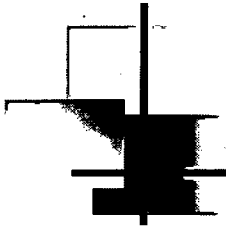
State Plan Amendments

- State Plan Amendments (SPAs) delays have had little impact on shortfalls over the past three years, and the SPA process appears to be effective.

- Projected savings were not realized because DMA's projections did not account for implementation time.

Medicaid Performance Audit Overview
February 14, 2013

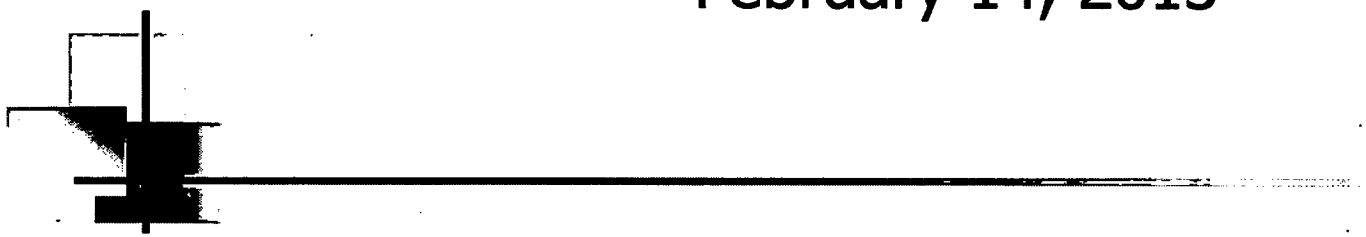
- DMA never intended to retroactively implement SPAs to achieve savings.
- Two problems:
  - Potential provider appeals and/or lawsuits for retroactive implementation
  - Medicaid Management Information System constraints



Reporting

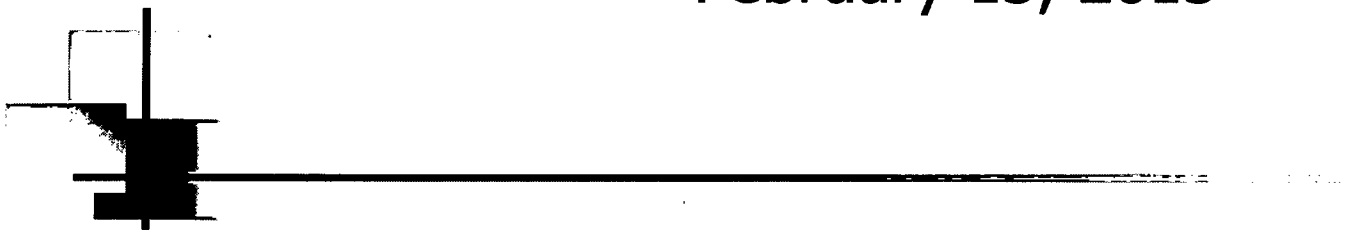
- DMA is not providing timely and useful reports and essential data to stakeholders such as Office of State Budget and Management (OSBM) and Fiscal Research.

Medicaid Performance Audit Overview
February 14, 2013



- Thank you to:
  - The General Assembly for giving us the opportunity to perform this audit
  - Our subject matter experts PHBV
  - My staff, particularly Kenneth Barnette, Laura Bullock, Jane Seo and Eric Faust

Medicaid Performance Audit Overview
February 13, 2013



Questions?

Medicaid Performance Audit – Findings Overview

Administrative Expenses

- Compared to other states with similar medical assistance payment spending, NC administrative costs are significantly higher. In addition, the Division of Medical Assistance (DMA) consistently exceeds budgeted amounts for contracted administrative costs (**page 18, 24**).

- DMA only controls about 33% ($256.7 million) of the total administrative expenses for the NC Medicaid program. Other Department of Health and Human Services (DHHS) divisions spend the remaining 67% ($524.3 million), and there is little internal oversight of these expenses (**page 25**).

- DHHS does not have a comprehensive Public Assistance Cost Allocation Plan, and DMA does not have a cost allocation plan. Having comprehensive cost allocation plans would allow better management of administrative costs (**page 27, 29**).

Budget and Financial Projections

- DMA's budget has significantly exceeded Certified Budget and incurred State General Fund shortfalls of $418.2 million in 2012, $403.6 million in 2011, and $316.7 million in 2010 (**page 36**).

- Contrary to state statute, DMA retained $131.8 million of federal funds owed in FY12. Most of this was drug rebate money (**page 39**).

- Directives to achieve budgeted savings were not followed. For example, DMA failed to comply with a legislative mandate to eliminate inflationary increases for nursing facilities (**page 51**).

- DMA focuses on forecasts for medical payments. Financial projections do not include all relevant expenses. Known expenditures, such as repayments for personal care services ($41.7 million) and an installment repayment for the 2009 overdraw ($40.9 million), were not included in the budget for 2012. Therefore, DMA began the year with an $82.6 million shortfall (**page 43**).

- DMA does not follow best practices to improve its forecasting methodology by comparing forecasts to actual budget performance to determine the reasons for variances (**page 45**).

- Financial projections do not extend beyond the current biennium. Best practices recommend multi-year forecasts to allow policymakers to engage in informed long-term planning (**page 46**).

State Plan Amendments

- State Plan Amendment (SPAs) delays have had little impact on the shortfalls over the last three years, and the SPA process appears to be effective. Projected savings were not realized because DMA's projections did not take into account implementation time, and DMA never intended to retroactively implement the SPAs to achieve the savings due to Medicaid Management Information System (MMIS) constraints and avoidance of potential provider appeals and/or lawsuits for retroactive implementation of these SPAs (**page 59**).

Reporting

- DMA is not providing timely and useful reports and essential data to stakeholders such as Office of State Budget and Management (OSBM) and Fiscal Research (**page 62**).

Attachment 1: Total Administrative Cost Comparison

(Excerpt from page 18 in the Performance Audit Report)

State	Total Cost ($)	Administrative Cost ($)	Admin to Total
Tennessee	7,969,998,389	413,622,139	5.19%
Missouri	8,011,172,212	286,268,889	3.57%
Georgia	8,064,611,365	400,415,522	4.97%
Arizona	8,988,386,558	155,835,205	1.73%
North Carolina	**10,297,057,563**	**648,762,805**	**6.30%**
New Jersey	10,501,136,233	571,374,290	5.44%
Michigan	12,062,932,510	515,345,364	4.27%
Illinois	12,835,985,780	678,614,042	5.29%
Massachusetts	13,007,366,707	555,838,633	4.27%
Average	$10,193,183,035	$469,564,099	4.56%

Source: Center for Medicare and Medicaid Services reports and auditor calculations

Attachment 2: State Plan Amendment Examples

(Excerpt from page 60 in the Performance Audit Report)

SPA	Submission Date	Budget Implementation Date	CMS Approval
10-031	10/25/2010	1/1/2011	4/15/2011
11-001	3/24/2011	1/1/2011	1/17/2012
10-024	9/1/2010	11/1/2010	3/21/2011

Attachment 3

(Excerpt from page 20-21 in the Performance Audit Report)

Title XIX Administrative Resources Expended for the SFYE 6/30/12									
#	Medicaid Administrative Functions	# of Staff	PERSONAL SERVICES	OTHER IN-HOUSE	OUTSOURCED CONTRACTS	TOTAL COMPUTABLE EXPENDITURE(1)	FEDERAL SHARE	NON-FEDERAL SHARE(2)	TC %
1a	Beneficiary Outreach and Enrollment	53.54	3,350,916.94	1,082,891.28	614,483.09	5,048,291.31	2,818,623.63	2,229,667.68	2.5%
1b	Medicaid Admin Claiming (MAC) for School-Based Services (SBS)	-	-	-	47,034,695.29	47,034,695.29	23,517,347.64	23,517,347.65	23.1%
1	Subtotal: Beneficiary Outreach and Enrollment	53.54	3,350,916.94	1,082,891.28	47,649,178.38	52,082,986.60	26,335,971.27	25,747,015.33	25.6%
2	Defining the Scope of Covered Benefits	51	4,422,816.37	61,284.51	242,386.98	4,726,487.86	3,514,610.92	1,211,876.94	2.3%
3	Setting Provider and Plan Payment Rates	26.5	1,799,740.44	71,452.75	4,994,018.24	6,865,211.43	3,845,053.60	3,020,157.83	3.4%
4	Enrolling Providers and Plans	25.46	1,580,127.88	558.17	-	1,580,686.05	790,343.39	790,342.66	0.8%
5	Payment of Providers and Plans	26	2,653,801.00	(1,095.60)	54,492,245.59	57,144,950.99	41,324,222.71	15,820,728.28	28.0%
6	Monitoring Service Quality	32	2,347,461.18	84,386.25	217,627.30	2,649,474.73	1,536,658.08	1,112,816.65	1.3%
7	Ensuring Program Integrity	53	3,477,530.84	1,287,744.60	55,324,260.62	60,089,536.06	41,217,923.89	18,871,612.17	29.5%
8	Processing Appeals	42.5	3,134,469.13	4,874,775.33	-	8,009,244.46	4,027,722.02	3,981,522.44	3.9%
9	Collection and Reporting of Information	1	186,971.76	-	3,289,245.17	3,476,216.93	2,005,490.33	1,470,726.60	1.7%
GA	General Administration	49	3,897,084.71	2,782,454.70	671,797.44	7,351,336.85	3,675,668.43	3,675,668.43	3.6%
	DMA's Total Title XIX Admin Resources	360	26,850,920.25	10,244,451.99	166,880,759.72	203,976,131.96	128,273,664.64	75,702,467.33	100.00%
	Other DMA Claimed Title XIX Expenditures (3)	-	-	52,692,458.69	-	52,692,458.69	51,381,572.10	1,310,886.60	
	Total DMA Resources	360(4)	26,850,920.25	62,936,910.68	166,880,759.72	256,668,590.65	179,655,236.73	77,013,353.92	

NOTES:

(1) Total Computable Expenditure is the total of both federal and state expenditures
(2) Non-Federal Share is the State's portion of expenditures
(3) Other DMA claimed expenditures consist mostly of 100% federally funded payments
(4) Position counts do not include vacancies

Continued on the next page...

Continued from the previous page....

Administrative Costs Incurred in Other DHHS Divisions								
	Disability Determination Section					5,317,998.64	2,658,999.32	2,658,999.32
	Division of Public Health					9,879,947.62	5,564,278.98	4,315,668.64
	Division of Central Administration					164,814,047.00	141,029,132.16	23,784,914.84
	Division of Aging					1,251,001.85	625,500.93	625,500.92
	Division of Child Development					49,304.63	24,652.32	24,652.31
	Office of Education Services					63,156.00	31,578.00	31,578.00
	Division of Social Services					238,290,743.33	119,403,365.23	118,887,378.10
	Division of Health Services Regulation					7,911,281.82	4,652,223.64	3,259,058.18
	Division of Vocational Rehabilitation Services					83,124.67	41,562.34	41,562.33
	Division of Mental Health					96,689,334.43	52,560,655.54	44,128,678.89
	TOTAL TITLE XIX ADMIN EXPENDITURES					781,018,530.64	506,247,185.19	274,771,345.45

Attachment 4: Budgeted vs Actual Expenditures

2009 - 2011

(Excerpt from page 34 in the Performance Audit Report)

DMA Budget Code 14445

Budgeted vs Actual Expenditures 2009 - 2011

Fiscal Year	Actual	Certified Budget	Variance	Percent Over Certified Budget
2012	$14,241,450,471	$12,885,349,949	$1,356,100,522	10.52%
2011	$13,270,350,502	$11,903,629,348	$1,366,721,154	11.48%
2010	$12,838,121,597	$11,046,775,749	$1,791,345,848	16.22%
2009	$12,623,281,487	$11,769,988,426	$853,293,061	7.25%

STATE OF NORTH CAROLINA

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH AND HUMAN SERVICES – DIVISION OF MEDICAL SERVICES

MEDICAID

JANUARY 2013

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

STATE AUDITOR

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH AND HUMAN SERVICES – DIVISION OF MEDICAL SERVICES

MEDICAID

JANUARY 2013

STATE OF NORTH CAROLINA
Office of the State Auditor

Beth A. Wood, CPA
State Auditor

2 S. Salisbury Street
20601 Mail Service Center
Raleigh, NC 27699-0601
Telephone: (919) 807-7500
Fax: (919) 807-7647
Internet
http://www.ncauditor.net

January 31, 2013

The Honorable Pat McCrory, Governor
Members of the North Carolina General Assembly
Dr. Aldona Wos, Secretary, Department of Health and Human Services
Mrs. Carol Steckel, Director, Division of Medical Services

Ladies and Gentlemen:

We are pleased to submit this performance audit titled "*Department of Health and Human Services, Division of Medical Services - Medicaid.*" The audit objectives were (1) to determine if the Divisions' administrative functions, including assigned internal and external resources, complied with the Medicaid State Plan and federal requirements, and provided for an efficient use of State and federal funds; (2) to evaluate the Divisions' processes for preparing annual budgets and monitoring expenditures to determine if the Divisions is accurately predicting and assessing program costs; (3) to review the process by which the Division made State Plan Amendments from initiation to final Center for Medicare and Medicaid Services approval for compliance with federal requirements; and (4) to assess the timeliness, completeness and flow of budget and expenditure information from the Division to other stakeholders, including the Department Secretary, The Governor, and the General Assembly.

Secretary Wos reviewed a draft copy of this report. Her written comments are included in the appendix.

The Office of the State Auditor initiated this audit at the request of the North Carolina General Assembly.

We wish to express our appreciation to the staff of the Division of Medical Services for the courtesy, cooperation, and assistance provided us during the audit.

Respectfully submitted,

Beth A. Wood

Beth A. Wood, CPA
State Auditor

TABLE OF CONTENTS

PURPOSE

The audit objectives were (1) to determine if the Division of Medical Assistance's (DMA) administrative functions, including assigned internal and external resources, complied with the Medicaid State Plan and federal requirements, and provided for an efficient use of State and federal funds; (2) to evaluate DMA's processes for preparing annual budgets and monitoring expenditures to determine if DMA is accurately predicting and assessing program costs; (3) to review the process by which DMA made State Plan Amendments from initiation to final Center for Medicare and Medicaid Services approval for compliance with federal requirements; and (4) to assess the timeliness, completeness and flow of budget and expenditure information from the Division to other stakeholders, including the Department Secretary, the Governor, and the General Assembly.

SUMMARY OF RESULTS

Administrative Functions

When compared to states with similar size medical assistance payment (MAP) spending, the state fiscal year (SFY) aggregate administrative costs (ADM) of the North Carolina Medicaid program as a percentage of MAP is significantly greater. In SFY 2011, North Carolina Medicaid incurred administrative expenses of approximately $648.8 million which when compared to MAP spending of $10.3 billion produced an ADM/MAP percentage of 6.3 percent. This percentage was significantly greater than the ratio for states with comparable spending. Other state's ratio ranged from 1.73 percent in Arizona to 5.44 percent in New Jersey.

One possible reason for the high amount of North Carolina's administrative spending relative to other states is due to the high level of Medicaid administrative expenses being incurred by other divisions within the Department of Health and Human Services (DHHS). For example, of the $781 million in Medicaid administrative costs claimed during SFY 2012, only $256.7 million or about 33 percent of the total were for costs incurred by DMA. Of the $524.3 million in costs incurred by the other DHHS Divisions, the three (3) divisions that spent the largest amounts were the Division of Social Services at $238.3 million, the Division of Mental Health at $96.7 million, and the Division of Central Administration at $164.8 million.

While important administrative functions such as eligibility determinations, administrative case management and Medicaid Management Information System (MMIS) design, development, and implementation occur at these other DHHS Divisions, these functions are not under the administrative control of DMA. As a result, DMA is not afforded the opportunity to control these costs.

Another contributing factor to the high amount of North Carolina's administrative spending is insufficient monitoring of administrative services that are contracted out by DMA.

Private contractor payments represent about $120 million (46.7%) of DMA's $257 million in administration expenditures for SFY 2012. It is always important for a state government to

exercise sound management practices with regard to the contracted services, but it becomes even more critical when almost half of the administrative expense is made up of contract payments.

Although contract payments represent a high percentage of its administrative budget, DMA was not able to provide a listing of contracts and the related expenditures in each SFY under review for this audit. DMA's inability to provide this information is indicative of its inadequate oversight of contractual expenditures. The initial list DMA provided only included amounts expended to date per contract. However, we were able to eventually obtain contracted service expenditures for FY12 and compile this information.

While our review of Medicaid contracted services was limited to DMA, insufficient monitoring of contracted administrative services could be an issue at other DHHS divisions. As noted above, $524.3 million in Medicaid administrative costs were incurred by other DHHS Divisions in SFY 2012.

Additionally, DMA did not track contract expenditures by year against their yearly certified budget to monitor whether and when they were approaching the limit of their authority. As such, DMA did not know when to invoke corrective actions to avoid exceeding their certified budget such as issuing stop work orders and/or cease entering into additional contractual obligations.

Consequently, DMA has consistently exceeded budgeted amounts for contracted administrative costs and interagency transfers[1]. DMA expenditures in fund[2] 1102, in which the vast majority relate to Medicaid, have significantly exceeded its certified budgets for contracts and other interagency transfers every year for the four SFYs 2009-2012 as follows:

	Amount exceeded in 2012	Amount exceeded in 2011	Amount exceeded in 2010	Amount exceeded in 2009
Contracted Admin.	$25.9 million	$28 million	$21.4 million	$37.2 million
Interagency Transfers[2]	$12.2 million	$23 million	$0.5 million	$18.1 million

It's also important to note that DHHS does not have two tools that could help it better monitor and control Medicaid administrative costs – (1) a comprehensive Public Assistance Cost Allocation Plan (PACAP) and (2) a DMA cost allocation plan.

[1] Interagency transfers are expenditures DMA incurs when transferring funds to another division or agency to reimburse them for a Medicaid administrative expenditure made on behalf of DMA.
[2] Funds are set up to account for revenues and expenditures for specific activities within the overall Medicaid Program.

Federal regulations define a cost allocation plan as "a narrative description of the procedures that the State agency will use in identifying, measuring, and allocating State agency costs incurred in support of all programs administered or supervised by the State agency."

Because a large amount of Medicaid administrative expense is incurred by divisions other than DMA, it is important to establish and monitor the Medicaid cost allocation plans. DHHS is the single State agency responsible for the supervision of the administration of the State's Medicaid Plan, and DHHS has many divisions under its authority that allocated significant administrative costs to the Medicaid program in SFY 2012.

However, DHHS does not have a comprehensive PACAP that can be reviewed from a Medicaid perspective to ensure that costs are allocable and allowable for the proper and efficient administration of the Medicaid State Plan.

Although the divisions (except for DMA) have individual PACAPs, the lack of a single comprehensive controlling document weakens the ability to monitor Divisional allocations to Medicaid and prevent inappropriate cost shifting and inappropriate federal claiming. Furthermore, the lack of a comprehensive PACAP presents an increased risk of federal scrutiny and the potential for cost disallowances.

Similarly, DMA does not have a cost allocation plan for appropriately allocating indirect expenditures and tracking expenditures eligible for increased federal funding.

According to its Assistant Director of Budget Management, the Division's position is that it is not required to have a cost allocation plan because all of its expenditures are direct to Medicaid.

While it is true that most of DMA's expenditures are for Medicaid program services costs, Medicaid is not the only activity or program benefiting from the Division's administrative costs. There are several grant programs that are administered by DMA. Most of these programs are relatively small and may be considered immaterial; however, the North Carolina Health Choice (NCHC) incurred about $14 million in Medicaid administrative costs for SFY 2012.

Consequently, the lack of a DMA cost allocation plan could also result in inappropriate cost shifting, inappropriate federal claiming, and the potential for cost disallowances.

***Recommendations*:**

1. DHHS and DMA need to ensure that proper measures are in place to monitor other divisions' Medicaid spending. Interagency memorandums of understanding (IMOU) or cost allocation plans (CAP) should address the Medicaid program costs being necessary for the proper and efficient administration of the Medicaid State Plan and not the responsibility of a non-Medicaid program.

2. Beginning in SFY 2013, DMA began tracking current year expenditures against total claimed amounts for the year by individual contract to identify cases where no

purchase order is on file, no current claim is in NCAS or the amount is questionable, or the contract is over budget. As a result, three months into SFY 2013, DMA discovered it was already over budget for contracts. While DMA has taken a step in the right direction by tracking costs against individual contracts, DMA still needs to ensure expenditures do not exceed certified budgeted amounts by contract.

3. As the Medicaid single state agency, DHHS should include a Medicaid PACAP in its department-wide comprehensive PACAP, and incorporate the other divisional PACAPs through reference. In addition, DHHS should have individuals with a Medicaid programmatic and financial understanding review the comprehensive PACAP to ensure that costs from other divisional PACAPs are allocable and allowable for the proper and efficient administration of the State Plan.

4. As the Medicaid single state agency, DHHS should incorporate only Medicaid costs at the DHHS level into its comprehensive PACAP and then reference a DMA PACAP (for costs incurred at the DMA level) as well as other Divisional PACAPs that incur Medicaid costs. A DMA PACAP would serve to allocate costs to all benefiting programs, especially NCHC, as well as support the allocation of Medicaid administrative costs to activities with increased FFP and identify costs from outside agencies that are also being claimed for Medicaid administrative reimbursement.

Budget Forecasting

DMA's budget development and administrative practices do not ensure division and legislative accountability for public expenditures.

Incomplete Financial Projections

Most of DMA's expenditures support the North Carolina Medicaid program. Budget Code 14445 designates Medicaid budgets. The Budget Code 14445 includes 14 separate funds to account for Medicaid revenues and expenditures. Funds 1101 and 1102 account for the Medicaid administration funds expended by DMA. Fund 1310 includes current year medical claims and certain other payments, such as Medicare Part D and payments to the DHHS Controller. These are the principle funds that are responsible for Medicaid expenditures and account for a significant part of DMA's shortfalls in State General Fund. However, all of the DMA funds are important and significant shortfalls in total budget authority and State General Fund expenditures occur in Funds other than 1310. This makes it important for Office of State Budget and Management (OSBM) and the General Assembly to understand these budget accounts and receive an accounting for what occurs in all of them throughout the fiscal year.

But prior to July 2012, DMA did not project costs for other expenses that have had a significant impact on total Medicaid expenses.

For example, DMA did not include Fund 1330 (drug rebates and program integrity receipts) in its financial projections. Yet, Fund 1330 has experienced a significant State General Fund

shortfall for the past three years. In 2012, the shortfall was $96.5 million; in 2011, it was $40.5 million; and in 2010, it was $16.4 million.

Additionally, DMA did not include Fund 1992 (receipts from prior year federal payments) in its financial projections. DMA did not budget any State General Fund expenditures for this fund from 2010-2012. However, the program used $93.2 million in 2012, $78.2 million in 2011, and $69.5 million in 2010.

Furthermore, DMA did not include Fund 1320 (cost settlements paid to Medicaid providers) in its financial projections. The fund spent far less than the State General Fund budget amount, but it is as important to be aware of potential surpluses as it is to be aware of potential shortfalls. General Fund surpluses in Fund 1320 could be used to offset shortfalls in other Division funds, reducing the total amount of funding needed. In the past three years, the General Fund surpluses in this Fund 1320 have been: $127.5 million in 2012, $35.6 million in 2011, and $110 million in 2010.

Carried Debt Forward

In 2012, DMA carried state debt into the next fiscal year by retaining $131.8 million of federal funds in violation of state law.

On May 24, 2012, the General Assembly passed Senate Bill 797, which required that "neither the Director of the Budget nor any other state official, officer, or agency shall draw down or transfer unearned or borrowed receipts or other funds if doing so would create or increase a financial obligation for the 2012-2013 fiscal year."

The General Assembly's intent was clear. Personnel from OSBM, Fiscal Research, and DMA all stated that the purpose of the clause cited above was to prevent the State from retaining 2012 drug rebate revenues that were payable to the federal government.

OSBM told DMA not to retain the federal funds. OSBM stated that DMA said it intended to repay the 2012 drug rebates in 2013 because this was DMA's "normal accounting process." However, in an interview with auditors, the DMA Chief Business Operations Officer said that not repaying federal funds represented a change from normal accounting practices. The Chief Business Operations Officer also said that retaining the federal funds was done with the knowledge of "legislative leadership," so the Division believed it was permissible. But OSBM cautioned the Division not to carry the 2012 debt forward into 2013.

Nevertheless, DMA failed to repay in SFY 2012 the federal government for the funds owed in SFY 2012. When the DMA budget was closed for SFY 2012, the federal Medicaid grant remained overdrawn by approximately $131.8 million. About $106.2 million was for the federal share of drug rebate revenues collected during May and June 2012. The remaining $25.6 million represented the federal share of medical assistance accounts receivable collections. Although these funds were owed to the federal government prior to the end of SFY 2012, the Division did not repay the funds until SFY 2013, resulting in a $131.8 million SFY 2013 beginning budget shortfall.

Unreliable Forecasts

Another problem is that DMA's budget forecasting methodology has not incorporated comprehensive multiyear projections and does not provide an accurate picture of the current year's financial position. Reliable forecasts require state agencies to forecast major revenues and expenses using complete data. However, DMA only prepares formal forecasts for one of their 14 funds, 1310 - Medical Assistance Payments. Only preparing a forecast for one major expenditure does not provide an accurate picture of the Medicaid program's status in complying with the Certified Budget or achieving State General Fund reductions that have been mandated by the General Assembly.

Additionally, DMA's forecasting methodology does not allow for reliable forecasts beyond the current fiscal year. As previously noted, DMA does not formally forecast for funds other than 1310 - Medical Assistance, so the only projections available for other Medicaid funds are the amounts in the Certified Budgets. Expenditures that DMA knew would occur have been omitted from these budgets in the past, so the budgeted amounts cannot be relied upon as reliable projections.

Furthermore, DMA has not provided evidence that it compares forecasts to actual budget performance. While DMA only forecasts for one fund - Medical Assistance Payments, it is the largest expenditure. Therefore, a comparison of forecasts to actual budget performance is important to identify the source of variances for actual expenditures.

Costs Not Managed

DMA does not appropriately manage Medicaid costs that are subject to agency control. Three significant cost drivers are (1) caseload, (2) price (the reimbursement rate provided to the medical provider), and (3) consumption (the Medicaid recipient's utilization of services).

Medicaid is an entitlement program, thus caseload is a cost driver that DMA can only control through good fraud detection to prevent individuals who are not truly eligible from qualifying for and using services.

Price (reimbursement rates) is a cost driver that DMA could make improvements to control. The current reimbursement methodologies allow rates to increase automatically unless action is taken to stabilize or reduce rates. However, it is possible to structure reimbursement methodologies so that rates remain stable unless positive action such as legislation is taken to increase them. This strategy provides greater control of the price component of medical services costs.

While North Carolina Medicaid relies on several strategies to control consumption, the single strategy that is invested with creating the greatest cost savings is Community Care of North Carolina (CCNC). The State expected to save $90 million per year with CCNC during SFYs 2012 and 2013, but fell $39.5 million short of its goal in 2012. CCNC is a form of managed care that provides case management services in a medical home environment. It is assumed to provide savings in providing medical services to participants. More than a decade of data exists that would allow a study by medical researchers on whether the medical home

model truly saves money and/or results in better medical outcomes. It would be a service to the nation as well as North Carolina to use this data to genuinely evaluate the questions associated with medical homes.

Lastly, a cultural change may be necessary to improve Medicaid cost management. In September 2010, OSBM issued a reported titled *Analysis of Medicaid Staffing and Organization*. In that report, OSBM found that cost containment was not an organizational priority. The reported stated, "Historically the Medicaid program has been more concerned about how to provide more services to more people than in containing costs."

Inflationary Increases Not Eliminated

DMA failed to comply with a legislative mandate to eliminate inflationary increases for nursing facilities. The 2011–2013 budget, as reported in the Senate Appropriation Committees substitute for HB 200, included Item 52 for the DMA budget which "[e]liminates automatic inflation increases for Medicaid providers. The Division of Medical Assistance is not to authorize any inflationary increases to Medicaid provider rates during the 2011-13 biennium, except as provided for in Section 10.43."

However, following the close of state fiscal year 2011, DMA reported to OSBM that Item 52, which was projected to save $62.9 million in 2012, failed to reach its target by $36 million. Included in the $36 million shortfall was $12.9 million that was attributed to "DHHS Decision" to include inflationary increases in nursing facility reimbursement for 2012.

DMA said that it could not eliminate inflationary increases and achieve the budgeted savings because of the complex "case mix" methodology used to reimburse nursing facilities. In a document submitted to Fiscal Research dated November 8, 2011, DMA made the following statement in response to a legislative inquiry about whether the Division had eliminated inflationary increases as mandated by S.L. 2011-145:

> The cost included in the inflation amount related to skilled nursing facilities was not based upon increases due to inflationary costs, but rather increased acuity of patients served in the nursing facilities. The Legislature adopted an approach called "case mix" for reimbursing nursing facilities several years ago. Under this approach, nursing facilities are reimbursed based upon the medical complexity or acuity of the patients in the facility. The elimination of the projected change in costs for increased acuity of the patients would effectively eliminate case mix reimbursement; as a result, DHHS was informed that the elimination of the case mix was not anticipated or desired by the Legislature. This impacts the targeted budget amount by $12 million.

While it is true that the nursing facility reimbursement methodology is complex, it is not true that eliminating inflationary increases in the nursing facility would necessitate "a change in the overall reimbursement system for nursing home service" or that it would eliminate adjustments to nursing facility rates based on acuity.

Of the four annual inflationary increases included in the nursing facility rate setting methodology, only one is related to a case mix adjusted portion of the nursing facility rates. However, it would be possible to eliminate inflationary adjustments to this portion of the rate without eliminating the case mix adjustment. In fact, this can be accomplished in a variety of ways without increasing overall nursing facility reimbursement. And the remaining three inflationary adjustments have nothing to do with the portion of the rate that is case-mix adjusted.

Therefore, it appears that the former DHHS Secretary's decision not to eliminate inflationary increases for Skilled Nursing Facilities may be based solely on the perception that this "would have an adverse impact on nursing facilities and the resulting access and care for Medicaid enrollees." However, no support has been offered for this perception.

Recommendations:

1. DMA and the DHHS should be required to submit reasonable estimates for all known Medicaid expenditures in their agency budget requests. If expenditures exceed allowable limits, DHHS, the Governor, or the General Assembly should take actions to reduce expenditures to stay within spending caps, rather than omit known expenditures from the budget.

2. DMA's agency request budget should adjust expenditures for all known costs that increase or decrease with fluctuations in caseload, including costs in administrative funds 1101 and 1102. These requests should be accompanied by appropriate documentation.

3. When DMA perceives that the General Assembly has included unachievable savings in their budgets, DMA should provide OSBM with documentation of this at the beginning of the biennium or fiscal year, along with a forecast of the additional total dollars and State General Fund that will be required to cover this unachievable savings.

4. DMA should discontinue the practice of incurring liabilities for the State at the beginning of the fiscal year because they have overdrawn federal funds in the prior fiscal year to offset State General Fund shortfalls.

5. Because Medicaid is such a large and complex program with a significant impact on the State budget, DMA may require more oversight than any individual Department Secretary with multiple other divisions and programs can provide. The General Assembly should consider organizational changes that could provide the oversight needed to ensure that the Medicaid program is operated in compliance with legislative mandates.

6. DMA should forecast for all Medicaid funds and these forecasts should be provided in an agreed upon format to OSBM and Fiscal Research Division at least quarterly.

7. DMA should maintain a comparison of forecasted expenditures and revenues to actual expenditures and subject it to analysis that can improve the ability to project expenditures.

8. DMA should prepare a five-year analysis to contribute to the Governor's budget message and should routinely forecast expenditures and revenues for a minimum of three years in the future.

9. Because caseload is a significant cost driver for Medicaid, DMA should perform multiyear caseload projections to support multiyear expenditure forecasts, and these forecasts should be tracked against actual caseload growth to evaluate the accuracy of the forecasting methodology.

10. DMA should perform a study to evaluate reimbursement methodology reform which should have a goal of establishing stable reimbursement methodologies that do not increase automatically but are only increased by actions approved by the General Assembly.

11. The State of North Carolina should engage medical researchers to perform a scientifically valid study based upon actual data to determine whether the CCNC model saves money and improves health outcomes.

12. Actions should occur, probably from outside the agency, to enforce a change in Division organizational culture to provide a focus on a health insurance perspective that encourages cost containment in an environment of increasing medical services and expanding payments to providers.

13. DMA should give complete and accurate information to the General Assembly when seeking approval to not comply with legislative mandates. Approval by the General Assembly should occur in a recognized forum with authority to provide this approval, rather than in informal discussions with individual legislators.

State Plan Amendments

The State Plan is a comprehensive written statement describing the nature and scope of its Medicaid program and giving assurance that it will be administered in accordance with federal and state laws. The State Plan contains all information necessary for the Center for Medicare and Medicaid Services (CMS) to determine whether the plan can be approved to serve as a basis for federal financial participation (FFP) in the State Program.

An approved Medicaid State Plan is allowed to be amended, if necessary, due to changes in laws, regulations, policies, court decisions, operations, or organization. State Plan Amendments (SPAs) should be promptly submitted for review, as sometimes mandated by the State Legislature as part of a budget or other bill, to the Associate Regional Administrator with CMS.

DMA is budgeting for savings related to SPAs upon mandate by the Legislature and in most cases failing to achieve the budgeted amounts. DMA submitted 44 SPAs to CMS for approval. According to DMA documentation, the amendments were budgeted to save $72.2 million but only saved $34.2 million (or $38 million less than budgeted). Once the savings are not achieved, DMA excuses much of the lost savings to delays in the SPA process.

However, the cost savings incorporated into the budget for specific SPAs are not always realized due to varying factors - some within DMA's control. For example, given that CMS has 90 days to either approve a SPA or ask for additional information, DMA documentation indicates that some SPAs were not submitted in time to be approved and implemented by the budgeted implementation date. Furthermore, DMA did not plan for retroactively implementing SPAs in cases where DMA should have been reasonably certain that the SPA would not be approved and implemented by the budgeted implementation date. As a result, cost savings opportunities afforded to the State, commensurate with CMS' approval of the amendments, were not pursued and, therefore, the State did not realize the savings.

Recommendation:

The savings incorporated into the state budget need to be more realistically calculated by the DMA and DHHS with consideration of implementation costs and realistic implementation dates given current system constraints.

Reporting

DMA does not issue readily understandable and timely Medicaid performance reports to government officials who oversee the Medicaid program.

DMA provides periodic reports with detailed Medicaid financial data to the DHHS Secretary, Fiscal Research, and OSBM. The reports include detailed financial data regarding medical claims payments, cash flow, and monthly fees.

However, DMA does not provide clear, succinct, summarized information showing the year-to-date fiscal status and projections for the Medicaid program and reasons for deviations from the certified budget. To draw conclusions from the detailed data, report users must perform their own analyses or seek additional information.

Fiscal Research and OSBM report users are not satisfied with the usefulness and timeliness of the reports. Report users have noted a lack of targeted information to help them quickly identify unanticipated events or outlays that could indicate Medicaid program expenditures will differ significantly from established forecasts and budgets. Report users also noted that reports have been delayed or not available prior to scheduled meetings. The lack of timeliness has reduced report users' ability to prepare for meetings about Medicaid's financial status.

***Recommendations*:**

1. DMA should consult with the DHHS Secretary, Office of the Governor, OSBM, and Fiscal Research Division of the North Carolina General Assembly to determine the informational needs of those charged with governance over the State's Medicaid program. Medicaid reporting requirements, including report formats and timeframes, should be formally established and followed.

2. Once reporting formats and timeframes have been established, the DHHS Secretary should ensure DMA is held accountable for providing accurate and timely reports to stakeholders.

AGENCY'S RESPONSE

The Agency's response is included in Appendix B.

INTRODUCTION

BACKGROUND

The North Carolina Department of Health and Human Services ("DHHS" or "Department") has been designated in the North Carolina Medicaid State Plan as the single State Medicaid agency. The Centers for Medicare and Medicaid Services (CMS) require that each State name a single agency that is responsible to the Federal government for the Medicaid program. However, most of the responsibility for administering the Medicaid program has been delegated to the Division of Medical Assistance (DMA or Division) within DHHS.

Medicaid was established by Title XIX of the Social Security Act in 1965. It is a partnership between the Federal government and the various States. The Federal government provides a portion of the funds for providing medical services and administering the program. The States have the option of determining whether or not they will participate in Medicaid. All 50 States, as well as the District of Columbia and several U.S. territories, have Medicaid programs. If a State elects to participate in Medicaid, it must comply with all requirements of the Social Security Act and the Code of Federal Regulations. While these laws and regulations require all Medicaid programs to establish minimum levels of eligibility and provision of medical services, the States have broad latitude to offer eligibility to additional groups, to provide optional medical services, and to design service delivery systems.

In recent years, Medicaid budgets have been growing while revenues in many States have been shrinking. In most States, Medicaid represents the second largest expenditure behind education. Medicaid grows inversely with the health of the economy. As economic indicators such as employment decline, Medicaid caseloads increase. As caseloads increase, total Medicaid expenditures increase. State legislatures throughout the nation have been exploring methods for slowing the growth of Medicaid expenditures and have introduced a variety of measures to reduce Medicaid budgets.

This cost consciousness has affected the philosophy of many Medicaid managers. Where once Medicaid may have been viewed as a welfare program with emphasis on providing as much service to as many people as possible, today Medicaid is regarded by many as a governmental insurance program that should encourage cost containment.

Revenues and expenditures for North Carolina's Medicaid program are included in 14 funds[3] in Budget Code 14445. In 2012 the total Medicaid budget expended more than $14 billion, which included more than $3 billion in State General Fund. The Medicaid budget has grown 23 percent over the past four years, and it has experienced significant State General Fund shortfalls in each of the past three years. In 2012, the General Fund shortfall was more than $400 million at year end. The General Assembly had to appropriate an additional $200 million for DMA. Additionally, State funds were transferred from other DHHS

[3] Funds are set up to account for revenues and expenditures for specific activities within the overall Medicaid Program

agencies, and Federal revenues were retained in 2012 that had to be repaid in State Fiscal Year 2013.

In October 2011, DMA testified before a legislative committee that they anticipated a State General Fund shortfall in Medicaid of $139 million. In January 2012, DMA reported to a legislative subcommittee that they anticipated a $149 million General Fund shortfall in Medicaid. The actual General Fund shortfall was more than $400 million. In 2011, the General Fund shortfall also exceeded $400 million and in 2010 it was more than $300 million.

Medicaid has also incurred significant costs because of required repayments of funds to the Federal government. In 2012 DMA had to repay $41 million for disallowances for Federal payments for personal care services. In 2010 DMA received a $15 million disallowance for Federal payments on community support services. In 2009 DHHS erroneously drew $300 million in Federal funds, resulting in installment payments to CMS of $40 million each year in 2011 and 2012 and $30 million in 2013.

OBJECTIVES, SCOPE, AND METHODOLOGY

The audit objectives were: (1) To determine if the Division's administrative functions, including assigned internal and external resources, complied with the Medicaid State Plan and Federal requirements, and provided for an efficient use of State and Federal funds; (2) To evaluate the Divisions' processes for preparing annual budgets and monitoring expenditures to determine if DMA is accurately predicting and assessing program costs; (3) To review the process by which the Division made State Plan Amendments (SPAs) from initiation to final CMS approval for compliance with Federal requirements; and (4) To assess the timeliness, completeness and flow of budget and expenditure information from the Division to other stakeholders, including the Department Secretary, the Governor, and the General Assembly.

The Office of the State Auditor initiated this audit in accordance with Section 10.9A(a) through (b) of the 2012–2013 North Carolina State Budget.

The audit scope included a review of the Division's administrative functions, budget forecasting, State Plan Amendments, and reporting for the period of time beginning July 31, 2009 through July 31, 2012. We conducted the fieldwork from August 2012 through October 2012.

To evaluate the administrative functions, we conducted interviews of Department and Division personnel, reviewed organizational charts, reviewed vendor contracts, and reviewed administrative expenditures of North Carolina and other States.

To evaluate the budgeting and monitoring processes, we interviewed Department and Division personnel, interviewed North Carolina Office of State Budget and Management (OSBM) personnel, interviewed North Carolina General Assembly Fiscal Research Division (Fiscal Research) personnel, reviewed budgets and actual expenditures, and reviewed the causes of actual budget shortfalls.

To evaluate the SPA process, we interviewed Division personnel, and reviewed documents related to SPAs with significant fiscal impact.

To evaluate fiscal reporting, we interviewed Department and Division personnel, interviewed North Carolina Office of State Budget and Management (OSBM) personnel, interviewed North Carolina General Assembly Fiscal Research Division (Fiscal Research) personnel, reviewed actual Federal and State reports, and reviewed the communications regarding actual budget shortfalls.

Because of the test nature and other inherent limitations of an audit, together with limitations of any system of internal and management controls, this audit would not necessarily disclose all performance weaknesses or lack of compliance.

As a basis for evaluating internal control, we applied the internal control guidance contained in professional auditing standards. As discussed in the standards, internal control consists of five interrelated components, which are (1) control environment, (2) risk assessment, (3) control activities, (4) information and communication, and (5) monitoring.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We conducted this audit under the authority vested in the State Auditor of North Carolina by North Carolina General Statute 147.64.

ADMINISTRATIVE FUNCTIONS

The Federal financial participation (FFP) matching portion of most administrative functions is 50 percent. However, some administrative functions, such as operating an approved Medicaid Management Information System (MMIS), are matched at rates greater than 50 percent FFP. For these costs, some stringent Federal requirements have been imposed on the State Medicaid programs to limit their administration costs claimed for specific types of cost that either: (1) receive enhanced rates of FFP higher than 50 percent or (2) pertain to specific areas of cost that Congress deems to be worthy of special attention.

Enormous variation exists among how state governments have chosen to organize the administration of their Medicaid programs. Although the federal matching rates for the amounts spent by the states on Medical Assistance Payments (MAP) for the costs of covered services in each state's approved State Medicaid Plan varies by state, the federal matching rates for administrative costs are the same for all states.

For the largest portion of administrative costs for which the State will receive the 50 percent FFP rate, Congress stipulates in section 1903(a) (7) of the SSA that each state shall be paid "...an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan." (Underlining supplied for special emphasis.)

It is the expression "proper and efficient administration" that has afforded the states such broad flexibility in accomplishing the administration of their Medicaid program without jeopardizing the availability of their Federal financial participation (FFP) in those administrative costs. If a State Medicaid program incurs administrative costs for which it is only claiming FFP at the 50 percent rate, it can be difficult for the Federal government to disallow that FFP based on the argument that the cost was not necessary for the State in the course of properly and efficiently administering its State Medicaid Plan. The natural result is tremendous variation among State Medicaid programs' administrative costs.

Comparison with Other State Medicaid Programs

When compared to states with similar size medical assistance payment (MAP) spending, the state fiscal year (SFY) aggregate administrative costs of the North Carolina Medicaid program as a percentage of MAP is significantly greater, as shown in the following table:

Total Administrative Cost Comparison

State	Total Cost ($)	Administrative Cost ($)	Admin to Total
Tennessee	7,969,998,389	413,622,139	5.19%
Missouri	8,011,172,212	286,268,889	3.57%
Georgia	8,064,611,365	400,415,522	4.97%
Arizona	8,988,386,558	155,835,205	1.73%
North Carolina	**10,297,057,563**	**648,762,805**	**6.30%**
New Jersey	10,501,136,233	571,374,290	5.44%
Michigan	12,062,932,510	515,345,364	4.27%
Illinois	12,835,985,780	678,614,042	5.29%
Massachusetts	13,007,366,707	555,838,633	4.27%
Average	$10,193,183,035	$469,564,099	4.56%

Source: Center for Medicare and Medicaid Services reports and auditor calculations

In SFY 2011, North Carolina Medicaid incurred administrative expenses of approximately $648.8 million, which when compared to MAP spending of $10.3 billion produced an ADM/MAP percentage of 6.30 percent. This percentage was significantly greater than the ratio of other states.

Additionally, states that came the closest to spending as much in Medicaid administration as North Carolina's $648.8 million are Illinois at $678.6 million, Massachusetts at $555.8 million, and New Jersey at $571.4 million. However, all three of these states have larger total cost, and therefore larger Medicaid programs to be administered. For example, only Illinois spent more than North Carolina in administrative costs; however, because they were administering a program almost $3 billion larger, their percentage of administrative costs is still below North Carolina's, at 5.29%. Similar results were also found with comparisons made to the same states in SFYs 2009 and 2010.

Core Administrative Functions

To better understand and appreciate the North Carolina Division of Medical Assistance's (DMA) performance for its portion of the administration of the State Medicaid program, it is important to understand the required administrative functions for operating a proper and efficient state Medicaid program. The Kaiser Foundation's "The Medicaid Resource Book" examined the Federal guidelines and surveyed various State Medicaid programs, and they reached the conclusion that a State Medicaid program has the following nine core administration functions:

(1) **Beneficiary Outreach and Enrollment**: States must identify and inform the individuals who are potentially Medicaid eligible of their potential eligibility, and then enroll those applicants who are deemed eligible.

(2) **Defining the Scope of Covered Benefits**: States must determine what benefits the plan will cover and in what settings. The type and scope of each service that a

state offers to its Medicaid beneficiaries must be specified in its State Medicaid plan. Any additions, deletions, or modifications of this benefits package must be done through the submission of an amendment to the State Medicaid plan (State Plan Amendment, or SPA), which must be approved by CMS to ensure the requirements for FFP matching funds are still being satisfied.

(3) **Setting Provider and Plan Payment Rates**: States must determine how much the plan will pay for the Medicaid benefits it covers and whether it will buy those benefits/services from fee-for-service (FFS) providers and/or managed care plans. A state's Medicaid reimbursement policies (FFS or risk-based) must be defined in its State Medicaid plan, and any changes in those policies and institutional reimbursement plans must be reflected in SPAs and must receive prior federal approval before the FFP can be claimed for the corresponding changes.

(4) **Enrolling Providers and Plans**: States must establish standards for the providers and managed care plans from which they will purchase covered benefits and enroll (or contract with) those which meet the standards.

(5) **Payment of Providers and Plans**: States must process and pay the Medicaid reimbursement claims received from fee-for-service providers and make capitation payments to the managed care plans.

(6) **Monitoring Service Quality**: States must monitor the quality of the services the plans purchase to ensure that beneficiaries are protected from, and that Federal taxpayers are not subsidizing, substandard care.

(7) **Ensuring Program Integrity**: States must ensure that state and federal health care funds are not spent improperly or diverted by fraudulent providers. Program integrity related activities include not only the pursuit of recoveries from the abusive providers and beneficiaries, but also activities designed to prevent the inappropriate payments from being made in the first place.

(8) **Processing Appeals**: States must have a process for resolving grievances by applicants, beneficiaries, and providers.

(9) **Collection and Reporting of Information**: States must collect and report information necessary for effective administration and program accountability.

In North Carolina, approximately 33 percent ($256.7 million) of the Medicaid program administration costs claimed for FFP during the SFY12 was within DMA control. The remaining 67 percent ($524.3 million) is claimed by other Department of Health and Human Services (DHHS) agencies (see Table on the next page). DMA has very little input and control over the manner in which other DHHS divisions perform their duties and the amount of administrative expenditures they incur on behalf of the Medicaid program. As the single state agency for the NC Medicaid program, DHHS is responsible for overseeing all its divisions and for consolidating all division Medicaid program administrative expenditures into one consolidated Federal Medicaid expenditure report (i.e. Form CMS 64 report).

Department of Health and Human Services Medicaid Administrative Expenses

To categorize DMA funds, staff, and other resources into these nine core administrative function categories, we used the DMA organizational chart, human resource and financial data gathered from internal reports, and input from DMA personnel. Since all organizations have staff who perform general administrative duties, which are allocated to all the activities of the organization, we have added a 10th function that we call General Administration (GA) for purposes of this report. The following table provides a summary of Medicaid expenditures in SFY12 for DMA and other DHHS agencies claiming Medicaid administrative costs.

Title XIX Administrative Resources Expended for the SFYE 6/30/12

#	Medicaid Administrative Functions	# of Staff	PERSONAL SERVICES	OTHER IN-HOUSE	OUTSOURCED CONTRACTS	TOTAL COMPUTABLE EXPENDITURE(1)	FEDERAL SHARE	NON-FEDERAL SHARE(2)	TC %
1a	Beneficiary Outreach and Enrollment	53.54	3,350,916.94	1,082,891.28	614,483.09	5,048,291.31	2,818,623.63	2,229,667.68	2.5%
1b	Medicaid Admin Claiming (MAC) for School-Based Services (SBS)	-	-	-	47,034,695.29	47,034,695.29	23,517,347.64	23,517,347.65	23.1%
1	Subtotal: Beneficiary Outreach and Enrollment	53.54	3,350,916.94	1,082,891.28	47,649,178.38	52,082,986.60	26,335,971.27	25,747,015.33	25.6%
2	Defining the Scope of Covered Benefits	51	4,422,816.37	61,284.51	242,386.98	4,726,487.86	3,514,610.92	1,211,876.94	2.3%
3	Setting Provider and Plan Payment Rates	26.5	1,799,740.44	71,452.75	4,994,018.24	6,865,211.43	3,845,053.60	3,020,157.83	3.4%
4	Enrolling Providers and Plans	25.46	1,580,127.88	558.17	-	1,580,686.05	790,343.39	790,342.66	0.8%
5	Payment of Providers and Plans	26	2,653,801.00	(1,095.60)	54,492,245.59	57,144,950.99	41,324,222.71	15,820,728.28	28.0%
6	Monitoring Service Quality	32	2,347,461.18	84,386.25	217,627.30	2,649,474.73	1,536,658.08	1,112,816.65	1.3%
7	Ensuring Program Integrity	53	3,477,530.84	1,287,744.60	55,324,260.62	60,089,536.06	41,217,923.89	18,871,612.17	29.5%
8	Processing Appeals	42.5	3,134,469.13	4,874,775.33	-	8,009,244.46	4,027,722.02	3,981,522.44	3.9%
9	Collection and Reporting of Information	1	186,971.76	-	3,289,245.17	3,476,216.93	2,005,490.33	1,470,726.60	1.7%
GA	General Administration	49	3,897,084.71	2,782,454.70	671,797.44	7,351,336.85	3,675,668.43	3,675,668.43	3.6%
	DMA's Total Title XIX Admin Resources	360	26,850,920.25	10,244,451.99	166,880,759.72	203,976,131.96	128,273,664.64	75,702,467.33	100.00%
	Other DMA Claimed Title XIX Expenditures (3)	-	-	52,692,458.69	-	52,692,458.69	51,381,572.10	1,310,886.60	
	Total DMA Resources	360(4)	26,850,920.25	62,936,910.68	166,880,759.72	256,668,590.65	179,655,236.73	77,013,353.92	

Administrative Costs Incurred in Other DHHS Divisions

	Disability Determination Section					5,317,998.64	2,658,999.32	2,658,999.32	
	Division of Public Health					9,879,947.62	5,564,278.98	4,315,668.64	
	Division of Central Administration					164,814,047.00	141,029,132.16	23,784,914.84	
	Division of Aging					1,251,001.85	625,500.93	625,500.92	
	Division of Child Development					49,304.63	24,652.32	24,652.31	
	Office of Education Services					63,156.00	31,578.00	31,578.00	
	Division of Social Services					238,290,743.33	119,403,365.23	118,887,378.10	
	Division of Health Services Regulation					7,911,281.82	4,652,223.64	3,259,058.18	
	Division of Vocational Rehabilitation Services					83,124.67	41,562.34	41,562.33	
	Division of Mental Health					96,689,334.43	52,560,655.54	44,128,678.89	
	TOTAL TITLE XIX ADMIN EXPENDITURES					781,018,530.64	506,247,185.19	274,771,345.45	

NOTES:

(1) Total Computable Expenditure is the total of both federal and state expenditures
(2) Non-Federal Share is the State's portion of expenditures
(3) Other DMA claimed expenditures consist mostly of 100% federally funded payments
(4) Position counts do not include vacancies

The table above shows that $166.8 million of total DMA expenditures were for outsourced contracts. These outsourced expenditures were made up of $47 million in Medicaid Administrative Claiming (MAC) for School-Based Services and about $120 million of additional private contracts. Since the non-Federal share of the MAC expenditures is the responsibility of the public schools and/or counties and is not a responsibility of DMA, this $47 million claimed for the MAC at the schools skews this analysis regarding DMA's resources. When we remove the $47 million of MAC, the remaining $120 million of private contractor payments still represents 46.7% of the total Division administration expenditures. This represents a high percentage of its budget. See Appendix A for an inventory of DMA Medicaid administrative contracts.

It is always important for a state government to exercise sound management practices with outsourced contracts, but it becomes even more critical when almost half of the annual budget is contract payments. And, as will be explained in more detail later in this report, these contract expenditures were not effectively managed by DMA. As a result, the strain on the State's annual budget due to Medicaid budget shortfalls in recent years has been exacerbated by these contract expenditures exceeding the certified budgeted amounts for the SFY. We will now take a closer look below at the make-up of the Division's internal resources and outsourced contracts, as expended in SFY12 to accomplish each of the nine core Medicaid administrative functions:

(1) Beneficiary Outreach and Enrollment: Of the total spent for this function, $47 million is for MAC performed at the schools. We categorized this expenditure amount here because a significant portion of the tasks performed by these school-based employees involves outreach to the Medicaid-eligible school children. And, because the non-federal share of these expenditures does not come out of the Division's budget, we only address the remaining $5 million spent primarily for the salaries and other in-house costs for 54 staff, who report to the various Clinical Services components on the organizational chart, and the costs for these staff are captured in five Responsibility Cost Centers (RCCs). After removing the MAC, DMA's expenditures were $5 million for this administrative function because most of the State's cost for the eligibility related activities is incurred by the Division of Social Services at the county level.

(2) Defining the Scope of Covered Benefits: DMA's expenditures for this function include salaries for 51 skilled professional medical personnel (SPMP) claimed by DMA at the 75 percent FFP rate. Congress encourages states to employ the services of medical professionals for these duties, so states have been authorized to claim 75 percent FFP for their salaries and other benefits so that the states will be willing to pay the higher salaries that SPMP can demand in the work place. Although these SPMP are scattered throughout many of the Clinical Services components of the organizational chart, the personnel costs have been captured in one RCC to ensure their costs are easily identified for proper reporting on the Form CMS 64 category line for SPMP claimed at the 75 percent FFP rate.

(3) Setting Provider and Plan Payment Rates: DMA's in-house costs for this function contained about $1.8 million in salaries and benefits for 27 staff that were classified primarily as auditors, who work in the various organizational components within DMA's business office. Their duties mostly include activities to ensure that provider reimbursement rates are appropriate in accordance with the approved State Plan provisions. However, almost $5 million was paid to outsourced contractors for services such as hospital field audits used in rate determinations and cost benefit comparisons for various provider types. Many State Medicaid agencies choose to outsource these highly specialized, analytical services because in-house personnel typically don't have the same level of expertise as the consulting firms.

(4) Enrolling Providers and Plans: We identified the smallest amount of DMA administrative expenses for this function because it is very difficult to separate these costs from those assigned to the administrative functions **(5)** and **(6)** below.

$1.6 million includes salaries and benefits for the 25 staff in two RCCs that have staff positioned throughout various Clinical Services organizational components.

(5) Payment of Providers and Plans: DMA expenditures for this administrative function represent 28 percent of DMA's expenditures primarily due to outsourced contracts expenditures. Most of the $57 million for this function was claimed in one RCC for the fiscal agent contract and related services. These fiscal agent fees have been claimed by DMA at the 75 percent Federal matching rate allowed for the State's operational costs incurred for its Medicaid Management Information System (MMIS). Also included in this function are two other smaller contracts expenditures, one for about $2.4 million for PASARR (Preadmission Screening and Annual Resident Review) related screenings (also claimable at the 75 percent

FFP rate) and the other at just over $1 million paid for verification of the nursing facility minimum data set assessments and supporting documentation.

(6) Monitoring Service Quality: DMA expenditures for this function include salaries and benefits for 32 staff that are captured in three RCCs claimed by DMA at the 75 percent FFP rate. One of the RCCs had 10 staff performing oversight and administration of the Health Information Technology (HIT) initiative claimed at the 90 percent FFP rate. This federally mandated initiative promotes the nationwide adoption of the uniform electronic health record for patients to be used by medical providers to improve the medical outcomes for patients and to facilitate better distribution of patient health records. The other RCC had the salaries and benefits for 19 quality analysts scattered throughout various clinical services organizational components.

(7) Ensuring Program Integrity: The Program Integrity (PI) function is the administrative function for which the DMA incurred the largest expenditures in SFY12 – more than 29 percent of DMA administrative expenditures. This amount does not include the State's Medicaid PI-related expenditures claimed by the Division of Information Resource Management (DIRM). As with function **(5)** above, the primary reason for this high percentage is $55 million for outsourced contracts with private firms and information technology companies like IBM. Based on the input received from the DMA, we assigned 15 of the DMA's RCCs to the PI function, and 11 of them were RCCs used for the expenditures incurred for outsourced contracts. Two of these contracts were not competitively procured: (i) the IBM contract ($1.1 million in SFY12) for development of the Fraud and Abuse Management System (FAMS); and (ii) Carolinas Center for Medical Excellence (CCME) contract ($10.5 million in SFY12) for the independent assessments of individuals applying for in-home personal care services (PCS). For DMA's in-house PI related costs, 53 staff members contained in the other 4 RCCs were scattered throughout many of the clinical services organizational components. The salaries and benefits for 27 staff in one of the RCCs have been claimed as SPMP at the 75 percent FFP rate because their duties require them to use their medical expertise to make decisions about the medical necessity of the providers' services during the PI related reviews. The other 26 staff positions are in RCCs for the normal PI and for third party liability costs.

(8) Processing Appeals: The DMA's $8 million of in-house costs for this function included about $3.1 million of salaries and benefits for 43 staff, plus $4.9 million for other purchased services. The in-house staff positions were assigned in three RCCs, but the staff were actually scattered throughout the clinical services organizational components. No outsourced contracts were identified for this administrative function.

(9) Collection and Reporting of Information: The SFY12 expenditures identified for this administration function represented only 1.7 percent of the total DMA expenditures because a significant amount of the personnel involved in the collection and reporting of information were assigned to the General Administration (GA) function. Some of those 49 GA staff positions performed significant amounts of information gathering and reporting. However, because they were assigned to the two RCCs that were identified as primarily engaged in GA activities that are allocable to all the functions, it would not have been practical to split them

into this function. As a result, only one staff position was allocated to this function. $3.3 million of this function's identified costs were incurred for four outsourced contracts.

(10) General Administration: The expenditures remaining in this GA function represent 3.6 percent of DMA's administrative expenditures because the vast majority of the staff assigned to work in the business office, including the State Medicaid Director's office and his supporting staff, were allocated to this administrative function. 49 staff member salaries and benefits from two RCCs accounted for the $3.9 million personal services expenditures.

Finding #1: The Division has consistently exceeded budgeted amounts for contracted administrative costs and interagency transfers due to an apparent lack of oversight.

DMA expenditures in Fund 1102 (for contracts for the fiscal agent and other private vendors, as well as interagency transfers[4]) have significantly exceeded their certified budgets every year for the four SFYs 2009-2012 as follows:

	Amount exceeded in 2012	Amount exceeded in 2011	Amount exceeded in 2010	Amount exceeded in 2009
Contracted Admin.	$25.9 million	$28 million	$21.4 million	$37.2 million
Interagency Transfers[2]	$12.2 million	$23 million	$0.5 million	$18.1 million

As previously described, about half of the administrative expenses within DMA are for contracted services. There is an overall need for more precise monitoring of administrative costs with both DMA and DHHS. The General Assembly's budget expects agencies to comply with amounts certified in each fund. (Note: Further details regarding budgeting requirements are discussed in the Budgeting Section of the report; here we address only the administrative costs.)

Prior to FY13, DMA did not track current year contract expenditures against current year certified budget amounts by contract to manage contract expenditures to stay within budget. As a result, DMA's contractual obligations exceeded the certified budget amounts as indicated in the table above. Therefore, DMA was not able to identify if any corrective actions were necessary to avoid exceeding its certified budget on a contract-by-contract basis, such as issuing stop work orders and/or ceasing to enter into additional contractual obligations. DMA management noted that they have begun monitoring individual contractual expenditures in FY13.

To cover contract amounts that exceed the certified budget, DMA must obtain approval through the budget revision system in DHHS and OSBM to transfer budget authority from other funds into Fund 1102 so expenditure overages can be covered. If budget authority from

[4] Interagency transfers are expenditures DMA incurs when transferring funds to another agency or division to reimburse them for a Medicaid administrative expenditure made on behalf of DMA.

other funding sources cannot be found, DMA would obligate the State debt beyond the authority of its legislative approved budget.

Recommendation:

Beginning in SFY 2013, DMA began tracking contract expenditures to date against total claimed amounts over the term of individual contracts to identify cases where no purchase order is on file, no current claim is in NCAS or the amount is questionable, or the contract is over budget. As a result, three months into SFY 2013, DMA discovered it was already over its certified budget for contracts. While DMA has taken a step in the right direction by tracking costs against certified budget limits, DMA needs to ensure expenditures do not exceed certified budgeted amounts.

Finding #2: Other Department of Health and Human Services (DHHS) division administrative spending is not controlled by DMA and is not sufficiently monitored by DHHS to ensure proper drawdown of federal funds.

One possible reason for the high amount of North Carolina's administrative spending relative to other states is the high level of Medicaid administrative expenses being incurred by other divisions within DHHS.

For example, of the $781 million in Medicaid administrative costs claimed during SFY 2012, only $256.7 million, or about 33 percent of the total, was for costs incurred by DMA. Of the $524.3 million in costs incurred by the other DHHS divisions, the three (3) divisions that spent the largest amounts were the Division of Social Services at $238.3 million, the Division of Mental Health at $96.7 million, and the Division of Central Administration at $164.8 million.

While important administrative functions such as eligibility determinations, administrative case management and MMIS design, development, and implementation occur at these other DHHS divisions, DMA does not control these costs.

The main issue with Medicaid administrative claim expenses in other divisions pertains to oversight and responsibility. That is, to be allowable costs covered under the Medicaid program, costs must be necessary for the proper and efficient administration of the Medicaid State plan and not the responsibility of a non-Medicaid program. Currently, DHHS could not provide any evidence that DHHS as the Single State agency is fulfilling this oversight role, nor that DMA as the Medicaid unit has assumed this responsibility.

There are additional deficiencies regarding DHHS procedures for funding the non-Federal share of administrative costs and medical assistance transportation costs under the Medicaid State Plan by other DHHS divisions, as well as options for acceptable Medicaid financing for these costs.

DHHS includes DMA and a number of other divisions that may provide health care services (transportation) and administrative costs as part of the State Medicaid Plan. Under the current

arrangements, when administrative costs and medical assistance transportation costs are incurred by another division, funding for the costs is appropriated by the General Assembly to that division. The division then bills the DHHS Controller's Office for the costs incurred based on the corresponding federal financial participation (FFP) rates. In turn, the DHHS Controller's Office draws federal funds for FFP based on the bill from the division, and provides the FFP to the division.

Under this arrangement, the division does not transfer funds to DMA to fund the non-Federal share, nor is there any type of certification of public expenditure from the division other than posting costs to the North Carolina Accounting system (NCAS).

This process does not appear to comply with Federal regulations governing expenditures in the Medicaid program. As defined at 45 CFR 95 .13(b) and (d), a Medicaid expenditure for a medical service occurs when any state agency makes a payment to the service provider. A Medicaid expenditure for administration occurs in the quarter in which payment was made by a State agency or in which costs were allocated in accordance with regulations. Pursuant to 42 CFR 433.10(a), the expenditure must be a total computable payment, including both Federal and state share, which forms the basis of the claim to draw down the corresponding FFP in accordance with the Federal Medical Assistance Percentage (FMAP) rate.

Federal regulations require that there be one designated agency that administers and controls the Medicaid funds. DHHS has been designated this single state agency. Even though all the divisions providing Medicaid administration and/or Medicaid services are within DHHS, the division budgets are appropriated independently and remain under the control of each individual division. DMA serves as the Medicaid agency in making payments to the provider, and as a result, the funds used to make the total computable payment to the other divisions should be under the administrative control of DMA. 42 CFR 433.51 requires that before DMA may make a total computable payment to another state division (administrative or medical assistance payment), one of two things must occur: (1) DMA must possess the non-Federal share; or (2) the other division must certify its expenditures eligible for FFP (subject to cost reconciliation).

In interviews, the DHHS Controller's Office indicated that a division's act of booking expenditures in NCAS was sufficient documentation to support a payment of FFP only. The DHHS Controller's Office believes that this satisfies the requirement for the division to certify its expenditures. However, the booking of expenditures in NCAS is not sufficient documentation of the certifying of expenditures. For the DHHS Controller's Office to pay the division only the FFP under a Certified Public Expenditure (CPE) arrangement, an inter-agency memorandum of understanding (IMOU) between DMA/DHHS and the other division needs to detail the services purchased, the basis for billing, and billing based on actual costs subject to reconciliation. As a result, the current practices of paying only the FFP to other divisions and the current processes for funding the non-federal share of Medicaid expenditures are not consistent with section 1903(w)(6)(A) of the Social Security Act (the Act), nor with the federal regulations at 42 CFR 433.10, 42 CFR 433.51 and 45 CFR 95.13(b).

The State needs to act quickly to ensure that there is proper funding for the State share of expenditures related to services provided to Medicaid beneficiaries. The lack of appropriate funding may prevent approval of future SPAs and may result in further financial management reviews and potential deferrals and/or disallowances by CMS/OIG.

Recommendation:

DHHS and DMA need to ensure that proper measures are in place to monitor other divisions' Medicaid spending. Interagency memorandums of understanding (IMOU) or cost allocation plans (CAP) should address the Medicaid program costs being necessary for the proper and efficient administration of the Medicaid State Plan and not the responsibility of a non-Medicaid program.

Finding #3: The Department does not have a comprehensive Public Assistance Cost Allocation Plan that can be reviewed from a Medicaid perspective to ensure that costs are allocable and allowable for the proper and efficient administration of the Medicaid State Plan.

The Department of Health and Human Services (DHHS) does not have a Public Assistance Cost Allocation Plan (PACAP) that allows for the effective monitoring of expenditures allocated to the Medicaid program by the various Divisions within DHHS. Therefore, there is an increased risk of inappropriate cost shifting, which can strain the Medicaid budget, and may lead to improper claims for the Federal Financing Participation (FFP).

A cost allocation plan is defined by 45 CFR § 95.505 as "a narrative description of the procedures that the State agency will use in identifying, measuring, and allocating State agency costs incurred in support of all programs administered or supervised by the State agency." 2 CFR Part 225 (formerly OMB Circular A-87) Appendix C speaks to the purpose of a cost allocation plan. It is a "process whereby these central service costs can be identified and assigned to benefitted activities on a reasonable and consistent basis."

2 CFR Part 225 Appendix D is specific to PACAPs, and extends the requirements of Appendix C to "all Federal agencies whose programs are administered by a State public assistance agency." Such programs include Medicaid, Temporary Assistance to Needy Families (TANF), and Food Stamps.

DHHS is designated as the single State agency responsible for the supervision of the administration of the North Carolina State Plan for Medical Assistance (State Plan). According to 42 CFR § 433.34, the "single or appropriate Agency will have an approved cost allocation plan on file with the Department in accordance with the requirements contained in subpart E of 45 CFR part 95."

According to 42 CFR § 95.505:

> State agency means the State agency administering or supervising the administration of the State plan for any program cited in § 95.503. A State agency may be an organizational part of a larger State department that also

> contains other components and agencies. Where that occurs, the expression State agency refers to the specific component or agency within the State department that is directly responsible for the administration of, or supervising the administration of, one or more programs identified in § 95.503.

DHHS has many divisions under its authority, including the following that allocated significant dollars to the Medical Assistance program in SFY 2012:

- Disability Determination Section (DDS)
- Division of Public Health (DPH)
- Division of Central Administration (DCA)
- Division of Social Services (DSS)
- Division of Health Services Regulation (DHSR)
- Division of Mental Health (DMH)
- Division of Medical Assistance (DMA)

The divisions, except for DMA, have individual PACAPs. However, none of the divisions are the single State agency responsible for the supervision or the administration of the Medical Assistance program. The lack of a DMA PACAP is discussed as a separate finding.

While the DHHS Controller's Office has oversight responsibility with respect to the Divisions' PACAPs, the lack of a single comprehensive controlling document weakens the ability to monitor Divisional allocations to Medicaid and prevent inappropriate cost shifting and inappropriate federal claiming. The existence of a comprehensive PACAP would demonstrate that proper oversight of the administrative costs billed to Medicaid is being performed by State Medicaid personnel that have the proper knowledge of the Medicaid program requirements to ensure that they are both allocable and allowable. The lack of a Single State agency PACAP presents an increased risk of Federal scrutiny and the potential for cost disallowances. According to 45 CFR § 95.519, "[i]f costs under a Public Assistance program are not claimed in accordance with the approved cost allocation plan (except as otherwise provided in § 95.517), or if the State failed to submit an amended cost allocation plan as required by § 95.509, the costs improperly claimed will be disallowed."

The proper allocation and claiming of Medical Assistance administrative costs is an area of review by the US DHHS Office of Inspector General (HHS-OIG). HHS-OIG's annual Work Plans for 2009-2012 indicated that reviews of Medicaid administrative expenses will be conducted "to determine whether they were properly allocated and claimed or directly charged to Medicaid."

Our discussions with representatives from the DHHS Controller's Office with cost allocation oversight responsibilities confirmed their use of a decentralized approach to cost allocation. They also indicated that this approach had not been previously questioned.

Recommendation:

DHHS should prepare a department-wide comprehensive PACAP, even if to incorporate the divisional PACAPs through reference. In addition, DHHS should have individuals with a Medicaid programmatic and financial understanding review the comprehensive PACAP to ensure that costs are allocable and allowable for the proper and efficient administration of the State Plan.

Finding #4: DMA does not have a cost allocation plan for appropriately allocating indirect expenditures and tracking expenditures eligible for increased federal funding.

DMA does not have a cost allocation plan. According to their Assistant Director of Budget Management, the Division's position is that it is not required to have a cost allocation plan because all of its expenditures are direct to Medicaid. A cost allocation plan distributes indirect costs (expenditures that benefit two or more activities) in reasonable proportion to the amount of benefit the expenditures provide to each activity. General requirements for allocation of indirect costs to federal grants are included in 2 CFR Part 225 (formerly OMB Circular A-87). This regulation requires that all activities which benefit from a governmental unit's indirect costs must receive an appropriate allocation of indirect costs.

Allocation Between Programs

While it is true that most of DMA's expenditures are for Medicaid program services costs, it is not correct that Medicaid is the only activity or program benefiting from the Division's administrative costs. There are several grant programs that are administered by DMA. Most of these programs are relatively small and may be considered immaterial; however, the costs incurred for the North Carolina Health Choice (NCHC) program (North Carolina's Children's Health Insurance Program (CHIP)) are substantially greater than for the other grants. If the administrative costs are proportionate to the percent of medical costs incurred by NCHC, some $14 million in administrative costs attributable to NCHC are being charged to Medicaid. CMS may not allow classification of the NCHC indirect costs as direct Medicaid costs for three reasons:

1. The total amount could be considered significant, and CMS would require these costs to be charged to the appropriate grant and covered by the appropriate federal appropriation.

2. There is a cap on administrative expenditures for CHIP. Per Social Security Act (SSA) Section 2105(c)(2), no more than 10 percent of total program expenditures can be paid for administration. If the State is not charging all of its costs, including indirect costs, to the CHIP program, CMS cannot determine whether the State has remained within the limitations on administrative spending. If the CHIP expenditures exceed the administrative cap, they are currently reimbursed by Medicaid. However, the State is not entitled to any federal reimbursement for CHIP costs that exceed the administrative cap.

3. Each state is given an allocation of federal funds for the CHIP program each year in accordance with Section 2104(m) of the SSA. Unless some states spend less than their allocation and the excess funds are redistributed to other states, the initial allocation is the maximum amount of federal funding that is available to the state, no matter what it actually spends. Even if redistribution does occur, there is no assurance that the State would receive all the funds need to cover its CHIP expenditures. If North Carolina is charging expenditures to Medicaid, which has no limitation on federal funding, that should be charged to CHIP, which has a limitation on federal funding, the State could be receiving federal funds it is not entitled to.

It is unknown whether the State would receive significant additional revenues from properly allocating costs among the different grant programs. 2 CFR Part 225 does allow that a governmental unit is not required to classify a cost as indirect if accounting for it would require "efforts disproportionate to the benefits received." The North Carolina DHHS Controller's office stated that they performed an analysis of the impact of a CAP on their administrative costs and determined that it was not significant enough to warrant a CAP.

Allocation to Increased FFP Activities

Attachment D to 2 CFR Part 225 indicates that the federal Department of Health and Human Services requires certain public assistance programs that receive federal funding to have a Public Assistance Cost Allocation Plan (PACAP) that meets specific requirements with respect to development, documentation, submission, negotiation, and approval. These requirements are set forth in 45 CFR 95, Subpart E. States receiving federal Medicaid funds are required to have a PACAP.

Whether a qualifying PACAP is submitted by DHHS or DMA, the plan must address "[t]he procedures used to identify, measure, and allocate all costs to each benefiting program and activity (including activities subject to different rates of FFP)." FFP, or federal financial participation, is the percentage of the total expenditure that the federal government pays. Medicaid administration has a variety of FFP rates, which are identified in Section 1903 of the SSA. The rates vary for the activity, and include MMIS operations and maintenance (75%), Skilled Professional Medical Personnel (75%), MMIS implementation under an approved Advanced Planning Document (90%), family planning (90%), resident review (75%), preadmission screening (75%), immigrant status (100%), and external review (75%). All Medicaid administration that does not have a specific increased FFP assigned to it by federal law receives a 50 percent federal match. In order to claim the increased FFP, North Carolina must have a PACAP for Medicaid that demonstrates how these costs are measured, per 45 CFR 95.507(b)(4). North Carolina does not have this in place.

In the case of skilled professional medical personnel, certain licensed employees are eligible, and their costs can only be claimed for that time spent on activities that require use of their medical expertise. Travel and training expenditures can be reimbursed, as can the time of clerical staff assigned to the skilled staff, when the clerical personnel are supporting activities that required medical expertise. DMA currently is not tracking time that skilled medical

professionals spend on tasks requiring their medical expertise. However, DMA declared $7.3 million for costs of skilled medical professionals on the CMS 64 for quarter ending June 30, 2012. Some or all of these costs could be subject to disallowance because DMA has no methodology for tracking them.

Additionally, DMA may not be charging all allowable expenses at an increased FFP. For example, skilled medical professional time in other agencies may be charged, if an appropriate agreement is in place and these staff can track their time that is spent on Medicaid activities. Costs of DMA administrative staff may be charged at 75 percent FFP for a variety of approved activities, including contract administration, if the time can be appropriately tracked.

Recommendation:

DHHS should reassess their conclusion that a DMA CAP is not necessary. A DMA CAP would serve to allocate costs to all benefiting programs, especially NCHC, as well as support the allocation of Medicaid administrative costs to activities with increased FFP.

BUDGET FORECASTING

The Budget Process

In the 2006 GASB White Paper: Why Governmental Accounting and Financial Reporting Is – and Should Be – Different, The Governmental Accounting and Standards Board (GASB) states:

> [T]he budget is the principal source of control over operations in government. The budget generally is a legal document that authorizes the government to utilize its resources to conduct operations and provide services....budgets of governments are public documents that express public policy priorities and financial intent. Citizens and their elected representatives have the right to know whether the government actually used funds and resources in accordance with the approved budget. Demonstrating accountability for compliance with budget authority is a distinguishing objective of governmental financial reporting.

The budget process is the primary method that North Carolina's elected officials have for establishing and enforcing priorities in State government. The budget process begins in the individual agencies of the State's three governmental branches and moves through a consolidation process to the Office of State Budget and Management (OSBM), where a governor's recommended biennial budget is developed and presented to the General Assembly. The North Carolina General Assembly has the final word on how the State's revenues are raised and funds are expended when it ratifies a biennial budget during the regular legislative session in each odd-numbered year. After the budget is signed by the Governor, OSBM certifies the budget to each agency. The Certified Budget becomes the spending plan for the State, against which actual revenue collections and expenditures are monitored. The Certified Budget for the second year of the biennium is amended during the shorter legislative session which convenes each even-numbered year. Thus, the Certified Budgets approved by the North Carolina General Assembly are the principle means by which State government priorities are established, and they are the standard against which these priorities are enforced. The Certified Budget passed by the North Carolina General Assembly is, perhaps, the single most critical action in providing State government accountability to its citizens.

Generally, legislatures formally stipulate that agencies and individuals acting on their behalf must comply with the approved budget. In North Carolina, this legal stipulation resides in the State Budget Act (North Carolina General Statute, Chapter 143C), which makes the Governor or his or her delegate, the Office of State Budget and Management (OSBM), responsible for enacting the budget as it is adopted by the General Assembly.

Accountability, thus, distinguishes governmental financial management. Public monies must be on the table and clearly visible to all who choose to view them. North Carolina's State government seeks to achieve this accountability, and the transparency that is required to support it, in the following manner:

1. The General Assembly enacts a Certified Budget during the regular legislative session that provides the legal basis for State expenditures during the biennium.
2. The General Assembly rebases[5] the Certified Budget in its short session to respond to additional information available for the second year of the biennium.
3. By authority of the State Budget Act, OSBM oversees administration of the Certified Budget and revisions that may be required based on new information during the biennium.
4. Through the State Budget Act, the General Assembly requires agencies to administer the Certified Budget as it is written and to comply with all requirements of OSBM.
5. Revisions to Certified Budgets may only be made by the limited authorization of OSBM or through approval by the General Assembly.

DMA Budgets

In its 2011 session, the North Carolina Legislature appropriated nearly $20 billion per year in General Funds for operations of State government. The Department of Health and Human Services received nearly 23 percent of the total State General Fund Appropriation. The Division of Medical Assistance, which administers North Carolina's Medicaid program, comprised over 65 percent of the Department operating budget and over 15 percent of the State's total General Fund Appropriation.

Most of the Division's expenditures support the North Carolina Medicaid program. Budget Code 14445 designates Medicaid budgets. The total Certified Budgets for 14445 Medicaid budgets have increased from $11.4 billion in 2008 to $12.9 billion in 2012, an increase of 12.7%. Actual expenditures have increased from $11.6 billion in 2008 to $14.2 billion in 2012, almost 23%. Medicaid spending has exceeded budget amounts in all of the past four years. In 2011 and 2012, total expenditures exceeded the Certified Budget by $1.4 billion each year and in 2010 the certified budget was exceeded by $1.8 billion, as shown in the following table.

[5] A rebasing is adjustments to the budget during the second year of the biennium to accommodate changes in program operating requirements, such as enrollment changes and inflation.

DMA Budget Code 14445 Budgeted vs Actual Expenditures 2009 - 2011				
Fiscal Year	Actual	Certified Budget	Variance	Percent Over Certified Budget
2012	$14,241,450,471	$12,885,349,949	$1,356,100,522	10.52%
2011	$13,270,350,502	$11,903,629,348	$1,366,721,154	11.48%
2010	$12,838,121,597	$11,046,775,749	$1,791,345,848	16.22%
2009	$12,623,281,487	$11,769,988,426	$853,293,061	7.25%

The Budget Code 14445 includes 14 separate funds[6] to account for Medicaid revenues and expenditures. In State Fiscal Years 2010 and 2011, a 15th fund, 1R17, was added to account for certain monies realized from passage of the American Recovery and Reinvestment Act of 2009 (ARRA), but this fund was no longer in use in 2012. Funds 1101 and 1102 account for the Medicaid administration funds expended by the Division of Medical Assistance (Division). Fund 1310 includes current year medical claims and certain other payments, such as Medicare Part D and payments to the DHHS Controller. These are the principle funds that are responsible for Medicaid expenditures and account for a significant part of the Division's shortfalls in the State General Fund. However, all of the Division funds are important, and significant shortfalls in total budget authority and State General Fund expenditures occur in Funds other than 1310. This makes it important for OSBM and the General Assembly to understand these budget accounts and receive an accounting for what occurs in all of them throughout the fiscal year. The Medicaid budgets, Code 14445, are described in the following table.

Fund	Fund Title	Purpose
1101	Division of Medical Assistance Administration	Division salary and operating costs except for contracts and interagency transfers in Fund 1102
1102	Division Admin Contracts and Interagency Transfers	Contracts for fiscal agent and other private vendors; transfers to other agencies
1210	Medical Assistance County Administration	Non-emergency transportation costs managed by the counties
1310	Medical Assistance Payments	Payments to providers for medical claims; supplemental payments
1320	Medical Assistance Cost Payments	Cost settlements paid to Medicaid providers

[6] Funds are set up to account for revenues and expenditures for specific activities within the overall Medicaid Program

1330	Medical Assistance Adjustments & Refunds	Drug rebates & program integrity
1336	Disproportionate Share Hospital (DSH) Payments	DSH payments
1340	Undispositioned Refunds	Refunds and recoveries of Medicaid payments whose source has not been identified or credited
1350	Periodic Interim Payments	Provider advance payments
1810	Revenue Clearing Account	Deposits and disbursements of Federal funds
1910	Reserves & Transfers	Transfer of non-tax revenues and miscellaneous receipts to State Controller
1991	Federal Indirect Reserves	Federal share of Department of Health and Human Services Statewide Cost Allocation Plan
1992	Prior Year Revenue Earned	Receipts from prior year Federal payments
1993	Prior Years Audits and Adjustments	Payments or recoveries from prior year audits and adjustments
1R17	American Recovery and Reinvestment Act of 2009 (ARRA) DSH	Temporary fund for 2010 and 2011 established to account for additional DSH funds provided by ARRA

DMA Budget Forecasting

Most of the Medicaid funds in Budget Code 14445 contribute significant expenditures or, in some cases, revenues to the State. However, DMA does not routinely budget for at least five of the funds and forecasts expenditures only for Fund 1310 – Medical Assistance. The only routine forecast provided for the Medicaid funds projects expenditures by 14 different eligibility categories.

Medical claims costs are forecast for these groups by budget line item, which include costs for various provider types (hospital inpatient general, hospital inpatient specialty, outpatient hospital general, podiatry, etc.) Year-to-date (YTD) expenses for each line item/provider type are divided by YTD average monthly caseload to calculate an actual monthly cost per eligible (CPE) for the line item. This CPE is adjusted for inflation and an economic factor, if appropriate. Inflation is the percentage increase or decrease in reimbursement that is anticipated. The economic factor is the increase or decrease in cost due to policy changes, code updates or new codes, times a percentage adjustment for consumption which projects that actual number of eligibles who are receiving services.

Projection Methodology for Eligibility Categories:

YTD Expenses / YTD average monthly caseload = YTD CPE

YTD CPE x Economic Factor X Inflation = Adjusted CPE

Adjusted CPE X Average Monthly Projected Caseload for the Remainder of the Year X Months Remaining in Year = Total Projected Expenditures for Remainder of the Year

YTD Expenses + Projected Expenditures Remainder of the Year = Projected Expenditures for Fiscal Year

The projected expenditures for all eligibility categories are aggregated on a worksheet entitled "All Eligibles." Payments and adjustments made outside the claims payment system, such as Medicare Part D and payments to the Office of the State Controller, are added to the aggregated medical services costs for the eligibility categories to yield total projected expenditures for the fiscal year. Revenue projections from all sources other than the appropriations are summed to yield expected receipts from Other Revenues. Other Revenues are subtracted from Total Expenditures to estimate the State General Fund Appropriation required to support Fund 1310.

Total Projection of Fiscal Year:

Sum of Aggregated Eligibility Category Costs + Other Payments and Adjustments = Total Projected Expenditures

Total Projected Expenditures – Sum of Other Revenues = Estimated Appropriation Requirement

The Medicaid budget and current year projections depend on a caseload projection that is made using SAS forecasting software. Caseload projections are made for each eligibility category used in the budget projection. Caseload is the only element of Medicaid forecasting that depends on a software application.

Medicaid Budget Shortfalls

The Medicaid budget shortfalls in the past three fiscal years have been significant, both in total expenditures and State General Fund requirements. They have not been confined to Fund 1310 – Medical Assistance Payments, but have been attributable to a variety of factors aside from unpredicted increases caseload or medical claims.

For 2012, OSBM provided documentation that the total shortfall was $375,369,958. This was offset by unanticipated revenues from Qualified Public Hospitals Claims and the Medicaid Hospital Gap Plan in the amount of $88,965,547, plus an appropriation from the Health and Wellness Trust Fund of $10,904,411. This left $275,500,000 in General Fund that had to be acquired through a combination of additional appropriations and transfers from other agencies. However, the Department also failed to refund drug rebate revenues and various receivables that were collected in 2012 to the Federal government, resulting in an overdraw of

$131,802,454. These Federal funds were used to offset State expenditures in 2012 and were paid back from State funds in 2013. The State General Fund shortfall in 2012 was:

Operating Shortfall	$375,369,958
Minus Unbudgeted Revenues (QPH & Gap)	(88,965,547)
Plus Federal funds used for State expenditures	131,802,454
Total State General Fund shortfall 2012	$418,206,865

OSBM calculated the 2011 Medicaid shortfall at $601,259,304. $271,005,067 was due to a debt carried forward from 2010, when the Division used Federal DSH funds for 2011 and Federal revenues from drug rebates earned after June 21 to pay the State share of 2010 expenditures. However, the Division was able to fund $197,404,307 of this shortfall with State General Fund savings on claims payments:

ARRA FMAP shortfall	$222,402,035
Repayment of 2010 DSH / rebate funds	271,005,067
Repayment of 2009 Federal overdraw	41,326,752
Contracts, settlements, other	66,259,304
Division internal savings	(197,404,307)
Total State General Fund shortfall 2011	$403,588,851

OSBM documents indicate that the State General Fund shortfall in 2010 was $316,667,659. Most of this was covered by using $203,014,184 in Federal funds for DSH that were drawn in 2010 for payments to be made in the first quarter of 2011. An additional $67,014,184 in Federal drug rebates collected after June 21, 2010, were also used to offset the State shortfall. These funds had to be repaid with State General Fund in 2011 and contributed significantly to the subsequent fiscal year's General Fund shortfall.

In 2009 the Division had a surplus in State General Fund. Because ARRA was passed in February 2009 and was retroactive to October 1, 2008, enhanced Federal Medical Assistance Percentage (FMAP) provided by the bill substantially reduced State General Fund requirements for Medicaid expenditures.

Finding #1: The Division's budget development and administration practices are potentially non-compliant with State statutes that have been enacted to ensure agency and legislative accountability for public expenditures.

DMA's actual expenditures have significantly exceeded Certified Budget authority in each of the past four fiscal years. In State governments, General Fund expenditures tend to dominate the focus of policy makers and financial managers because State General Fund expenditures create the necessity to raise State revenues. However, all of the funds in the budget are important. The North Carolina Certified Budget serves as the financial and operations plan of

the State. It outlines how the State will use all of the resources available to it, including resources that are available from sources other than State revenues. The Certified Budget is the General Assembly's plan, and when a single agency's deviation from the Certified Budget exceeds a billion dollars a year, the agency is operating outside the planning authority of the General Assembly. Governmental accountability has been put at risk.

The State Budget Act mandates that, "In accordance with Section 5(3) of Article III of the North Carolina Constitution, the Governor shall administer the budget as enacted by the General Assembly." DMA's dramatic variance from the Certified Budget in the past three years suggests that the budget enacted by the General Assembly has not been implemented. DMA provided accountings for shortfalls in the total Certified Budget for fiscal years 2010, 2011, and 2012. Many of the items creating the shortfalls were not requested in the agency expansion budget. Fund 1310 – Medical Assistance is the only fund that the Division rebases to increase expenditures in the budget. Items outside Fund 1310 must be requested in the expansion budget. For the 2012-2013 biennium, DMA's only expansion request was for 76 new positions. DHHS did not submit this request to OSBM to be included in the biennial budget.

DMA representatives gave a variety of explanations as to why the agency exceeded its Certified Budget and incurred State General Fund shortfalls in the past three years. For example:

- Though they knew an expenditure would be incurred, they did not know the exact amount of the expenditure, so they didn't budget anything. DHHS stated that the reason the disallowance for personal care services was not included in the agency request budget is because, though they knew the expenditures would occur, they did not know the exact cost.
- DMA has not been allowed to rebase Fund 1102 to account for changes in enrollment that increase the cost of claims processing and prior authorizations.
- The General Assembly has included unachievable cost savings in the budget.
- DHHS did not include known expenditures in the budget, including the installment repayments to CMS.

DMA has stated repeatedly that variances in their budget are approved by OSBM. However, the State Budget Act does not allow OSBM unlimited authority to approve changes in the Certified Budget. According to the State Budget Act: "under no circumstances shall the total requirements for a State department exceed the department's certified budget for the fiscal year by more than three percent (3%) without prior consultation with the Joint Legislative Commission on Governmental Operations." The DMA budget variations in 2010, 2011, and 2012 exceeded 3 percent of the total DHHS budget. It is not apparent how changes are tracked to alert DMA when it will exceed 3 percent of the departmental budget. Because of the substantial variances in different DMA funds, approval of a series of single variations could result in a cumulative variance that created the need for legislative approval.

Drug Rebates and Senate Bill 797

When DMA's budgets closed for State Fiscal Year 2012, the federal Medicaid grant was overdrawn by $131,802,454.20. This represented funds that were owed to the federal government prior to June 30, 2012, but were not repaid until State Fiscal Year 2013. $106,184,205 was for the federal share of drug rebate revenues collected during May and June 2012. The remaining $26 million represented the federal share of accounts receivable collections of medical assistance.

On May 24, 2012, the General Assembly passed SB 797 which required that "neither the Director of the Budget nor any other State official, officer, or agency shall draw down or transfer unearned or borrowed receipts or other funds if doing so would create or increase a financial obligation for the 2012–2013 fiscal year." Representatives of OSBM, Fiscal Research, DHHS, and DMA all stated that the purpose of this clause was to prevent the State from retaining 2012 drug rebate revenues that were payable to the Federal government. Nevertheless, DMA delayed repaying the Federal government for the funds owed in 2012.

When representatives of the DHHS Controller were interviewed, they stated they did not have any knowledge of whether the revenues were returned to the Federal government in 2012, though the Federal rebates were declared correctly on the CMS 64 for the quarter ending June 30, 2012. When the DHHS Director of Budget Analysis was interviewed, he stated that only a small amount of the rebates for June were left unpaid in 2012 and, for this reason, they felt that they had followed SB 797. He stated that OSBM was "at the table" when this decision was made. When the DMA Chief Business Operations Officer was interviewed, he acknowledged that $131.8 million in drug rebates and other recoveries were not repaid to the Federal government and this represented a change from their normal accounting practice. He stated that this was done with the knowledge of "legislative leadership," so the agency believed it was permissible. OSBM stated that the DMA told them that they intended to repay the 2012 drug rebates in 2013 because this was their "normal accounting process." OSBM cautioned DMA to follow the provisions of SB 797 by not carrying 2012 debt forward into 2013. Fiscal Research stated that DMA's action was not compliant with SB 797. The staff who are conducting the Single Audit for the Office of the State Auditor have stated that the 2012 Single Audit will include a finding that retaining the federal drug rebate and receivables revenue in 2012 and repaying it in 2013 is not compliant with approved federal cash management practices.

Drug rebate revenues are returned to the federal government by offsetting a federal draw for Medicaid expenditures that have already occurred by the amount of money owed to the Federal government. The DMA staff member who has been responsible for this activity stated that his normal practice has been to estimate the amount of drug rebates owed the federal government for a month in the third week of that month. This estimate would be deducted from the Federal draw for Medicaid expenditures. After month end, when the actual amount of drug rebate revenue owed the Federal government became known, DMA would do a true-up draw to adjust the refunds to the federal government. This staff member was told by his supervisor not to return drug rebate revenues for May or June 2012. This represented a change from the process that he had been using since he had begun doing these tasks. It

should be noted that the federal share of drug rebate revenues for April 2012 were not paid until late in June.

While acknowledging that it retained these federal revenues from May and June 2012 and did not repay them until State Fiscal Year 2013, DMA provided the following written explanation for this:

> The decision in June 2012 was that DMA had substantially met its obligation for returning the Federal share of rebates to CMS during SFY 2012. Decisions regarding return of rebates at year end 2012 were made in consultation with DMA, DHHS, and OSBM. There was also consultation with Legislative leadership prior to a final decision.

It is not clear why DMA felt that that North Carolina Medicaid had "substantially met its obligation for returning the Federal share of rebates to CMS during 2012" when $106 million in drug rebates and an additional $26 million in miscellaneous revenues remained unpaid. However, it does appear that this action was potentially non-compliant with SB 797. While DMA seems to imply that their "consultation" with OSBM and legislative leadership constituted some sort of approval for their action, this "consultation" did not give the agency license to not follow the statute. SB 797 clearly prohibited State agencies from carrying forward debt from 2012 to 2013, and it did not include any provision that allowed OSBM or individual legislators to authorize DMA to interpret the statute this way.

In 2010, DMA drew federal revenues for hospital DSH payments that were to be paid in 2011. They also retained $67 million in federal drug rebate revenues earned after June 21, 2010. This federal revenue was used to offset a State General Fund shortfall in 2010. This resulted in the State repaying the federal drug rebate revenues in State Fiscal Year 2011 and paying the first DSH payments of 2011 with 100 percent State fund. This contributed $271 million to DMA's State General Fund shortfall in 2011.

OSBM indicated that they were aware that these funds were drawn in 2010, and the Division planned to use them to offset the State shortfall. OSBM understood that the Federal DSH revenues were earned revenue because the State had already drawn them and believed this quarterly DSH draw and the repayment of the drug rebates earned after June 21 were part of DMA's normal processes. However, federal revenue is supposed to be drawn as it expended, not in the quarter prior to the expenditure. It is unclear whether refunding federal drug rebates earned after June 21 in the following fiscal year was, at the time, the normal accounting process for DMA. However, it is quite clear that using the drug rebate revenues to offset a shortfall in 2010 resulted in a $67 million liability for the State as it started Fiscal Year 2011.

CCNC Savings Not Realized

The 2011–2013 budget included $90 million per year in General Fund savings for "budget savings to be achieved by DHHS, in conjunction with CCNC Networks and North Carolina Community Care, Inc., through the cooperation of Medicaid health care providers" (Senate Appropriations Committee Report HB 200). In interviews, DMA representatives stated that

the Community Care of North Carolina (CCNC) cost savings did not have the support of DMA. DMA representatives stated that they knew that they could not achieve $90 million in State General Fund cost savings through CCNC in 2012. In October 2011, DMA informed the General Assembly that they expected a shortfall of $39 million in General Fund savings for CCNC. At year end, DMA reported that their General Fund shortfall for the CCNC cost savings item was $39,518,804.

HB 200 included the following statement regarding the CCNC cost savings: "To the extent these savings are not achieved, DHHS is to undertake whatever actions necessary to affect the savings, including: 1) reducing provider rates; and 2) eliminating or reducing the level or duration of optional Medicaid services."

DHHS did not take actions to make up for the remaining $39 million CCNC projected saving; however, DHHS does not agree that it failed to take the additional steps required by the state budget. DHHS said it presented various proposals for reducing rates and optional services to offset the unachieved CCNC savings in December 2011. DHHS said the actions were not implemented based on discussions between the DHHS Secretary and Legislative leadership. Furthermore, DHHS says any changes made to provider rates and optional services would not have been implemented in time to impact state fiscal year 2012 shortfalls.

Federal Cash Management Procedures

The Statewide Single Audit is a federally mandated audit of all Federal funds received by North Carolina. It is conducted annually by the Office of the State Auditor. Between 2009 and 2011, DMA had findings in the Single Audit pertaining to deficiencies in their federal cash management procedures for the Medicaid programs. In 2012 DMA will again have a finding of deficiency pertaining to its failure to return Federal drug rebate and miscellaneous receivables to the Federal government in a timely manner.

In 2011, the finding indicated that DMA failed to minimize the time elapsed between drawing down federal funds and disbursing federal cash. The agreement between the State and the U.S. Treasury requires that rebates and refunds must be returned to the federal government before additional federal funds are drawn to pay for State disbursements. Particularly with respect to drug rebates, this process was not followed on at least three occasions during fiscal 2011. The audit report notes that DMA "implemented new procedures to incorporate drug rebate credits into the drawdown process effective May 2011." Yet, at the end 2012, DMA repeated the practice of failing to return rebates and refunds prior to drawing Federal cash to cover disbursements.

In 2010, the Single Audit noted that, "Our review of the Department's Cash Management Improvement Act spreadsheets identified significant positive federal cash balances that exceeded the three-day rule throughout the fiscal year." This finding shows that DMA has drawn in federal Medicaid funds and failed to fully disburse them in a timely manner. The audit stated that there had been similar cash management findings in the past two years.

In 2009, the Single Audit again noted deficiencies in federal cash management procedures. In 2009, DMA overdrew $321 million in federal funds, which the agency has been repaying in installments over the past three years and will finally fully repay in fiscal 2013. The finding also noted that reconciliation procedures were insufficient to assure that federal draws did not exceed federal expenditures and noted that there were positive cash balances for federal funds in January 2009 and at year end.

These findings demonstrate that DMA has an established history of mismanaging federal funds. In some cases, this mismanagement is deliberate, as with the retention of federal receipts at 2012 yearend and the use of federal DSH funds to pay state expenditures in 2010. In other cases, it appears that the mismanagement results from deficient cash management procedures, as with the $321 million overdraw of federal funds in 2009. In either case, this mismanagement jeopardizes the financial position of the State because, ultimately, federal funds that are improperly drawn or used must be repaid with General Funds.

Recommendations:

1. DMA and DHHS should be required to submit reasonable estimates for all known Medicaid expenditures in their agency budget requests. If expenditures exceed allowable limits, DHHS, the Governor, or the General Assembly should take actions to reduce expenditures to stay within spending caps, rather than omit known expenditures from the budget.
2. DMA's agency request budget should adjust expenditures for all known costs that increase or decrease with fluctuations in caseload, including costs in administrative funds 1101 and 1102. These requests should be accompanied by appropriate documentation.
3. When DMA perceives that the General Assembly has included unachievable savings in their budgets, DMA should provide OSBM with documentation of this at the beginning of the biennium or fiscal year, along with a forecast of the additional total dollars and State General Fund that will be required to cover this unachievable savings.
4. DMA should discontinue the practice of incurring liabilities for the State at the beginning of the fiscal year because they have overdrawn federal funds in the prior fiscal year to offset State General Fund shortfalls.
5. Because Medicaid is such a large and complex program with a significant impact on the State budget, DMA may require more oversight than any individual Department Secretary with multiple other divisions and programs can provide. The General Assembly should consider organizational changes that could improve the oversight needed to ensure that the Medicaid program is operated in compliance with legislative mandates.

Finding #2: The Division's budget forecasting methodology has not incorporated comprehensive multiyear projections and does not provide an accurate picture of the current year's financial position.

The Division prepares formal forecasts for only one of their funds, 1310 – Medical Assistance Payments. This does not provide a complete picture of the Medicaid program's status in complying with the Certified Budget or achieving State General Fund reductions that have been mandated by the General Assembly.

In 2012, OSBM's documentation showed the following shortfalls in Medicaid funds:

- $264,638,431 in medical payments and operating shortfall.
- $40,932,072 for the 2012 installment to repay the Federal government for the $321 million overdraw in 2009.
- $41,734,368 to repay the Federal government for a disallowance for personal care services.
- $28,074,087 to pay the Federal government for drug rebates under new rules established by the Affordable Care Act (ACA).

The total shortfall for these four items was $375,369,958 in State General Fund. On October 27, 2011, the Division testified before the Joint Legislative Committee on Governmental Operations that they anticipated a shortfall of $139 million as follows:

Unbudgeted Liabilities	
Repayment of Overdraw 2009	$41 million
Repayment PCS Disallowance	42 million
Payment of Federal drug rebates ACA	28 million
Other Federal payments	9 million
PCS claims paid for services under appeal	6 million
Total Unbudgeted Liabilities	$126 million
Unbudgeted Revenues	
Retroactive hospital provider taxes	($22 million)
Qualified Public Hospital claims	(62 million)
Total Unbudgeted Revenues	($84 million)

Shortfalls from Medicaid Budget Cuts	
CCNC savings	$39 million
Inflationary adjustments	36 million
Provider assessment recoveries	13 million
Expansion 1915b/c waiver	9 million
Provider rate cuts	2 million
Mandatory and optional services	7 million
Total Shortfall from Medicaid Budget Cuts	$106 million
Net Budget Shortfall	$148 million

As stated earlier, the Division reported that their expected budget shortfall on October 27, 2011 would be $139 million. The explanation for the difference between the calculated amount of $148 million and the stated shortfall of $139 million is unknown.

Budget Forecasting

In the documentation request for this audit, the Office of State Auditor requested two types of budget forecasts from the Division:

- Multiyear budget forecasts or projections provided to the Office of State Budget and Management or other State agencies.
- Budget forecasts for Medicaid medical services produced during SFY 2010, 2011, and 2012 to support projected expenditures for the current fiscal year.

The only forecasts received from the Division were monthly projections pertaining to Fund 1310. These forecasts showed that Fund 1310 would experience the following projected shortfalls:

- September 2011 - $152.8 million
- October 2011 - $98.7 million
- November 2011 - $104.5 million

DMA has stated that they used SAS forecasting software to forecast caseload. Caseload is a critical cost driver in Medicaid expenditures because it is the chief factor in determining the quantity of services provided and because it is a factor over which Medicaid managers can exercise little or no control. In its forecasts, DMA uses actual caseload for that portion of the year which actual numbers are available and caseload forecasts for the remainder of the year to project expenditures.

DMA's forecasting methodology does not allow for reliable forecasts beyond the current fiscal year. As previously noted, DMA does not formally forecast for funds other than 1310 – Medical Assistance Payments, so the only projections available for other Medicaid funds are the amounts in the Certified Budgets. Expenditures DMA knew would occur have been omitted from these budgets in the past, so the budgeted amounts cannot be relied upon as reliable projections.

When compiling the budget rebase for Fund 1310 – Medical Assistance Payments, the Division sometimes includes a two-year forecast and sometimes does not; however, when the second year forecast has been included it has not been complete:

- In the 2012 rebase, the forecast for 2013 did not include a 2013 caseload projection. Expenditure projections for 2013 used the caseload forecast for 2012.
- In the 2011 rebase, there was no expenditure projection for 2012.
- In the 2010 rebase, expenses and revenues were projected for 2011, but no documentation was provided to the auditors to support the projections.

In the 2010 rebase, DMA included adjustments for funds in addition to 1310 – Medical Assistance. While adjustments were requested in the administrative funds 1101 and 1102, there was no request for additional costs for caseload increases, for claims processing, or for programming for the MMIS contract. DMA stated that their inability to include these costs has resulted in the most significant shortfalls in the administrative budgets; however, DMA has provided no evidence that they forecast for these costs or that they requested funding to pay for them.

No Comparison of Forecasts to Actual Expenses

DMA does not follow best practices to improve its forecasting methodology. Specifically, DMA has not provided evidence that it compares forecasts to actual budget performance after the close of the forecast period to determine why projected amounts vary from actual expenditures.

If performed, a forecast-to-actual comparison would allow DMA to revise its forecast methodology to more accurately project expenditures. DMA revises the data it uses in its forecasts on a monthly basis. However, DMA has not significantly revised its forecast methodology since July 2009 in spite of substantial variances between forecasted and actual expenditures.

The Government Finance Officers Association (GFOA) recommends that governments compare forecasts to actual results. The GFOA states:

> To improve future forecasting, the variances between previous forecast and actual amounts should be analyzed. The variance analysis should identify the

> factors that influence revenue collections, expenditure levels, and forecast assumptions.[7]

Failure to compare forecasts to actual results may prevent DMA from identifying ways to improve its forecasting methodology. Consequently, the State's Medicaid expense forecast may not be as accurate and reliable as possible. Reliance on inaccurate and unreliable forecasts could force the State to search for funds to meet unanticipated Medicaid expenses.

No Multiyear Financial Projections

DMA does not follow best practices to improve the reliability and usefulness of its Medicaid forecasts. Specifically, DMA does not provide forecasts of expenditures for years beyond the current biennium. Such comparisons are necessary to provide an early warning of issues and problems because "Budget issues and problems are not limited to a single fiscal year, they trend over several years."[8] Best practices recommend multiyear forecasts to allow the State policymakers to engage in informed long-term planning. The State Budget Act requires the Governor to include a five-year fiscal analysis as part of the budget message, and the State's budget outlook for the next five years cannot be assessed without consideration of Medicaid's anticipated expenditures.

The GFOA recommends that governments produce multiyear financial forecasts. The GFOA states:

> The GFOA recommends that governments at all levels forecast major revenues and expenditures. The forecast should extend at least three to five years beyond the budget period and should be regularly monitored and periodically updated. The forecast, along with its underlying assumptions and methodology, should be clearly stated and made available to participants in the budget process.[9]

The "Best Practices Guide for Preparation of Medicaid Budget Estimates" provides another reason for preparing multiyear financial forecasts. The guide states:

> Particular benefit changes may be phased-in according to a schedule set by legislation. Such peeks into the future should be sought and utilized wherever possible. It is a statistically sound observation that a peek is worth two finesses in bridge and more in projecting the cost of health care programs.[10]

Failure to prepare multiyear financial projections may prevent DMA from timely identification of problematic issues and trends. Consequently, the Governor and General Assembly may not have the information needed to facilitate long-term planning and decision-making.

---

[7] GFOA, Financial Forecasting in the Budget Preparation Process, 1999
[8] Michigan GFOA, Multi-year Budgeting and Long-term Financial Forecasting, 2010 (presentation)
[9] GFOA, Financial Forecasting in the Budget Preparation Process, 1999
[10] Actuarial Research Corporation, Best Practices Guide for Preparation of Medicaid Budget Estimates

Recommendations:

1. DMA should forecast for all Medicaid funds, and these forecasts should be provided in an agreed upon format to OSBM and Fiscal Research Division at least quarterly.
2. DMA should maintain a comparison of forecasted expenditures and revenues to actual year end budget performance and subject it to analysis that can improve the ability to project expenditures and revenues.
3. DMA should prepare a five-year analysis to contribute to the Governor's budget message and should routinely forecast expenditures and revenues for a minimum of three years in the future.

Finding #3: The Division of Medical Assistance does not appropriately manage Medicaid costs that are subject to agency control.

Medicaid Cost Overview

Medicaid is an entitlement program. This means that North Carolina residents who qualify for Medicaid under the State's eligibility rules must be placed on the Medicaid rolls. Once a resident is approved for Medicaid, that person must be provided with all benefits that are available to his or her eligibility group under the North Carolina Medicaid State Plan. Both American Recovery and Reinvestment Act (ARRA) and later, the Affordable Care Act imposed maintenance of eligibility requirements on the states that do not currently allow them to make their eligibility rules more restrictive if the State wishes to benefit from enhanced Federal matching rates available through the Acts.

Caseload for existing Medicaid eligibility groups is, thus, a Medicaid cost driver that the Division can only control through fraud detection to prevent individuals who are not truly eligible from qualifying for and using services. Costs due to expansion of eligibility to new groups are avoidable; however, the North Carolina Medicaid program has not expanded eligibility in the past four years.

Caseload is one of three significant cost drivers for claims-based medical services. The other two cost drivers are price (the reimbursement rate provided to the medical provider) and consumption (the Medicaid recipient's utilization of services). The Division can exercise some degree of control over price and consumption. The State has considerable latitude in setting reimbursement rates. The Social Security Act Section 1902(a)(30)(A) stipulates that Medicaid "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Within these broad guidelines, the states may structure their own rate methodologies (subject to CMS approval) and, thus, control the price variable.

There are a variety of methodologies for controlling consumption. Some of the most effective include prior authorization of costly services, fraud and abuse detection, imposing cost sharing, and limiting optional services offered by the program. Managing care, through

programs such as risk-based commercial managed care or case management through medical homes or commercial administrative services organizations, are options that are employed by states to control medical services cost, but there is controversy concerning their short- and long-term effectiveness in controlling medical services costs.

Cost Per Eligible

The price and consumption components of medical services are represented in the Cost per Eligible statistic (CPE). CPE is the average cost of providing services to an average Medicaid eligible over a specified period. North Carolina's annual CPE is the highest in Federal Region IV and it is more than 10% higher than the US average, which indicates that the NC Medicaid program provides a rich benefit package.

Annual Cost Per Eligible (CPE) 2009

Region IV Medicaid Program

State	Aged	Disabled	Adults	Children	Total	Rank
North Carolina	$10,664	$16,050	$4,059	$2,796	$6,098	1
Kentucky	$9,759	$10,430	$4,649	$2,952	$5,890	2
South Carolina	$10,936	$13,331	$3,254	$2,312	$5,181	3
Mississippi	$9,775	$9,697	$3,352	$2,225	$4,890	4
Tennessee	$7,484	$9,826	$4,115	$2,376	$4,742	5
Florida	$7,917	$10,883	$2,569	$1,627	$4,168	6
Alabama	$8,265	$7,020	$2,035	$2,398	$4,081	7
Georgia	$8,183	$8,999	$4,424	$1,811	$3,979	8
US	$13,186	$15,453	$2,926	$2,313	$5,535	

Optional services play a role in a North Carolina's high cost per eligible. In a September 9, 2011 presentation to North Carolina's Medical Care Advisory Committee, Division staff provided statistical data showing that North Carolina spent 29 percent of Medicaid dollars on optional services compared to the U.S. average of 13 percent.

Reimbursement Rates

Reimbursement rates play a role in North Carolina's high cost per eligible. Many of Medicaid's rate methodologies provide for automatic rate adjustments every year, which typically results in increases in rates annually. For example:

- Inpatient hospital rates are paid according to Diagnostic Related Groups (DRG) and the group is updated annually with Medicare updates.
- Inpatient psychiatric rates are based on costs and adjusted annually for inflation.
- Outpatient hospital and clinics are paid cost-based rates. Costs tend to increase annually.
- Nursing facilities receive case mix and inflationary adjustments. This resulted in a cost of $12.9 million in State General Fund in 2012.
- Physician rates are based on the Medicare fee schedule in effect on the date of service. The Medicare fee schedule tends to increase annually.
- Personal care services, independent laboratory services, durable medical equipment, private duty nursing, and other practitioner services receive an annual inflationary increase.

The 2011-2013 budget, as reported in the Senate Appropriation Committee substitute for HB 200, included an item to address accelerating Medicaid reimbursement rates:

> Item 53 – Adjust Provider Rates: "Reduces Medicaid provider reimbursement rates. The Division of Medical Assistance is to reduce Medicaid provider rates by 2%, except as provided for in Section 10.37." This was estimated to save the State General Fund $46.4 million in 2012 and $46.5 million in 2013.

The current reimbursement methodologies allow rates to increase automatically unless action, such as that cited above, is taken to stabilize or reduce rates. However, it is possible to structure reimbursement methodologies so that rates remain stable unless positive action is taken to increase them. This strategy provides greater control of the price component of medical services costs.

Community Care of North Carolina (CCNC)

While North Carolina Medicaid relies on several strategies to control consumption, the single strategy that is invested with creating the greatest cost savings is Community Care of North Carolina (CCNC). CCNC is a form of managed care that provides case management services in a medical home environment. It is assumed to provide savings in providing medical services to participants. In the 2011-2013 budget, the General Assembly budgeted $90 million dollars per fiscal year in cost savings for "[b]udget savings to be achieved by DHHS, in conjunction with CCNC Networks and North Carolina Community Care, Inc., through the cooperation of Medicaid health care providers." When the 2013 budget was

rebased and enacted during the General Assembly's short session, the amount of State General Fund savings to be created by CCNC was increased by $59 million to $149 million for fiscal 2013.

In October 2011, the Division estimated that it would miss meeting the targeted General Fund savings for CCNC by $39 million. At the end of the fiscal year, the Division stated it was $39.5 million short of meeting the $90 million target. In spite of the 2012 savings deficit, the Division stated it was confident it would realize the $149 million in State General Fund savings from CCNC operations that is budgeted for 2013. When the Division was asked what evidence it had that CCNC saves money, officials stated that the only evidence in is an actuarial analysis done by Milliman, Inc. Division representatives stated that they used the Milliman study as a basis for determining that they could realize the $149 million cost savings in the 2013 budget, stating that the study provided CPE for use in budgeting. However, Milliman includes a disclaimer in the study that cautions against using it for any purpose except to estimate cost savings for the years of the study based on the actuarial assumptions that were employed in the study.

North Carolina's managed care system is unique. North Carolina is the home of the medical home. Unlike any other state, it has employed a medical home model for patient care management since at least 1998. This is a model that other states are exploring to create savings through care management. Recent budget actions by the General Assembly have assumed that the model saves significantly on Medicaid expenditures. However, North Carolina's Medicaid cost per eligible is higher than any other state in Region IV and is higher than the national average. The question should arise, if CCNC saves significantly on Medicaid expenditures, why does North Carolina spend so much more on Medicaid than comparable states?

North Carolina's unique Medicaid delivery system offers a unique opportunity. More than a decade of data exists that would allow a study by medical researchers on whether the medical home model truly saves money and/or results in better medical outcomes. The actuarial study performed by Milliman is based on assumptions and adjustments to data. For instance, it adjusts the health status of relatively healthy adults and children in CCNC to be comparable to non-CCNC participants. However, this requires an assumption that the CCNC participants are much unhealthier before comparing the projected costs of the theoretically unhealthy population to the non-CCNC population. While such an exercise may be actuarially sound, it does not provide the same quality of data that could be derived from medical research. Nationally, the states are looking to medical homes as a possible vehicle for reducing health care costs and improving outcomes. It would be a service to the nation as well as North Carolina to use its data to genuinely evaluate the questions associated with medical homes.

In September 2010, OSBM issued a reported titled "Analysis of Medicaid Staffing and Organization." In that report, OSBM found that cost containment was not an organizational priority. The reported states, "Historically the Medicaid program has been more concerned about how to provide more services to more people than in containing costs." Providing more services may or may not benefit the recipient receiving the services; however, providing more services benefits the providers, who receive more total reimbursement for more for providing

more units of service. The Medicaid program, which is a government health insurance program, should encourage controlling the cost of medical services.

Recommendations:

1. Because caseload is a significant cost drive for Medicaid, DMA should perform multiyear caseload projections to support multiyear expenditure forecasts, and these forecasts should be tracked against actual caseload growth to evaluate the accuracy of the forecasting methodology.
2. DMA should perform a study to evaluate reimbursement methodology reform which should have a goal of establishing stable reimbursement methodologies that do not increase automatically, but are only increased by actions approved by the General Assembly.
3. The State of North Carolina should engage medical researchers to perform a scientifically valid study based on actual data to determine whether the CCNC model saves money and improves health outcomes.
4. Actions should occur, probably from outside the agency, to enforce a change in Division organizational culture to provide a focus on a health insurance perspective that encourages cost containment in an environment of increasing medical services and expanding payments to providers.

Finding #4: DMA failed to comply with a legislative mandate to eliminate inflationary increases for nursing facilities.

The 2011–2013 budget, as reported in the Senate Appropriation Committees substitute for HB 200, included Item 52 for the DMA budget which "Eliminates automatic inflation increases for Medicaid providers. The Division of Medical Assistance is not to authorize any inflationary increases to Medicaid provider rates during the 2011-13 biennium, except as provided for in Section 10.43." Following the close of fiscal year 2012, DMA reported to OSBM on the composition of their General Fund operating shortfall. The Division stated that Item 52, which HB 200 projected to save $62.9 million in 2012, failed to reach its target by $36 million. Included in the $36 million shortfall was $12.9 million that was attributed to "DHHS Decision."

During the course of this audit, DMA was asked to explain which "DHHS Decision" resulted in a budget shortfall of $12.9 million in State General Fund. The Division provided the following explanation:

> This amount was reflected as increased cost for the Nursing Case Mix index which was included as inflation in the Medicaid rebase, since it is an increased cost that is not in the control of DMA without a change in the overall reimbursement system for nursing home services. "Inflation" was removed by the Legislature from the Medicaid budget/rebase.

The nursing home reimbursement system is built on a complex formula that separates direct costs from indirect costs and identifies separate costs for capital related expenditures for each facility. Each is developed separately, with the final element of the formula being a quarterly adjustment for individual facility case mix index average for Medicaid residents. The decision was made that excluding this component from the rate methodology would have an adverse impact on nursing facilities and the resulting access and care for Medicaid enrollees.

In a document submitted to Fiscal Research dated November 8, 2011, DMA made the following statement in response to a legislative inquiry about whether the Division had eliminated inflationary increases as mandated by S.L. 2011-145:

> The cost included in the inflation amount related to skilled nursing facilities was not based upon increases due to inflationary costs, but rather increased acuity of patients served in the nursing facilities. The Legislature adopted an approach called "case mix" for reimbursing nursing facilities several years ago. Under this approach, nursing facilities are reimbursed based upon the medical complexity or acuity of the patients in the facility. The elimination of the projected change in costs for increased acuity of the patients would effectively eliminate case mix reimbursement; as a result, DHHS was informed that the elimination of the case mix was not anticipated or desired by the Legislature. This impacts the targeted budget amount by $12 million.

Some nursing facilities provide care for patients who are sicker or more medically complex than those in other facilities. This degree of medical complexity is labeled acuity. Case mix adjustments give increases or decreases in per diem rates based on the average acuity, or case mix, in each facility. Therefore, a nursing facility that has patients with a high average level of acuity would receive a higher adjustment for case mix to a portion of its per diem rate than a facility with a low level of average acuity.

While it is true that the nursing facility reimbursement methodology is complex, it is not true that eliminating inflationary increases in the nursing facility would necessitate "a change in the overall reimbursement system for nursing home service" or that it would eliminate adjustments to nursing facility rates based on acuity. It is unclear what DMA meant when it stated that "[i]nflation was removed by the Legislature from the Medicaid budget/rebase" and that "[t]he costs included in the inflation amount related to skilled nursing facilities was not based upon increases due to inflationary costs." If the nursing facilities were reimbursed according to the Medicaid State Plan, which was not amended in 2011-2012 to alter inflationary adjustments for this provider type, all of the inflationary components in the Plan were paid to the nursing facilities in fiscal year 2012.

North Carolina's nursing facility per diem rates are different for each facility. They are based on expenditures included in a cost report that must filed by all Medicaid nursing facility providers each year. Nursing facility rates include the following components:

- Direct Care Rate: The Direct Care Rate is generally the cost of operating the nursing facility. It includes two types of costs. The first type is called "case mix adjusted

costs" in the Medicaid State Plan. This is the cost of medical personnel, both staff and contracted. As the name implies, these costs receive a case mix adjustment when setting per diem rates. The second type of costs included in the Direct Care Rate is called "non-case mix adjusted costs." These include items such as nursing supplies, social services, food services, and other costs associated with operating the nursing facility. Non-case mix adjusted costs do not receive a case mix adjustment.

- Fair Rental Value Payment for Capital: This includes costs related to land, land improvements, renovations, repairs, buildings and fixed equipment, and major moveable equipment. This portion of the payment does not receive a case mix adjustment.

- Adjustment of Provider Assessments: North Carolina assesses a provider fee on nursing facilities. Per diem rates to each facility are adjusted based on these payments. This portion of the rates does not receive a case mix adjustment.

Nursing facility rates are set quarterly. According to the State Plan, the rates are derived using audited cost reports from a base year selected by DMA. In 2008, the base year was 2005. While the Division has the latitude to set the base year, the base year usually moves forward each year as audited cost reports from a new year become available. DMA determines a Direct Care Rate for each facility based on non-capital costs. Both the case-mixed adjusted costs and the non-case mix adjusted costs receive an inflationary adjustment each quarter based on the Skilled Nursing Facility Market Basket published by Global Insight. This percentage adjustment is published quarterly and historically has consistently trended upward annually.

The Medicaid State Plan includes a Direct Care Ceiling, which is the Medicaid direct care per diem cost for the base year times 1.026. There is a separate rate for case mix adjusted and non-case mix adjusted portions of the Direct Care Ceiling. This represents an inflationary increase in two ways: (a) when the base year changes from one year to the next, the base costs will increase; and (b) 2.6 percent is added to the new base year cost. The Direct Care Ceiling is used to limit the amount that nursing facility rates for the current year can increase.

The Fair Rental Value portion of the rate is set annually. It is based on replacement construction costs of $127 per square foot in 2007, which is adjusted each year by a national construction cost data index. It includes a $5,000 increase per licensed bed and percentage adjustments for land value and depreciation based on facility age. The Fair Rental Value is the replacement construction cost adjusted by the three-year rolling average interest rates on U.S. Treasury bonds.

If inflation is understood as the increase in prices over a given period of time, the following annual inflationary increases are in included in the nursing facility per diem rate setting methodology:

- The Direct Care Ceiling, controlling the maximum amount that nursing facility rates can increase, will generally go up as the base year used to calculate the ceiling changes from one year to the next.

- The Direct Care Ceiling increases base year costs by 2.6% each year.

- The facility per diem rates, both the case mix adjusted and the non case-mix adjusted portions, receive percentage increases based on nursing facility cost increases reported in the Skilled Nursing Facility Market Basket. (It is theoretically possible that the Market Basket rates could decrease; however, according to the CMS website where the rates are posted, this has not occurred since 2004 and is not anticipated to occur.)

- The Fair Rental Value receives adjustments based on a construction cost index and the U.S. Treasury Bond interest rate.

Only one of these inflationary increases is related to a case mix adjusted portion of the nursing facility rates. However, it would be possible to eliminate inflationary adjustments to this portion of the rate without eliminating the case mix adjustment. The case mix adjustments could be based on base year rates without the inflation adjustment. Since DMA has the latitude to select the base year, it could use the same base year in 2012 and 2013 that it used in setting 2011 rates. There are other methodologies that could be used as well because case mix adjustments reflect the difference in acuity among the various facilities, with higher acuity facilities receiving more reimbursement than lower acuity facilities. This can be accomplished in a variety of ways without increasing overall nursing facility reimbursement. The remaining three inflationary adjustments have nothing to do with the portion of the rate that is case-mix adjusted.

Eliminating the inflationary adjustments for Fair Rental Value and the 2.6% increase in the Direct Case Ceiling would probably require a State Plan Amendment. This should represent no more difficulty that the other State Plan Amendments that were submitted for nursing facility reimbursement in 2011–2012. In fact, DMA included a proposal to retain the Direct Care Ceiling at 100% of the base year rate (as opposed to 102.6 percent) in a document of cost saving initiatives, suggesting the Division did not foresee a problem with eliminating the inflationary increase in the Direct Care Ceiling.

It is likely that the inflationary adjustments pertaining to the Skilled Nursing Facility Market Basket could be eliminated without a State Plan Amendment. With respect to this adjustment (which is called Index Factor), the State Plan says the following:

> The index factor shall be based on the Skilled Nursing Facility Market Basket without Capital Index published by Global Insight.....The index factor shall not exceed that approved by the North Carolina General Assembly.

Since the General Assembly stipulated that there would be no inflationary increases, it is likely that CMS would allow elimination of these increases without amending the State Plan.

It appears that the DHHS Secretary's decision not to eliminate inflationary increases for Skilled Nursing Facilities may be based solely on the perception that this "would have an adverse impact on nursing facilities and the resulting access and care for Medicaid enrollees." No support has been offered for this perception. However, nursing facilities tend to be less likely than many providers to develop access issues as a result of rate reductions. Nationwide, Medicaid provides 70 percent of the reimbursement that nursing facilities receive. In most states, Medicaid is the single largest payer. While nursing facilities may state they will discontinue serving Medicaid recipients if they receive unfavorable action on their rates, few are able to continue operating without Medicaid reimbursement because it represents a significant amount of their income.

Recommendation:

DMA should give complete and accurate information to the General Assembly when seeking approval to violate legislative mandates. Approval by the General Assembly should occur in a recognized forum with authority to provide this approval, rather than in informal discussions with individual legislators.

STATE PLAN AMENDMENTS

Overview of the State Plan Amendment Process

In accordance with Section 1915 of the Social Security Act and stated in the Code of Federal Regulations (CFR 430.10 through 430.25), "The State Plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered within the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State Plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State Program." The State Plan is subject to a Governor's review, or review by designee of the Governor. Then any comments from the Governor must be submitted to CMS with the plan or plan amendment.

CMS regional staff review all state plans and plan amendments for approval. The CMS regional staff will discuss any issues with the Medicaid agency and consult with CMS central office staff on federal policy questions. Federal statutes and regulations, including guidelines in the interpretation of the regulations are used as requirements for approval. The regional administrator has delegated authority to approve or disapprove the State Plan, including previously approved material no longer meeting requirements for approval, and plan amendments.

An approved Medicaid State Plan is allowed to be amended, if necessary, due to changes in laws, regulations, policies, court decisions, operations, or organization. State Plan Amendments (SPAs) should be promptly submitted for review, as sometimes mandated by the State Legislature as part of a budget or other bill, to the Associate Regional Administrator with CMS. The submission is considered received by CMS when an electronic receipt is issued to the state.

CMS must approve, send a written notice of disapproval, or send a written notice to request additional information on a submitted plan amendment within 90 days of submission or otherwise, the plan amendment is considered approved. The 90-day calculation per CMS is noted on the confirmation electronic receipt. If CMS sends a written notice for additional information, the 90-day period begins again after submission of the additional documentation to CMS.

If a state is not satisfied with the CMS Regional Administrator's action, it may request reconsideration within 60 days after receipt of the notice. Within 30 days after the receipt of the request, the Administrator notifies the state of the time and place of the hearing that will occur not less than 30 days or more than 60 days after the date of the notice.

For an approved SPA, the effective date may not be earlier than the first day of the quarter in which an approvable plan is submitted to the regional office. Expenditures for medical assistance although, may not be earlier than the first day on which the plan is in operation on a statewide basis.

In addition to the timeline above per CMS and Federal Regulations, the State of North Carolina State Plan requires presenting the potential SPA to Native American tribes and to provide them with a 60-day waiting period to respond with comments.

SPAs are typically changes made to the state plan regarding eligibility, covered services, benefit structure, adding or removing optional services and changes in provider payment rates. The results of some of these amendments impact the program financially and therefore changes within the budget are needed. The budgeted amounts may include savings to the program that need to be accounted for in the budget. The amount of savings estimated varies based on the dates of approval, the effective dates, and the dates of implementation.

A SPA is created within DMA through a collaborative effort of the Medicaid Director, the Chief Business Operations Officer, the Chief Clinical Operations Officer, the SPA Coordinator, and others. DMA prepares a CMS 179 Form and attaches supporting documentation for the SPA including the existing pages from the State plan to be changed and the updated language for the change. Once DMA has completed the SPA, it is then sent to the DHHS for their approval. Upon DHHS's approval, the SPA is submitted to CMS to go through their approval process described above.

Impact of SPAs on Budgeted Savings

DMA and DHHS have frequently asserted that delays in the SPA approval process contributed to the budget short falls. The DHHS Secretary made statements through Memorandum on January 17th, 2010, in a Joint Legislative Commission on Governmental Operation Subcommittee meeting on January 19th, 2010, and in a Joint Legislative Commission on Governmental Operations meeting on January 20th, 2010 regarding delays in the SPA process for fiscal year end 2010 causing budgeted savings to not be achieved. The Secretary stated that for many budget reductions efforts state plan amendments must be submitted and cannot be implemented until CMS approval. He said they have submitted numerous SPAs required by the General Assembly's budget but had only received approval for rate reductions as of January 2010, and the lack of additional approvals has caused a delay of over $90 million in reductions. The Secretary also stated that the rate reductions were in place in the preceding October, before CMS' approval of the SPAs. He planned to reimburse the providers if the SPAs were not approved. He also stated SPAs were still outstanding from 2005 and 2007.

The Secretary's statement above was made in January of the state fiscal year 2010. The submission dates for the rate reduction SPAs were 9/29/2009 and all but one SPA had an effective date of 7/1/09, which means any savings for the full budget year could be achieved. The Secretary noted that DMA went ahead and implemented the rate reductions on 10/1/09 although they could go back to the effective date of 7/1/09 retroactively and recoup any savings as the reductions could have been calculated back to that date. The remaining SPAs during this fiscal year prior to the Secretary's statements were approved and effective within a reasonable timeline by CMS. Based on our review of SPAs provided by the DMA, there was no indication that there were SPAs still outstanding from 2005 and 2007.

Similar statements are found in the October 27, 2011 Presentation to the Joint Legislative Committee on Government Operations, Department Response to Questions Directed from Legislative Fiscal Research, and in the minutes from the January 25, 2012 meeting of the Joint Legislative Oversight Committee on Health and Human Services.

From interviews with DMA personnel, we noted several explanations as to how the SPA process contributed to the budget shortfalls. Below is a table indicating the Division's assertion and the results of our analysis.

Division Assertion	Results of Audit Review
Staff stated that being unable to submit a SPA until the Legislature approved state budget, which can occur late September and early October, prevented budgeted savings related to SPAs to be effective as of July 1st for 12 months of savings. The earliest possible submission date would be October 1st for 9 months of savings. This timing is due to the federal guideline that the effective date may not be earlier than the first day of the quarter in which an approvable plan is submitted to the regional office.	We performed a detailed review of SPAs that the Division documented as having budgeted savings in which the actual savings were less for fiscal years 2011 and 2012. We reviewed dates of submission, effective dates, and planned implementation dates by the Division. In each case of a SPA being submitted shortly after the beginning of the second quarter (October 1), where the legislative budget approval could have been an issue, it was noted that either the SPA did not have significant savings budgeted or the effective date set by CMS was also the planned implementation date set by the Division. This concern did not have a significant impact on budget shortfalls.
Staff noted the system of CMS approving SPAs sequentially has delayed SPAs budgeting savings if a SPA numbered ahead of those is being held up.	Upon our detailed review of submission, approval, implementation, and effective dates, there were no SPAs that had significant savings built into the budget that would have fallen into this area of not being approved due to the prior numbered SPA not being yet approved.
Staff noted a SPA waiting period can be extended before being sent to CMS due to the 60-day period the state has to allow Tribes to comment if their population is impacted by the SPA.	a. Upon our detailed review of submission, approval, implementation, and effective dates, there were no SPAs that had significant savings built into the budget that would have fallen into this area. b. We reviewed the Division's explanations as to why the SPAs savings were not achieved and this issue was not noted in any of the cases.

Staff noted that there are instances in which the Legislature does not order a specified SPA but rather provides a dollar amount of savings necessary to reduce the budget and leaves the Division to decide how the savings will be met.	a. Upon our detailed review of submission, approval, implementation, and effective dates, there were no SPAs that had significant savings built into the budget that would have fallen into this area. b. We reviewed the Division's explanations as to why the SPAs savings were not achieved and this issue was not noted in any of the cases.

DMA provided us with a list of all SPAs submitted for fiscal years 2009 through 2012. The list included details about each SPA including submission dates, approval dates, effective dates, and requests for more information. For fiscal years 2011 and 2012, the list of SPAs included details on the proposed budget savings for each SPA and the estimated actual program savings achieved. We performed a detailed analysis of significant SPAs that included budgeted savings for fiscal years 2011 through 2012. This analysis included reviews of the dates occurring within the process and the Division's explanations for any unachieved savings related to these SPAs.

Finding: The cost savings incorporated into the budget for specific State Plan Amendments (SPAs) are not always realized due to varying factors - some within DMA's control.

DMA did not take the necessary actions to realize budgeted savings in the following ways:

- DMA submitted SPAs with unreasonable effective dates given the time needed for the CMS approval process.
- These SPAs would have required retroactive implementation that DMA had no intention of doing. DMA did not plan for retroactively implementing SPAs in cases where DMA should have been reasonably certain that the SPA would not be approved and implemented by the budgeted implementation date.

For example, DMA submitted nine SPAs with budgeted cost-savings to CMS for approval in SFY 2011.[11] According to DMA documentation, the amendments were budgeted to save $72.2 million but only saved $34.2 million (or $38 million less than budgeted). Once the savings were not achieved, DMA excused much of the lost savings to delays in the SPA process.

However, a review of the nine SPAs indicates that $31.9 million of the $38 million in unachieved savings corresponds to only three SPAs. The additional savings would have been realized from the following SPAs:

[11] Presentation to Joint Legislative Committee on Governmental Operations, October 27, 2011

- SPA 10-031: Reform the personal care services program - $25.8 million.
- SPA 11-001: Eliminate reimbursement for preventable medical issues - $5 million.
- SPA 10-024: Improve the pharmacy program - $1.1 million.

Given that CMS has 90 days to either approve a SPA or ask for additional information, DMA documentation for the three SPAs indicates that the SPAs were not submitted in time to be approved and implemented by the budgeted implementation date.

The table below shows that the SPAs were not submitted to CMS within 90 days of the budgeted implementation date. Consequently, it was not reasonable for DMA to believe that the SPAs would be approved and implemented in time to achieve the expected savings, as shown in the following table:

SPA	Submission Date	Budget Implementation Date	CMS Approval
10-031	10/25/2010	1/1/2011	4/15/2011
11-001	3/24/2011	1/1/2011	1/17/2012
10-024	9/1/2010	11/1/2010	3/21/2011

Knowing that the SPAs would not likely be approved and implemented by the budgeted implementation date, DMA could only achieve the savings corresponding to the above mentioned SPAs by implementing them retroactively. Federal law allows states to retroactively implement Medicaid program changes back to the "effective date" which can be earlier than the CMS approval date.[12] Retroactive implementation would have allowed DMA to achieve the planned savings because the "effective date" for each SPA was either the same as or earlier than the SPAs budget implementation date. In other words, DMA could have met its budget implementation date through retroactive implementation.

However, DMA had not planned for retroactive implementation. As such, cost savings opportunities afforded to the State, commensurate with CMS' approval of the amendments, were not pursued and, therefore, the State did not realize the savings.

DMA provided the following reasons for not retroactively implementing the SPAs:

- Attempts to retroactively implement the amendments and collect overpayments from medical providers who had already provided services and been paid could result in lawsuits and appeals.
- The current Medicaid Management Information System (MMIS) does not have the capacity to process the number of transactions necessary to retroactively implement

[12] Code of Federal Regulations, Title 42 Section 447.256(c).

the changes. Division management indicated that the new MMIS under development will be able to handle retroactive transactions efficiently.

- The administrative cost to the Department and providers was cost prohibitive to retroactively implement all changes.

Therefore, DMA's plan for saving $72.2 million through these SPAs was never reasonable to achieve.

Recommendation:

The savings incorporated into the state budget need to be more realistically calculated by the DMA and DHHS with consideration of costs of implementation and realistic implementation dates given current system constraints.

REPORTING

In the 2006 GASB White Paper: Why Governmental Accounting and Financial Reporting Is – and Should Be – Different, The Governmental Accounting and Standards Board (GASB) states:

> Accounting and financial reporting requirements focus on the needs of the users of financial reports. Citizens and their elected representatives, such as legislatures, and other oversight organizations...are primary beneficiaries of the information in governmental financial reports. The needs of citizens and oversight organizations emphasize accountability for resources entrusted to the government.

Accountability is the distinguishing characteristic of governmental accounting, and reporting is how the accountability is achieved. North Carolina's Certified Budget is the operations plan for the State and the standard against which financial performance is measured. To achieve the desired accountability, public agencies must provide periodic information demonstrating how well they are performing.

In interviews, DMA and DHHS financial managers have suggested that, in many ways, Medicaid spending is beyond their control. Administratively, they have been unable to control programming and other costs associated with the Medicaid Management Information System (MMIS). They have been unable to control the costs associated with federal actions to recover funds. They have been unable to realize the full amount of cost savings that the General Assembly placed in their budget. To the extent that costs are driven by caseload or by unforeseeable events, they may, in fact, be beyond the control of financial managers. This makes frequent and complete reporting all the more important.

Finding: Medicaid reports do not provide easily understood and timely data.

DMA does not issue readily understandable and timely Medicaid performance reports to government officials who oversee the Medicaid program.

DMA provides periodic reports with detailed Medicaid financial data to the DHHS Secretary, the Fiscal Research Division, and OSBM. For example, the reports include detailed financial data regarding medical claims payments, cash flow, and monthly fees.

However, DMA does not provide clear, succinct, summarized information showing the year-to-date fiscal status and projections for the Medicaid program and reasons for deviations from the certified budget. To draw conclusions from the detailed data, report users must perform their own analyses or ask additional follow-up questions to obtain the necessary information.

Report users from Fiscal Research and OSBM are not satisfied with the usefulness and timeliness of the reports. Report users have noted a lack of targeted information to help them quickly identify unanticipated events or outlays that could indicate Medicaid program expenditures will differ significantly from previously established forecasts and budgets. Report users also noted that reports have been delayed or not available prior to scheduled

meetings. The lack of timeliness has reduced report users' ability to prepare for meetings about Medicaid's financial status.

Best practices recommend that a government agency's external performance reports provide readily understandable and timely information.

For example, the Governmental Accounting Standards Board (GASB) provides guidelines for voluntary service efforts and accomplishments (SEA) reporting that are applicable to the Department's external Medicaid performance reporting. The GASB guidelines state:

> In order for the information presented within an SEA report to be understandable, it needs to be expressed simply and clearly. Users have different purposes for reviewing SEA performance information, as well as different interests, needs, and levels of understanding, education, and public involvement. Governments, therefore, need to obtain feedback from actual or potential users of an SEA report in order to enhance the understandability of reported SEA performance information. It also is important to communicate SEA performance information in different forms and at different levels of detail so that the information can be understood by those who may not have a detailed knowledge of a government's programs and services.

In addition, the GASB guidelines recommend that government agency external performance reports provide timely information. The GASB guidelines state:

> Effective SEA reports provide SEA performance information to users before it loses its value for assessing accountability and affecting decisions.

Without readily understandable and timely information, government officials who oversee the Medicaid program may not have the information they need to make decisions and ensure medical services are provided to North Carolina's citizens in an economical and cost-effective manner.

Recommendations:

1. DMA should consult with the DHHS Secretary, Office of the Governor, OSBM, and Fiscal Research Division of the North Carolina General Assembly to determine the informational needs of those charged with governance over the State's Medicaid program. Medicaid reporting requirements, including report formats and timeframes, should be formally established and followed.
2. Once reporting formats and timeframes have been established, the DHHS Secretary should ensure DMA is held accountable for providing accurate and timely reports to stakeholders.

[This Page Left Blank Intentionally]

DMA Administrative Contracts with Expenditures in State Fiscal Year 2012

CONTRACT TYPE	CONTRACTOR	BRIEF DESCRIPTION SCOPE OF WORK	CONTRACT START DATE	CONTRACT END DATE (1)	STATE FISCAL YEAR 2012 EXPENDITURES
DMA Fiscal Agent and Related Services	HP Enterprise Services	Process Medicaid claims	1/17/1989	12/31/2013	$52,048,432
Independent Assessments for Personal Care Services	Carolinas Center for Medical Excellence	Provide independent assessments of all individuals applying for in-home personal care services	10/11/2009	6/30/2013	$10,544,102
Behavioral Health Utilization Review	Value Options	Utilization management and prior authorization of Medicaid and HC covered mental health and substance abuse rehab treatment services	9/20/2011	9/19/2016	$9,696,957
Post Payment Reviews	Public Consulting Group	Conduct post payment reviews of providers with suspected abusive or aberrant billing practices	7/1/2010	10/28/2013	$6,814,906
Third party recovery	Health Management Systems	Third party recovery for Medicaid and Health Choice	4/1/2010	12/31/2012	$3,175,538
ACS State Healthcare	Xerox (formerly ACS)	Pharmacy prior approval and help desk services	12/12/2001	12/31/2013	$3,173,018
Uniform Screening/PASRR	HP Enterprise Services	Preadmission screening and resident review (PASRR)	8/15/2006	12/24/2012	$2,358,817
Analytical & Clinical Services	Mercer Health & Benefits, LLC	Provide financial analysis, cost savings and cost benefit comparisons for pharmacy initiatives	12/1/2010	6/30/2014	$2,184,240
Prepayment Claims Review	Carolinas Center for Medical Excellence	Identify and perform cost avoidance for claims payments for clinically inappropriate care	11/2/2009	12/31/2013	$1,915,719
Authorization for Specialized Therapies	Carolinas Center for Medical Excellence	Prior approval and post payment validation of Outpatient Specialized therapies	11/1/2009	10/31/2012	$1,833,143
Actuarial & Analytical Services	Mercer Health & Benefits, LLC	Review/interpret the impact of various budget and policy issues and provide financial analysis/cost savings/cost benefit comparisons for PACE and PBH LME, PIHP and MedSolutions	1/1/2011	12/31/2013	$1,649,790
Utilization Review & Management	Durham Center	Utilization reviews, utilization management, and service authorizations for publicly funded mental health, developmental disabilities and substance abuse services	9/20/2010	9/19/2013	$1,188,570
Auditing Services	Myers & Stauffer, LLC	Provide auditing services, perform field audits on Medcaid cost reports and recalibrate hospital Medicaid diagnosis related group weights	1/15/2009	1/15/2014	$1,159,987
FAMS	IBM	Fraud and Abuse Management System	11/15/2011	9/30/2012	$1,108,000
NCFADS	Ingenix	Fraud and Abuse Detection System	9/22/1999	12/31/2012	$1,07
DRIVE	Ingenix	DRIVE database - DMA Decision Support System	8/5/1997	12/31/2013	$1,06
MDS Validation Program	Myers & Stauffer, LLC	Verify the Minimum Data Set (MDS) assessments and supporting documentation for nursing facilities	9/11/2009	9/10/2013	$1,024,832
Smart PA, Evidence based pharmacy Pas	Xerox (formerly ACS)	Provide evidence based pharmacy automated prior approvals	6/12/2007	12/31/2013	$997,923
Utilization Review & Management	Eastpointe	Utilization Reviews, Utilization Management and service authorizations for publicly funded mental health, developmental disabilities and substance abuse services	9/20/2010	9/19/2013	$798,169
HIV Case Management	Carolinas Center for Medical Excellence	HIV case management	6/29/2011	6/28/2013	$614,483
CCNC Network Cost Savings Study	Milliman, Inc.	Study to determine cost savings with CCNC Network	12/21/2010	12/31/2013	$542,500
Review of Emergency Services for Aliens	Maximus	Medical reviews of emergency cases for undocumented aliens and legal aliens not qualifying for full Medicaid benefits	9/22/2011	10/1/2013	$536,599
SAS OnDemand	SAS Institute Inc.	SAS OnDemand licenses and services	12/20/2010	3/19/2013	$500,000
Fiscal Management Services	GT Financial Services	Serve as fiscal/employer agent to administer funds and manage payroll for participants in the self-directed options of Medicaid waiver programs	5/15/2010	6/16/2013	$418,597
SAS Forecasting	SAS Institute Inc.	SAS forecasting implementation and consultation services	9/1/2011	6/30/2013	$120,081
North Carolina Physicians Advisory Group, Inc.	NCPAG	Advise NC DHHS on ways to expand access to quality cost-effective health care services. Contract for NCPAG is mandated through legislation	9/21/2011	6/30/2013	$94,013
Rapid Resource for Families	Easter Seals UCP NC and VA	Evaluate the effectiveness of intensive treatment interventions provided in therapeutic foster care settings for severely emotionally and behaviorally disturbed children and adolescents	1/4/2012	1/3/2014	$76,080
CAHPS Survey	UNC-Charlotte	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey	6/9/2011	4/30/2014	$57,136

Note: (1) Contracts may have been renewed or extended beyond the end dates listed here
Source: Supplied by Division of Medical Assistance

North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

January 30, 2013

The Honorable Beth A. Wood, State Auditor
Office of the State Auditor
2 South Salisbury Street
20601 Mail Service Center
Raleigh, North Carolina 27699-0601

Dear Auditor Wood:

We have reviewed your report on the findings and recommendations that resulted from the Division of Medical Assistance – Performance audit of the Department of Health and Human Services as outlined in Section 10.9A.(a) through (b) of the 2012-2013 North Carolina State Budget. We appreciate the work you have done on behalf of the people of North Carolina and look forward to our continued work together as we improve the operations of the Division of Medical Assistance. The following represents our responses to the Report Findings and Recommendations.

SUMMARY OF RESULTS

ADMINISTRATIVE FUNCTIONS

Finding #1: The Division has consistently exceeded budgeted amounts for contracted administrative costs and interagency transfers due to an apparent lack of oversight.

General Response: *The Department agrees with this recommendation. The Division will be implementing, within the next month, a system to track contract requirements and expenditures on a weekly basis. Under no circumstances will contractors be allowed to exceed the budgeted contract amounts without an approved amendment to the contract. In order to correct historical issues with the budget, we will be requesting a review of our certified budget to ensure that contracted amounts reflect accurate operational costs. For example, the line item for Hewlett Packard (HP) services has been held at the 2005 contracted amount; however, with the increase in the number of Medicaid eligibles and providers this contract amount has increased yet is not reflected in the budgeted line item for this contract.*

www.ncdhhs.gov
Telephone 919-855-4800 • Fax 919-715-4645
Location: 101 Blair Drive • Adams Building • Raleigh, NC 27603
Mailing Address: 2001 Mail Service Center • Raleigh, NC 27699-2001
An Equal Opportunity / Affirmative Action Employer

Recommendations:

Beginning in SFY 2013, DMA began tracking contract expenditures to date against total claimed amounts over the term of individual contracts to identify cases where no purchase order is on file, no current claim is in North Carolina Accounting System (NCAS) or the amount is questionable, or the contract is over budget. As a result, three months into SFY 2013, DMA discovered it was already over its certified budget for contracts. While DMA has taken a step in the right direction by tracking costs against certified budget limits, DMA needs to ensure expenditures do not exceed certified budgeted amounts.

DHHS Response: *The Department agrees with this recommendation in concept; however, as discussed in the previous recommendation, the line items for the budget must reflect approved amounts.*

Finding #2: Other Department of Health and Human Services (DHHS) division administrative spending is not controlled by DMA and is not sufficiently monitored by DHHS to ensure proper drawdown of federal funds.

General Response: *The Department agrees with the statement that other DHHS division administrative spending is not controlled by DMA. The Department will develop operating procedures which comply with the recommendation of this audit and as part of the development of the cost allocation plan.*

Recommendations:

DHHS and DMA need to ensure that proper measures are in place to monitor other divisions' Medicaid spending. Interagency memorandums of understanding (IMOU) or cost allocation plans (CAP) should address the Medicaid program costs being necessary for the proper and efficient administration of the Medicaid State Plan and not the responsibility of a non-Medicaid program.

DHHS Response: *The Department agrees with the recommendations. DMA provides a pass-through function for other DHHS Divisions to appropriately access federal Medicaid matching funds for administrative functions relating to Medicaid recipients. Other Divisions with administrative services that support the Medicaid program record expenditures in the NCAS in order to draw federal funds. The Cost Allocation Branch of the Office of the Controller, in conjunction with Division Budget Offices, maintains comprehensive cost allocation plans (CAPs) to ensure accurate and allowable allocations to the Medicaid program. The CAPs are submitted to the U.S. DHHS Division of Cost Allocation for distribution to Federal partners including CMS for approval. Expenditures that are eligible for Medicaid federal match are included on the CMS 64 report based on amounts recorded in NCAS.*

DMA does not directly audit other Divisions' expenditures for accuracy. However, financial reports are available that provide detail of the expenditures. The Division of Medical Assistance will work with other Divisions in order to ensure compliance with all Federal and State requirements. Program managers who have only been monitoring

program issues will have their role increased to monitor compliance with financial requirements.

Finding #3: The Department does not have a comprehensive Public Assistance Cost Allocation Plan that can be reviewed from a Medicaid perspective to ensure that costs are allocable and allowable for the proper and efficient administration of the Medicaid State Plan.

General Response: *The Department agrees with the finding. We will develop and implement a Public Assistance Cost Allocation Plan (PACAP) effective July 1, 2013.*

Recommendations:

DHHS should prepare a department-wide comprehensive PACAP, even if to incorporate the divisional PACAPs through reference. In addition, DHHS should have individuals with a Medicaid programmatic and financial understanding review the comprehensive PACAP to ensure that costs are allocable and allowable for the proper and efficient administration of the State Plan.

DHHS Response: *The Department agrees with the recommendation. As discussed above, the Division will implement a PACAP July 1, 2013.*

Finding #4: DMA does not have a cost allocation plan for appropriately allocating indirect expenditures and tracking expenditures eligible for increased federal funding.

General Response: *The Department agrees with the finding in regards to indirect cost. The Division direct charges expenditures wherever there is a basis to do so. Allocating indirect expenditures would augment the current process.*

Recommendations:

DHHS should reassess their conclusion that a DMA CAP is not necessary. A DMA CAP would serve to allocate costs to all benefiting programs, especially NCHC, as well as support the allocation of Medicaid administrative costs to activities with increased FFP.

DHHS Response: *The Department agrees with the recommendation. As discussed above, the Division will implement a PACAP by July 1, 2013.*

BUDGET FORECASTING

Finding #1: The Division's budget development and administration practices are potentially non-compliant with State statutes that have been enacted to ensure agency and legislative accountability for public expenditures.

General Response: *The Department agrees with the finding. The Division will implement, within 30 days, an operational policy in which the certified budget is compared to current expenditures by fund and budget code. This report will be updated no less frequently than once a month.*

Recommendations:

1. DMA and DHHS should be required to submit reasonable estimates for all known Medicaid expenditures in their agency budget requests. If expenditures exceed allowable limits, DHHS, the Governor, or the General Assembly should take actions to reduce expenditures to stay within spending caps, rather than omit known expenditures from the budget.

DHHS Response: *The Department agrees with the recommendations. The Division of Medical Assistance (DMA) agrees that reasonable estimates should be requested for all Medicaid expenditures. Beginning immediately, the Division will not only provide estimates for all costs/liabilities anticipated within the Medicaid program but will also provide detailed explanations regarding the expenditures.*

2. DMA's agency request budget should adjust expenditures for all known costs that increase or decrease with fluctuations in caseload, including costs in administrative funds 1101 and 1102. These requests should be accompanied by appropriate documentation.

DHHS Response: *The Department agrees with this recommendation. Beginning immediately, the Division will not only provide estimates for all costs/liabilities anticipated within the Medicaid program but will also provide detailed explanations regarding the expenditures.*

3. When DMA perceives that the General Assembly has included unachievable savings in their budgets, DMA should provide OSBM with documentation of this at the beginning of the biennium or fiscal year, along with a forecast of the additional total dollars and State General Fund that will be required to cover this unachievable savings.

DHHS Response: *The Department agrees with this recommendation. The Division will provide detailed, documented information regarding decisions before the General Assembly.*

4. DMA should discontinue the practice of incurring liabilities for the State at the beginning of the fiscal year because they have overdrawn federal funds in the prior fiscal year to offset State General Fund shortfalls.

DHHS Response: *The Department agrees with this recommendation. DMA will work with the Department, OSBM and Fiscal Research to manage cash and expenditures as appropriate.*

5. Because Medicaid is such a large and complex program with a significant impact on the State budget, DMA may require more oversight than any individual Department Secretary with multiple other divisions and programs can provide. The General Assembly should consider organizational changes that could improve the oversight needed to ensure that the Medicaid program is operated in compliance with legislative mandates.

DHHS Response: *The Secretary and the Medicaid Director are committed to ensuring access to any and all information regarding the operations of the Medicaid program.*

Finding #2: The Division's budget forecasting methodology has not incorporated comprehensive multiyear projections and does not provide an accurate picture of the current year's financial position.

General Response: *The Department agrees that the forecasting methodology does not allow for multiyear forecasting. However, the Department agrees that the process can always be improved as to budget forecasting methodology. The Division will improve its budget forecasting methodology. However, given the dramatic changes in the Medicaid program over the next two years, a long-term multiyear projection will decrease the accuracy of the forecast.*

Recommendations:

1. DMA should forecast for all Medicaid funds, and these forecasts should be provided in an agreed upon format to OSBM and Fiscal Research Division at least quarterly.

DHHS Response: *The Department agrees with this recommendation. We will convene a discussion with the Office of State Budget and Management (OSBM), Fiscal Research and the Department to develop a consistent reporting package that addresses the needs of these entities.*

2. DMA should maintain a comparison of forecasted expenditures and revenues to actual year end budget performance and subject it to analysis that can improve the ability to project expenditures and revenues.

DHHS Response: *The Department agrees with this recommendation. DMA will implement a process that incorporates the comparison of forecasts prepared in one period to forecasts prepared in subsequent periods to determine the source of changes in forecasting outcome. This will create opportunities for improvement. DMA prepares detailed analyses every month of variances between actual, forecasts and budget.*

3. DMA should prepare a five-year analysis to contribute to the Governor's budget message and should routinely forecast expenditures and revenues for a minimum of three years in the future.

DHHS Response: *The Department agrees with this recommendation. As discussed previously the Division will improve its budget forecasting methodology. However, given*

the dramatic changes in the Medicaid program over the next two years, a long-term multiyear projection will decrease the accuracy of the forecast.

Finding #3: The Division of Medical Assistance does not appropriately manage Medicaid costs that are subject to agency control.

General Response: *The Department agrees that improvements outlined in the recommendations would improve the management of Medicaid costs.*

Recommendations:

1. Because caseload is a significant cost drive for Medicaid, DMA should perform multiyear caseload projections to support multiyear expenditure forecasts, and these forecasts should be tracked against actual caseload growth to evaluate the accuracy of the forecasting methodology.

DHHS Response: *The Department agrees with the recommendation. DMA provides a multiyear caseload projection utilizing the Statistical Analysis System (SAS) statistical forecasting tool. We will enhance the caseload forecasting to support multiyear expenditures. Should it be determined that the Department, OSBM and the Legislature require forecasts beyond the 2 year biennium cycle, DMA will implement an extension of the forecast to accommodate whatever time period is requested.*

2. DMA should perform a study to evaluate reimbursement methodology reform which should have a goal of establishing stable reimbursement methodologies that do not increase automatically, but are only increased by actions approved by the General Assembly.

DHHS Response: *The Department agrees with this recommendation. Payment reform is a critical long term issue for the NC Medicaid program. The reform should include the design of a Medicaid program that defines the health outcomes and objectives of the state, including a payment system that supports the achievement of those goals.*

3. The State of North Carolina should engage medical researchers to perform a scientifically valid study based on actual data to determine whether the CCNC model saves money and improves health outcomes.

DHHS Response: *The Department agees with this recommendation. As we work to control costs and improve the quality within the Medicaid program, it is critically important that the data available is analyzed by a reputable research organization.*

4. Actions should occur, probably from outside the agency, to enforce a change in Division organizational culture to provide a focus on a health insurance perspective that encourages cost containment in an environment of increasing medical services and expanding payments to providers.

DHHS Response: *The Department agrees with this recommendation. The Secretary and Medicaid Director are committed to providing the leadership and tools necessary to ensure the proper staffing and focus for this health insurance program.*

Finding #4: DMA failed to comply with a legislative mandate to eliminate inflationary increases for nursing facilities.

General Response: *The Department agrees with the finding. The Division will ensure compliance with any and all state and federal mandates.*

Recommendations:

DMA should give complete and accurate information to the General Assembly when seeking approval to violate legislative mandates. Approval by the General Assembly should occur in a recognized forum with authority to provide this approval, rather than in informal discussions with individual legislators.

DHHS Response: *As stated above, the Division will ensure compliance with any and all state and federal mandates. In addition, we will maintain complete transparency with the General Assembly regarding issues and financing of the Medicaid program.*

STATE PLAN AMENDMENTS

Finding: The cost savings incorporated into the budget for specific State Plan Amendments (SPAs) are not always realized due to varying factors - some within DMA's control.

General Response: *The Department agrees with the finding.*

Recommendation:

1. The savings incorporated into the state budget need to be more realistically calculated by the DMA and DHHS with consideration of costs of implementation and realistic implementation dates given current system constraints.

DHHS Response: *The Department agrees with the recommendation and will review ways to improve calculations of cost savings.*

REPORTING

Finding: Medicaid reports do not provide easily understood and timely data.

General Response: *The Department agrees with the finding and will attempt to make reports more reader friendly. We will work with OSBM and Fiscal Research to ensure more user friendly report(s)*

Recommendations:

1. DMA should consult with the DHHS Secretary, Office of the Governor, OSBM, and Fiscal Research Division of the North Carolina General Assembly to determine the informational needs of those charged with governance over the State's Medicaid program. Medicaid reporting requirements, including report formats and timeframes, should be formally established and followed.

***DHHS Response**: The Department agrees with the recommendation.*

2. Once reporting formats and timeframes have been established, the DHHS Secretary should ensure DMA is held accountable for providing accurate and timely reports to stakeholders.

***DHHS Response**: The Department agrees with the recommendation.*

If you need any additional information, please contact Monica Hughes at (919) 855-3720.

Sincerely,

Aldona Wos, M.D.
Secretary

AW:mh

cc: Beth Melcher, Chief Deputy Secretary for Health Services
Dan Stewart, Assistant Secretary for Finance and Business Operations
Carol H. Steckel, Director of Medical Assistance
Tara Larson, Chief Clinical Operations Officer
Steve Owen, Chief Business Operating Officer
Laketha Miller, Director, Office of Controller
Thomas Edward Berryman, Director of Internal Audit

[This Page Left Blank Intentionally]

ORDERING INFORMATION

Audit reports issued by the Office of the State Auditor can be obtained from the web site at www.ncauditor.net. Also, parties may register on the web site to receive automatic email notification whenever reports of interest are issued. Otherwise, copies of audit reports may be obtained by contacting the:

Office of the State Auditor
State of North Carolina
2 South Salisbury Street
20601 Mail Service Center
Raleigh, North Carolina 27699-0601

Telephone: 919/807-7500

Facsimile: 919/807-7647

This performance audit required contracted subject matter experts at the rate of $420,000. In addition, Office of the State Auditor staff spent 2735 hours at an approximate cost of $225,582. The total cost of the audit represents .0046% of the total Medicaid budget (over $14 billion) for the fiscal year ended June 30, 2012.

Description	SFY 2004 Total	SFY 2005 Total	SFY 2006 Total	SFY 2007 Total	SFY 2008 Total	SFY 2009 Total	SFY 2010 Total	SFY 2011 Total	SFY 2012 Total	SFY 2013 Total*	SFY 2014 Total*	SFY 2015 Total	SFY 2016 Total	SFY 2017 Total	SFY TOTAL
PERSONAL SERVICES	$ 117,377	$ 272,800	$ 1,361,123	$ 1,566,748	$ 1,126,232	$ 1,184,507	$ 1,529,651	$ 1,859,914	$ 4,753,994	$ 10,716,423	$ 15,934,468	$ 14,230,845	$ 14,230,845	$ 14,230,845	$ 83,115,771
PURCHASED SERVICES	$ 316,112	$ 1,432,766	$ 2,482,515	$ 2,030,607	$ 1,109,457	$ 7,617,349	$ 11,398,758	$ 14,846,152	$ 45,057,873	$ 75,573,460	$ 72,652,269	$ 37,876,738	$ 31,915,150	$ 37,591,964	$ 341,901,169
SUPPLIES	$ -	$ 18,523	$ 11,346	$ 3,314	$ -	$ 1,000	$ 1,071	$ 9,558	$ 23,255	$ 32,750	$ 45,961	$ 20,000	$ 20,000	$ 20,000	$ 206,778
PROPERTY, PLANT & EQUIPMENT	$ -	$ 183,378	$ 30,867	$ 6,532	$ 715	$ 64,090	$ 178,435	$ 2,419,640	$ 1,383,870	$ 2,855,883	$ 1,027,868	$ 80,500	$ 80,500	$ 80,500	$ 8,392,778
OTHER EXPENSES & ADJUSTMENTS	$ -	$ -	$ -	$ 1,012	$ -	$ -	$ -	$ 48,468	$ 4,225	$ 19,042	$ 32,000	$ 32,000	$ 32,000	$ 36,000	$ 204,746
AID & PUBLIC ASSISTANCE	$ -	$ -	$ 772,743	$ 418,237	$ 116,839	$ 84,423	$ 82,353	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,474,595
RESERVES	$ 62,298	$ 288,439	$ 709,680	$ 769,819	$ 778,326	$ 311,560	$ 386,285	$ 335,232	$ 616,756	$ 2,188,352	$ 1,985,052	$ 955,903	$ 829,790	$ 493,585	$ 10,711,077
INTRAGOVERNMENTAL TRANSACTIONS	$ 79	$ 128	$ 1,649	$ 847	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,703
TOTAL EXPENDITURE	$ 495,865	$ 2,196,034	$ 5,369,924	$ 4,797,115	$ 3,131,568	$ 9,262,929	$ 13,576,553	$ 19,518,964	$ 51,839,972	$ 91,385,910	$ 91,677,618	$ 53,195,986	$ 47,108,285	$ 52,452,894	$ 446,009,618
FEDERAL FUNDS	$ -	$ -	$ 3,340,574	$ 2,048,210	$ 1,033,614	$ 2,955,983	$ 3,762,289	$ 7,494,418	$ 46,080,162	$ 80,962,250	$ 81,220,686	$ 47,128,345	$ 26,305,482	$ 28,043,835	$ 330,375,848
NON FEDERAL SHARE**	$ 495,865	$ 2,196,034	$ 2,029,350	$ 2,748,905	$ 2,097,955	$ 6,306,946	$ 9,814,264	$ 12,024,546	$ 5,759,811	$ 10,423,660	$ 10,456,933	$ 6,067,641	$ 20,802,803	$ 24,409,059	$ 115,633,770

* Includes Project 7 NC FAST Federally-Facilitated Exchange (FFE) Interoperability and assumes APDu approval for enhanced Medicaid Funding.

** Prior to SFY 05/06, DHHS was allocated $5.4M in recurring funds for an NC FAST Reserve.
In SFY 05/06, the $5.4M recurring allocation for NC FAST reserve was eliminated and replaced with a $4.9M non-recurring allocation for SFY 05/06 and a $6M non-recurring allocation for SFY 06/07.
An IT Automation 2-type budget code was established in SFY 07/08 and available funds in the amount of $21.5M were transferred to the 2-type budget for NC FAST.
In SFY 09/10, the Division of Social Services transferred $18,327,478 in Food and Nutrition Services Incentive Funds earned from the Federal Government as a result of payment error rate efficiencies to support NC FAST.
In SFY 11/12, $8,767,696 in available funds were identified within DHHS and transferred to the 2-type budget code to support NC FAST.
In SFY 12/13, $9,592,332 will be identified within DHHS to transfer to the 2-type budget code to support NC FAST.

THE JOINT CONFERENCE COMMITTEE REPORT ON THE CONTINUATION, EXPANSION AND CAPITAL BUDGETS

(Revised Pursuant to S.L. 2012-142, Section 27.3)

S. L. 2012-142 (House Bill 950)

North Carolina General Assembly
2012 Session

July 24, 2012

As amended by S.L. 2012-145 (Senate Bill 187); S. L. 2012-74 (House Bill 1015); S.L. 2012-36 (House Bill 1025); and S.L. 2012-194 (Senate Bill 847).

Conference Report on the Continuation, Capital and Expansion Budgets

	FY 12-13	
25 Non-State Entity Pass-Through Funds	($9,159,699)	R
Replaces $9,159,699 in recurring special appropriation (pass-through) funds for the following non-state entities with non-recurring funds:	$9,159,699	NR

North Carolina Senior Games, Inc. - $121,481
ARC of North Carolina - $305,598
ARC of North Carolina – Wilmington - $51,048
Autism Society of North Carolina - $2,941,818
The Mariposa School for Children with Autism - $339,879
Easter Seals UCP of North Carolina - $76,792
Easter Seals UCP of North Carolina and Virginia - $1,542,647
ABC of North Carolina Child Development Center - $366,703
Residential Services, Inc. - $ 246,424
Oxford House, Inc. - $200,000
Brain Injury Association of North Carolina - $225,223
Food Bank of Central and Eastern North Carolina, Inc. - $333,334
Food Bank of the Albemarle - $333,334
Manna Food Bank - $333,334
Second Harvest Food Bank of Metrolina, Inc - $333,334
Second Harvest Food Bank of Northwest North Carolina, Inc. - $333,332
Prevent Blindness NC - $308,163
Second Harvest Food Bank of Southeast NC $333,332

(6.0) Division of Social Services

26 Adoption Vendor Payments	($2,025,649)	R
Reduces funds for adoption vendor services through efficiencies gained by better program oversight by the Division of Social Services.		
27 FMAP IV-E Child Welfare Services	($379,116)	R
Increases State General Funds due to changes in the Federal Medical Assistance Percentage (FMAP). The change from 65.28% to 65.51% goes into effect in October of 2012.		
28 Foster Care Efficiencies	($6,674,351)	R
Reduces funds for the Foster Care Program due to a change in the case mix of foster care children in the care of the Division of Social Services.		

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.

REPORTS BY NON-STATE ENTITIES RECEIVING DIRECT STATE APPROPRIATIONS

SECTION 10.19.(a) The Department of Health and Human Services shall require the following non-State entities to match ten percent (10%) of the total amount of State appropriations received each fiscal year. In addition, the Department shall direct these entities to submit a written report annually, beginning December 1, 2012, of all activities funded by State appropriations to the Joint Legislative Oversight Committee on Health and Human Services, 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:

(1) North Carolina Senior Games, Inc.
(2) ARC of North Carolina.
(3) ARC of North Carolina – Wilmington.
(4) Autism Society of North Carolina.
(5) The Mariposa School for Children with Autism.
(6) Easter Seals UCP of North Carolina.
(7) Easter Seals UCP of North Carolina and Virginia.
(8) ABC of North Carolina Child Development Center.
(9) Residential Services, Inc.
(10) Oxford House, Inc.
(11) Brain Injury Association of North Carolina.
(12) Food Bank of Central and Eastern North Carolina, Inc.
(13) Food Bank of the Albemarle.
(14) Manna Food Bank.
(15) Second Harvest Food Bank of Metrolina, Inc.
(16) Second Harvest Food Bank of Northwest North Carolina, Inc.
(17) Second Harvest Food Bank of Southeast North Carolina
(18) Prevent Blindness NC.

SECTION 10.19.(b) The report required by subsection (a) of this section shall include the following information about the fiscal year preceding the year in which the report is due:

(1) The entity's mission, purpose, and governance structure.
(2) A description of the types of programs, services, and activities funded by State appropriations.
(3) Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.
(4) Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.
(5) A detailed program budget and list of expenditures, including all positions funded and funding sources.
(6) The source and amount of any matching funds received by the entity.

REPORT ON LAPSED SALARY FUNDS

SECTION 10.20. Beginning no later than November 1, 2012, the Department of Health and Human Services shall submit quarterly reports to the Joint Legislative Oversight Committee on Health and Human Services, 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 use of lapsed salary funds by each Division within the Department. For each Division, the report shall include the following information about the preceding calendar quarter:

(1) The total amount of lapsed salary funds.
(2) The number of full-time equivalent positions comprising the lapsed salary funds.
(3) The Fund Code for each full-time equivalent position included in the number reported pursuant to subdivision (2) of this section.

Food Bank of Central & Eastern NC

Reporting Requirements Fiscal Year 11/12 – Direct State Appropriations

Section 10.19.(b)

1) **Entity's Mission:** No One Goes Hungry in Central & Eastern North Carolina.
   Purpose: Receive donated food to the Food Bank through grocery stores, food manufacturers and distributors and community food drives. The food is then sorted, collected and stored throughout the branches in Sandhills, Durham, Greenville, New Bern, Wilmington and Raleigh. It is then distributed to a network of 800 partner agencies including food pantries, soup kitchens, shelters, day care centers and elderly care programs. This allows the Food Bank to assist in meeting basic needs of the children and families who are food insecure.
   Governance Structure: The Food Bank of Central & Eastern NC (FBCENC) is an incorporated organization through the State of NC with Articles of Incorporation and by-laws. The FBCENC has an active board of directors comprised of civil and community leaders who assist the President/CEO. The FBCENC is a 501(c)3 tax-exempt organization and was granted tax exemption in January, 1981.
2) **Description of types of program, services and activities funded by the State appropriations:** The goal of the utilization of the State appropriate funding is to provide approximately 607k meals of nutritious food, purchased primarily through North Carolina suppliers, to a majority of Food Bank partner agencies in a 19,000 square mile 34-county service area. This food will reach low-income families and individuals in the service area that come to partner agencies needing emergency food supplies.
3) **Statistical and demographical information on the number of persons served by these programs, services and activities, including the counties in which services are provided.** During the 11/12 fiscal year, Food Bank partner agency pantries served 1,220,522 households and 3,210,205 individuals. Please note that these are duplicated numbers since many of our partner agencies are not able to track unduplicated numbers. Partner agencies that are provided food from the state appropriation funding also served 920,182 meals through soup kitchens and 1,195,323 through emergency shelters. Demographic Data from the "Hunger in America 2010" study (a comprehensive study of hunger conducted every four years by Feeding America and its member food banks) provides the following data on food recipients served by Food Bank of Central & Eastern North Carolina partner agencies: 22.4% non-Hispanic White, 65.1% non-Hispanic Black/African American, 8.3 % Hispanic, 0% Asian, 0% Native Hawaiian or Other Pacific Islander and 2.1% other. The percentages add up to 101% because clients interviewed for the study could identify multiple races/ethnicities.

   The counties served by the Food Bank are: Brunswick, Carteret, Chatham, Columbus, Craven, Duplin, Durham, Edgecombe, Franklin, Granville, Greene, Halifax, Harnett, Johnston, Jones, Lee, Lenoir, Moore, Nash, New Hanover, Onslow, Orange, Pamlico,

Pender, Person, Pitt, Richmond, Sampson, Scotland, Vance, Wake, Warren, Wayne, and Wilson.

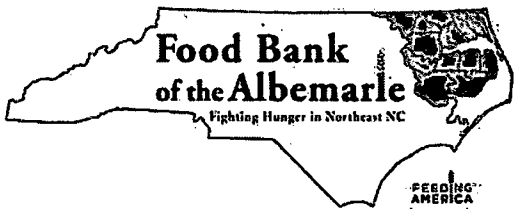
4) **Outcome measures that demonstrate the impact and effectiveness of the programs, services and activities.** The FBCENC purchased 727,768 lbs of food from State appropriations monies in 11/12 fiscal year, this equates to estimated meals provided of 606,473. The State appropriation % of total pounds distributed by the FBCENC is 2% of the total lbs distributed for 11/12 fiscal year.

5) **Detailed Program Budget and list of expenditures, including positions funded and funding sources:**
   a) Program Budget included the following:

a. Food Purchases	$817,842
b. Supplies and Operating Costs	$ 86,595
c. Salary and Fringes	$ 57,730
Totals	$962,167

   b) Program funds portions of: Marketing and Product Assistant/Shopping Coordinator who purchases food product, Driver – Class A, Outreach Coordinators, Director of Finance,
   c) Funding sources include: donations, food donations, agency contributions, NC Department of Agriculture, and NC Dept of Health and Human Services

6) **The source and amount of any matching funds received by the entity:**
   a) The amount of matching funds equal to 10% of the State appropriates is: $96,217. The amount is matched by sources of revenue such as individual contributions, direct mail, food donations, on-line giving.



Fighting hunger and poverty in northeast North Carolina

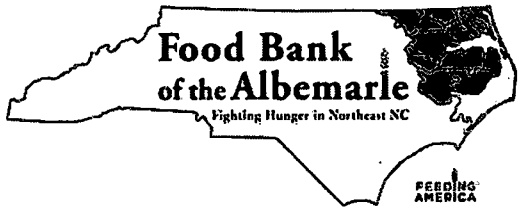
Serving Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Gates, Hertford, Hyde, Martin, Northampton, Pasquotank, Perquimans, Tyrrell and Washington Counties.

SNAP APPROPRIATION EXPENDITURE REPORT

FY 2011/2012

NOVEMBER 28, 2012

LIZ REASONER
EXECUTIVE DIRECTOR
252.335.4035 x110
lreasoner@feedingamerica.org



Fighting hunger and poverty in northeast North Carolina

Serving Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Gates, Hertford, Hyde, Martin, Northampton, Pasquotank, Perquimans, Tyrrell and Washington Counties.

The Food Bank of the Albemarle serves a fifteen county region that makes up northeast North Carolina. The mission of the Food Bank is to fight hunger and poverty in northeast North Carolina. Our vision is that our communities are hunger free. We are a regional clearinghouse for the collection and distribution of food and grocery items to non-profit and faith-based organizations for their food programs and to eligible individuals for their food needs. We are able to receive, stage, and store large quantities of food. This food is then distributed to the hungry in fifteen northeast North Carolina counties through our partner agencies. Since 1984, the Food Bank has been a member of the national network of Food Banks called Feeding America (originally America's Second Harvest).

The Food Bank of the Albemarle is a private, 501(c)3 non-profit organization incorporated in the state of North Carolina. An uncompensated Board of Directors governs the organization. Our board is comprised of civic and business leaders from throughout our service territory. The Executive Director leads the organization, oversees its activities and answers to the Board of Directors.

Across the more than 6,000 square miles served by the Food Bank of the Albemarle, we work in partnership with 130 non-profit member agencies. These agencies include food pantries, soup kitchens, day care centers, juvenile and senior citizen residential programs, and shelters. These partner agencies put the food into the hands of the hungry in our communities. Either these agencies pick up food from our warehouse in Elizabeth City or we deliver it to them for distribution to the hungry men, women, and children in their communities. In addition to these programs, we provide food to our most under- and un-served clientele via the Mobile Food Pantry. This program operates in areas where a traditional pantry is not available to help those in need of food assistance.

For Fiscal Year 2011/12, Food Bank of the Albemarle's share of the legislative appropriation was $961,666. The appropriation was larger than in years prior and the funds enabled us to provide food to even more of the hungry families and individuals throughout our fifteen county service area. Using these funds from the legislature, we were able to secure 1,285,276 pounds of food for our clients. Those pounds represent a 54% increase in SNAP product that went o hungry families here in northeast NC. We distributed the food via our participating, partner agencies in the manner described above. Please refer to the attached table for detailed information on the breakdown of our clients served and use of state funds.

The Food Bank of the Albemarle is a member of Feeding America, the largest domestic hunger relief organization and a national network of more than 200 food banks. We, in turn, have partner agencies that distribute food to clients. Each participating agency is bound, contractually, to adhere to rigorous standards for food safety. Agencies are required to screen clients for eligibility. They also receive Federal Civil Rights training, to ensure non-discriminatory practices. Further, we inspect our agencies at regular intervals to ensure compliance with Federal, state and Feeding America standards. Noncompliance can lead to revocation of an agency's participation agreement with the Food Bank of the Albemarle.

The Food Bank of the Albemarle, in FY10/11 and FY11/12, has raised enough money in private funding to cover the 10% match required for our appropriation. Our sources include private donations received through direct contact solicitations, direct mail campaigns, private grants, United Way participation and special events. Please see the attached table for details about our revenue sources. The Food Bank also has audited financial statements and IRS Form 990's for the past two fiscal years available at your request.

Food Bank of the Albemarle

Public Support and Revenue	2011/2012 Approved	Recommended change by line	2011/2012 Amendment to Revenue
Direct Public Support			
Individual Donors	$ 94,500.00	$ -	$ 94,500.00
Business Donors	$ 13,000.00	$ -	$ 13,000.00
Church Donors	$ 17,000.00	$ -	$ 17,000.00
Organization Donors	$ 10,000.00	$ -	$ 10,000.00
Total Direct Public Support	**$ 134,500.00**	**$ -**	**$ 134,500.00**
Annual Appeals			
Thanksgiving Appeal - Direct Mail	$ 17,500.00	$ 12,400.00	$ 29,900.00
Christmas Appeal - Direct Mail	$ 60,000.00	$ (11,200.00)	$ 48,800.00
Hunger Hurts Appeal - Insert	$ 6,000.00	$ (6,000.00)	$ -
Total Annual Appeals	**$ 83,500.00**	**$ (4,800.00)**	**$ 78,700.00**
Special Events			
SE, Dine Out	$ 12,500.00	$ 1,300.00	$ 13,800.00
SE, Walk for Hunger	$ 40,000.00	$ -	$ 40,000.00
Total Special Events	**$ 52,500.00**	**$ 1,300.00**	**$ 53,800.00**
Agency Fees & Purchases			
WH Handling/Delivery/Annual Fees	$ 239,000.00	$ -	$ 239,000.00
Coop Buying/Wholesale Food Purchases	$ 121,000.00	$ -	$ 121,000.00
Total Agency Fees & Purchases	**$ 360,000.00**	**$ -**	**$ 360,000.00**
Grants & Appropriations			
Grants, Foundations	$ 87,015.00	$ 20,000.00	$ 107,015.00
Settlements (MOVED TO STATE AWARDS)		$ -	$ -
County Appropriations	$ 13,500.00	$ -	$ 13,500.00
City Grants & Appropriations	$ 5,000.00	$ -	$ 5,000.00
FNS Outreach Reimbursement	$ 15,903.00	$ (4,903.00)	$ 11,000.00
Total Grants & Appropriations	**$ 121,418.00**	**$ 15,097.00**	**$ 136,515.00**
United Way Allocations			
UW, Albemarle Area	$ 28,000.00	$ -	$ 28,000.00
UW, Martin County	$ 3,000.00	$ -	$ 3,000.00
UW, United Way of America	$ 2,470.00	$ -	$ 2,470.00
Combined Federal Campaign	$ 8,500.00	$ -	$ 8,500.00
UW, Beaufort County	$ 14,500.00	$ -	$ 14,500.00
Total United Way Allocations	**$ 56,470.00**	**$ -**	**$ 56,470.00**
Miscellanous			
Interest Income	$ 1,000.00	$ (400.00)	$ 600.00
Misc. Income	$ 1,500.00	$ (1,000.00)	$ 500.00
Sales Tax Reimbursement	$ 2,800.00	$ -	$ 2,800.00
Small Business Health Care Tax Credit	$ 10,973.00	$ (4,500.00)	$ 6,473.00
Total Miscellanous	**$ 16,273.00**	**$ (5,900.00)**	**$ 10,373.00**
Federal Awards			
Emergency Food and Shelter Program	$ 16,000.00	$ (7,262.00)	$ 8,738.00
TEFAP Commodity Distribution	$ 24,000.00	$ 32,700.00	$ 56,700.00
CACFP After School Meal Program	$ 15,000.00	$ -	$ 15,000.00
Total Federal Awards	**$ 55,000.00**	**$ 25,438.00**	**$ 80,438.00**
State Awards			
Settlement AG	$ 24,810.00	$ -	$ 24,810.00
SNAP Food Purchases	$ 333,334.00	$ 628,800.00	$ 962,134.00
Total State Awards	**$ 358,144.00**	**$ 628,800.00**	**$ 986,944.00**
Suta Debit/Transfer inot operating Savings debit/transfer into operating	$ 49,600.00	$ -	$ 49,600.00
TOTAL PUBLIC SUPPORT & REVENUES	**$ 1,287,405.00**	**$ 659,935.00**	**$ 1,947,340.00**

Food Bank of the Albemarle

Expenses	2011/2012 Approved	net change increased by SNAP Portion.	2011/2012 Amended Expenses Effective 1/1/12
Expenses - Staff			
Staff, Salaries	$ 416,671.00	$ 22,969.00	$ 439,640.00
Staff, Health Insurance	$ 78,002.00	$ -	$ 78,002.00
Payroll Tax Expense	$ 31,875.00	$ 1,757.00	$ 33,632.00
SUTA Tax Expense	$ 4,167.00	$ 229.00	$ 4,396.00
Staff, Workers Compensation	$ 7,500.00	$ -	$ 7,500.00
Meetings/Training	$ 4,000.00	$ 3,500.00	$ 7,500.00
Inmate Transportation	$ 12,000.00		$ 12,000.00
Mileage Reimbursement	$ 3,080.00		$ 3,080.00
Staff, Shirt & Safety Shoes	$ 2,200.00	$ 1,500.00	$ 3,700.00
Payroll Processing	$ 2,200.00	$ 330.00	$ 2,530.00
Total Expenses - Staff	**$ 561,695.00**	**$ 30,285.00**	**$ 591,980.00**
Expenses - Equipment			
OPS Equip. Repair/Maint.	$ 4,000.00	$ 1,200.00	$ 5,200.00
OPS Equip. Purchases	$ 3,000.00	$ 900.00	$ 3,900.00
IT Equip. Rental	$ 5,040.00	$ -	$ 5,040.00
IT Equip, Hardware and Software	$ 11,000.00	$ 1,000.00	$ 12,000.00
IT Equip. Repair/Maint.	$ 7,200.00	$ 900.00	$ 8,100.00
Total Expenses - Equipment	**$ 30,240.00**	**$ 4,000.00**	**$ 34,240.00**
Expenses - Vehicles			
Vehicle Insurance	$ 4,700.00	$ 1,410.00	$ 6,110.00
Vehicle License and taxes	$ 2,500.00	$ 750.00	$ 3,250.00
Vehicle Gas & Oil	$ 60,000.00	$ 8,500.00	$ 68,500.00
Vehicle Repair/Maintenance	$ 15,000.00	$ 5,000.00	$ 20,000.00
Program, Freight	$ 20,000.00	$ 25,000.00	$ 45,000.00
Vehicle Rental	$ 2,000.00		$ 2,000.00
Vehicle Purchase	$ 42,600.00		$ 42,600.00
Total Expenses - Vehicles	**$ 146,800.00**	**$ 40,660.00**	**$ 187,460.00**
Expenses - Building			
Building Loan Payment	$ 29,412.00	$ 1,788.00	$ 31,200.00
Building Maintenance	$ 13,000.00		$ 13,000.00
Building Supplies	$ 3,500.00	$ 1,050.00	$ 4,550.00
Building Insurance	$ 8,600.00	$ 1,500.00	$ 10,100.00
Building Pest Control	$ 1,500.00	$ -	$ 1,500.00
Building - Lawn Care	$ 2,000.00	$ 800.00	$ 2,800.00
Trash	$ 4,500.00	$ -	$ 4,500.00
Utilities/Propane Gas/Electric	$ 23,000.00	$ 2,300.00	$ 25,300.00
Telephone	$ 6,500.00	$ -	$ 6,500.00
Miscellaneous	$ -	$ -	$ -
Supply - Office Furnishings	$ 650.00	$ -	$ 650.00
Total Expenses - Building	**$ 92,662.00**	**$ 7,438.00**	**$ 100,100.00**
Expenses - Supplies			
Supply, Office	$ 9,000.00	$ 1,820.00	$ 10,820.00
Supply, Printing	$ 6,000.00	$ 500.00	$ 6,500.00
Supply, Postage	$ 9,000.00	$ 4,100.00	$ 13,100.00
Subscriptions	$ 500.00	$ -	$ 500.00
Supply other	$ 800.00	$ -	$ 800.00
Non-food Supply ASP	$ 250.00		$ 250.00
Total Expenses - Supplies	**$ 25,550.00**	**$ 6,420.00**	**$ 31,970.00**
Expenses - Special Event			
Special Event Advertising	$ 2,000.00	$ -	$ 2,000.00
Spec Event Supplies & Direct Cost	$ 2,500.00	$ 1,000.00	$ 3,500.00
Media (web) & Education (static displays)	$ 2,000.00	$ 1,500.00	$ 3,500.00
Total Expenses - Special Event	**$ 6,500.00**	**$ 2,500.00**	**$ 9,000.00**

Expenses - Other			
Volunteer Appreciation	$ 800.00	$ -	$ 800.00
Director & Officers Insurance	$ 1,300.00	$ -	$ 1,300.00
Sales Tax	$ 3,750.00	$ -	$ 3,750.00
Professional Fees (Audit)	$ 6,000.00	$ 350.00	$ 6,350.00
NCAFAFB	$ 12,200.00	$ 6,000.00	$ 18,200.00
Bank Service Charges, C & P, late fees	$ 750.00	$ 1,350.00	$ 2,100.00
Dues	$ 1,000.00	$ -	$ 1,000.00
Interest Expenses	$ 500.00	$ 500.00	$ 1,000.00
Feeding America Fee	$ 3,460.00	$ -	$ 3,460.00
Brokerage Fees	$ 450.00	$ -	$ 450.00
Branding		$ 15,000.00	$ 15,000.00
Property Tax	$ 300.00	$ -	$ 300.00
Total Expenses - Other	**$ 30,510.00**	**$ 23,200.00**	**$ 53,710.00**
Expenses - Food Purchases			
Food Purchases SNAP	$ 280,000.00	$ 538,094.00	$ 818,094.00
Agency Food Purchases	$ 110,000.00	$ -	$ 110,000.00
CACFP Food Purchases	$ -	$ -	$ -
VAP	$ 1,300.00	$ -	$ 1,300.00
Total Expenses - Food Purchases	**$ 391,300.00**	**$ 538,094.00**	**$ 929,394.00**
TOTAL EXPENSES	**$ 1,285,257.00**	**$ 652,597.00**	**$ 1,937,854.00**
		(deficit)/reserve	**$ 9,486.00**

SNAP DOLLARS

Racial Composition of Clients (% of State Funds)*

$ 961,666.00			
White	$	387,551.40	40.30%
African American	$	323,119.78	33.60%
Hispanic/Latino	$	197,141.53	20.50%
Native American	$	37,504.97	3.90%
Asian	$	11,539.99	1.20%
Other	$	4,808.33	0.50%
	$	**961,666.00**	**100.00%**

Age Composition of Clients (% of State Funds)*

$ 961,666.00			
17 & Under	$	360,624.75	37.50%
18 to 64	$	524,107.97	54.50%
65 & Over	$	76,933.28	8.00%
	$	**961,666.00**	**100.00%**

SNAP LBS

Racial Composition of Clients (% of SNAP LBS)*

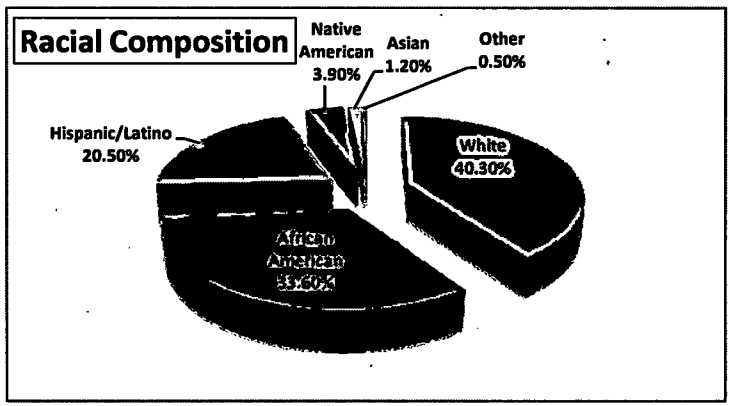
1,285,276		
White	517,966.23	40.30%
African American	431,852.74	33.60%
Hispanic/Latino	263,481.58	20.50%
Native American	50,125.76	3.90%
Asian	15,423.31	1.20%
Other	6,426.38	0.50%
	1,285,276.00	**100.00%**

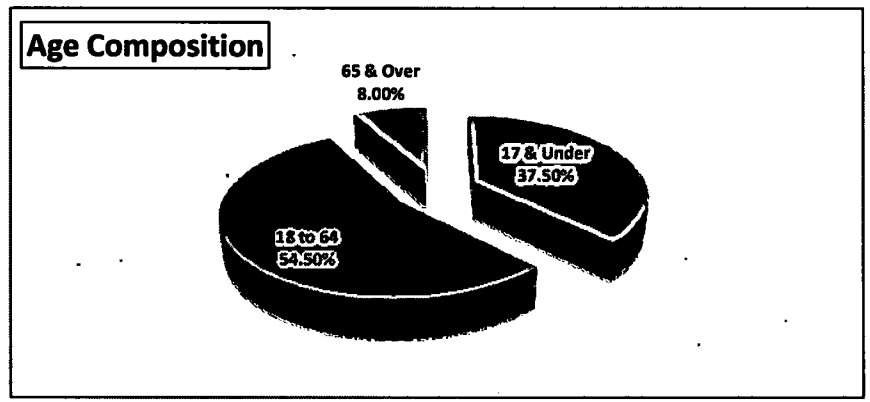
Age Composition of Clients (% of SNAP LBS)*

1,285,276		
17 & Under	481,978.50	37.50%
18 to 64	700,475.42	54.50%
65 & Over	102,822.08	8.00%
	1,285,276.00	**100.00%**

** Percentages based on the 2010 Feeding America Hunger Study*

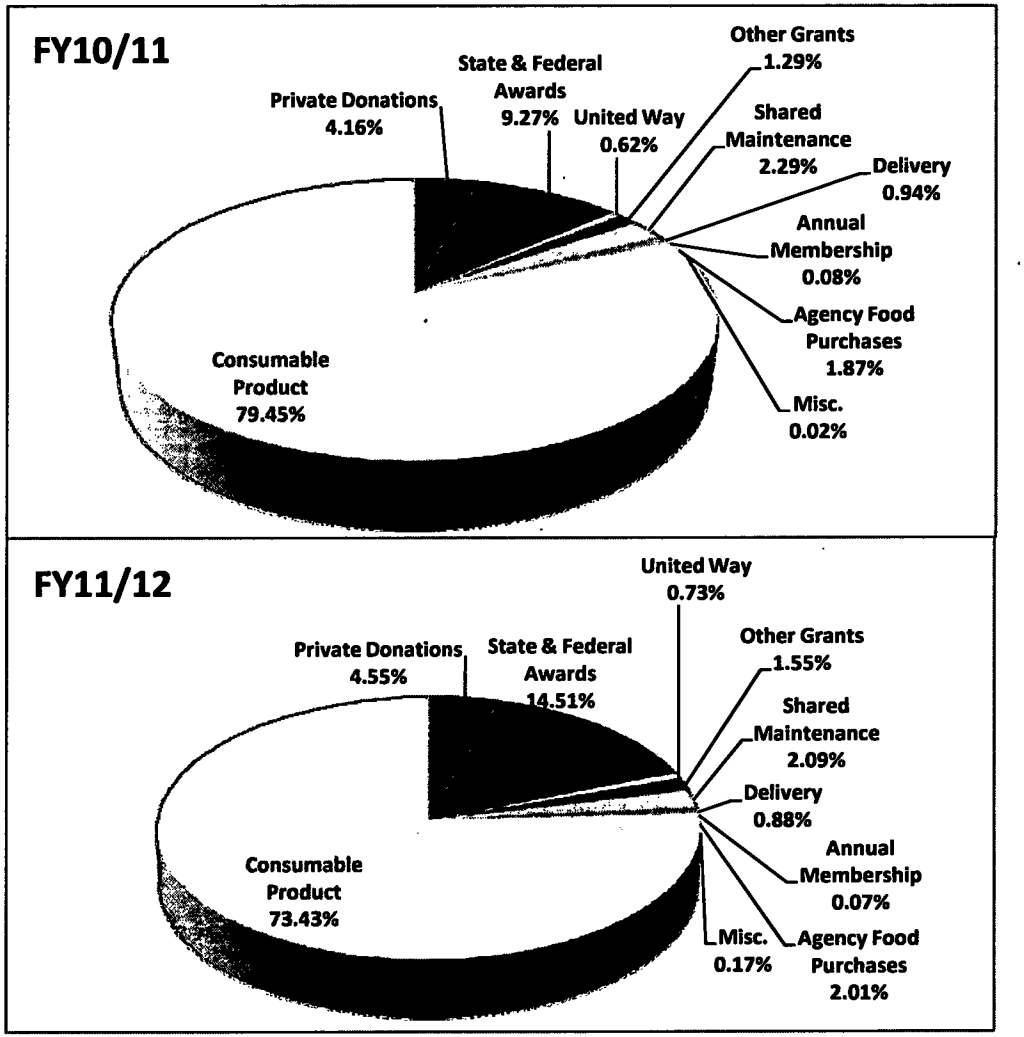
Client Race and Age Composition





Revenue Summary
FY 10/11 & 11/12

	2010/11	2011/12
Private Donations	$ 294,786.00	$ 338,914.00
State & Federal Awards	$ 657,217.00	$ 1,079,732.00
United Way	$ 44,272.00	$ 54,424.00
Other Grants	$ 91,683.00	$ 115,359.00
Shared Maintenance	$ 162,530.00	$ 155,382.00
Delivery	$ 66,874.00	$ 65,846.00
Annual Membership	$ 5,380.00	$ 5,338.00
Agency Food Purchases	$ 132,231.00	$ 149,678.00
Misc.	$ 1,756.00	$ 12,380.00
Consumable Product	$ 5,633,339.00	$ 5,464,285.00
Total Support and Revenue	**$ 7,090,068.00**	**$ 7,441,338.00**



MANNA FOOD BANK
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

(1) The entity's mission, purpose, and governance structure.

Mission: MANNA FoodBank's mission is to involve, educate and unite people in the work of ending hunger in Western North Carolina. MANNA's vision is a hunger free Western North Carolina.
Purpose: MANNA FoodBank collects usable grocery items, largely donated, from suppliers and distributes them to MANNA's approximately 255 accredited partner agencies in 16 counties in Western North Carolina. These partner agencies then provide direct food assistance to more than 106,000 unique clients each year. In addition to the general food distribution program, MANNA also engages in MANNA Packs for Kids, a program that provides a 3-5 pound bag of food to take home to more than 3,000 children each Friday during the school year; and Food and Nutrition Services outreach, which assists hundreds of clients each year to apply for FNS benefits (formerly called food stamps).
Governance Structure: MANNA was founded in 1982 and is a 501(c) (3) tax exempt, non-profit corporation doing business in the state of North Carolina. The property, affairs and business of MANNA are managed by a volunteer Board of Directors comprised of community leaders with a particular interest in hunger-related issues. The Board meets 8 times per year. Directors serve a term of three years, with no more than two terms served consecutively. MANNA's Executive Director reports directly to the Board.

The Board of Director offices are:

- President
- Vice President
- Past President
- Secretary
- Treasurer

Boards of Director Committees include:

- Executive
- Finance
- Membership & Governance
- Fundraising
- Audit

(2) A description of the types of programs, services, and activities funded by State appropriations.

MANNA FoodBank works with over 255 partner 501(c) (3) organizations, of which 149 are eligible as emergency food providers to receive and distribute SNAP-purchased food. The SNAP program enables MANNA to provide a high quality source of food to emergency food providing agencies (emergency food pantries, soup kitchens, homeless shelters, and domestic violence shelters) in our 16 county area thus providing greater food security to the citizens of Western North Carolina who are food insecure. Through SNAP funding, MANNA was able to purchase 1,294,052 pounds of food, providing an estimated 1,078,376 meals to children, adults and the elderly, living at or below the poverty line.

MANNA FOOD BANK
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

(3) Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.

Demographic Data Item	Source	Response
Estimated number of individuals in our service area seeking food assistance at a pantry, shelter, or kitchen, within a year.	Feeding America's Hunger In America 2010 Report – the most current comprehensive data we have on persons seeking food assistance from our network of emergency food organizations. Data collection for Hunger In America 2014 begins this spring.	106,600
Estimated Demographic spread of individuals in our service area seeking food assistance at a pantry, shelter, or kitchen.		**Gender** Male: 52.4% Female: 47.6 **Age** <18: 31% 18-64: 60% >64: 9% **Ethnicity** White: 70.4% Black: 14.7% Hispanic: 10.6% Native American: 3.5% Asian/Pac. Islander: <1%

Estimated Number of *MEALS* Served by SNAP Food in FY11/12

SNAP Pounds Purchased	Feeding America's lbs. to meal conversion metric	Estimated Meals provided by SNAP food purchased	SNAP % of Total Pounds Distributed by the MANNA FoodBank
1,294,052	**1 meal = 1.2 pounds**	**1,078,376**	**10%**

MANNA FoodBank's 16-County Service Area:
Avery County
Buncombe County
Cherokee County
Clay County
Graham County
Haywood County
Henderson County
Jackson County
Macon County
Madison County
McDowell County
Mitchell County
Polk County
Swain County
Transylvania County
Yancey County

MANNA FOOD BANK
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

(4) Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.

In FY 11-12, MANNA distributed 1,294,052 pounds of SNAP food to 149 SNAP eligible, participating member agencies (Emergency Food Assistance Organizations only) in our 16-county service area. SNAP funding was used to purchase the most needed products, ones not available through industry donations in WNC. Food product purchased include: tuna fish, green beans, rice, pinto beans, canned fruit and vegetables and peanut butter. Administrative funding for MANNA's SNAP program operations includes labor, warehousing, storage, refrigeration, order-picking/preparation and trucking to agencies.

(5) A detailed program budget and list of expenditures, including all positions funded and funding sources.

See separate attachment

(6) The source and amount of any matching funds.

No match was required in FY 2011/12

MANNA FOODBANK	
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)	
FY 11/12 Section 10.19 (b) reporting #5	
Description	**FY 11/12 Budget**
REVENUE	
Contributions Income	
INDIVIDUALS	465,989
CHURCHES	19,971
BUSINESS/CORPORATIONS	99,855
CIVIC ORGS/SCHOOLS/OTHER	16,642
GRANTS/ FOUNDATIONS	63,242
Contributions Income Total	**665,699**
SNAP FOOD PURCHASE INCOME	788,978
SNAP ADMINISTRATIVE REIMBURSEMENT INC.	173,190
CO-OP BUYING OVERHEAD	48,000
MISCELLANEOUS Income	8,500
TOTAL INCOME	**1,684,367**
EXPENSES	
SALARY & FRINGES	

MANNA FOOD BANK
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

Director of Operations	67,701
Warehouse Managers (1.5 FTE)	50,904
Warehouse Facilities & Safety Manager	60,469
Product Planning Coordinator (.5 FTE)	27,670
Warehouse Ordering Coordinator	37,345
Onsite Distribution Coordinator	42,896
Order Pickers (2 FTE)	64,096
Warehouse Asst (.25 FTE)	7,016
Truck Drivers (3 FTE)	123,367
Truck Driver/ Warehouse Asst (2 FTE)	78,905
Contract Labor	40,000
TOTAL SALARY & FRNGES	**600,369**
SNAP FOOD PURCHASES	**788,978**
PROFESSIONAL FEES - ANNUAL AUDIT	**13,500**
EQUIPMENT MAINTENANCE & REPAIR - WAREHOUSE	**14,800**
FOOD PACKAGING SUPPLIES	**18,000**
OCCUPANCY	
Insurance, Bldg & Flood	16,000
Electricity & gas	51,600
Water & Sewer	5,360
Food packing supplies	31,200
Propane	4,500
Waste Management	25,200
Pest Control	1,200
Franklin Warehouse utilities	1,525
Franklin Warehouse rent	4,275
TOTAL OCCUPANCY	**140,860**
TRANSPORTATION	
Vehicle Gas & Oil	60,000
Vehicle Repairs & Maintenance	15,600
Vehicle Insurance	19,660
Vehicle License & permits	5,500
Vehicle Tires	5,400
TOTAL TRANSPORTATION (TRUCK COSTS)	**106,160**
MISCELLANEOUS EXPENSE/WAREHOUSE	**1,700**
TOTAL EXPENSES	**1,684,367**

Second Harvest Food Bank of Metrolina
Reporting Requirements Fiscal Year 11/12 – Direct State Appropriations

Section 10.19.(b)

1) **Entity's Mission:** Second Harvest Food Bank of Metrolina strives through education, advocacy, and partnerships to eliminate hunger by the solicitation and distribution of food.
   Purpose: To receive donated food to the Food Bank through grocery stores, food manufacturers and distributors and community food drives. The food is then sorted, collected and stored throughout the food bank network of branches in Charlotte, Mt. Gilead, Dallas, and Hickory in NC and Spartanburg in SC. It is then distributed to a network of 550 partner agencies including food pantries, soup kitchens, shelters, day care centers and elderly care programs. This allows the Food Bank to assist in meeting basic needs of the children and families who are food insecure.
   Governance Structure: Second Harvest Food Bank of Metrolina (SHFBM) is an incorporated organization through the State of NC with Articles of Incorporation and by-laws. SHFBM has an active board of directors comprised of civil, community, and food industry leaders who assist the Executive Director. SHFBM is a 501(c) 3 tax-exempt organization and was granted tax exemption in March, 1984.
2) **Description of types of program, services and activities funded by the State appropriations:** The goal of the utilization of the State appropriate funding is to provide approximately 500,000 meals of nutritious food, purchased through North Carolina suppliers, to Food Bank partner agencies in the food bank's 14-county service area. This food will reach low-income families and individuals in the service area that come to partner agencies needing emergency food supplies.
3) **Statistical and demographical information on the number of persons served by these programs, services and activities, including the counties in which services are provided.** SHFBM serves 14 counties in NC. Listed below are the counties and their poverty population and the percentage of seniors and children living in poverty in the counties. The food purchased with SNAP funds goes to these counties to assist the food needs of the persons living in poverty.

County	Poverty Population	Percent of Population	Poverty Population over 65	Percent of Population	Poverty Population under 18	Percent of Population
Anson	5,519	22.6	634	16.5	1,894	32.3
Burke	16,377	18.7	1,846	13.5	5,167	26.6
Cabarrus	22,091	17.5	1,727	8.6	7,977	16.6
Catawba	21,950	14.5	2,134	9.8	8,405	23.3
Cleveland	20,024	20.9	2,055	14.0	7,287	32.3
Gaston	40,336	19.9	3,030	11.1	13,339	27.7
Iredell	20,998	13.3	2,453	12.0	7,139	17.9
Lincoln	11,620	15.0	976	9.7	4,165	22.9
Mecklenburg	141,435	15.6	6,489	8.0	49,261	21.3
Montgomery	6,569	24.6	816	18.7	2,261	34.3
Rowan	26,949	20.1	2,179	10.9	9,352	29.0
Rutherford	16,613	25.0	1,501	12.8	4,986	33.5
Stanly	9,038	15.4	1,093	11.5	3,025	22.4
Union	18,432	9.2	2,044	10.5	7,925	13.1

4) **Outcome measures that demonstrate the impact and effectiveness of the programs, services and activities.** SHFBM purchased 1,297,509 lbs of food from State appropriations monies in 11/12 fiscal year, this equates to estimated meals provided of 1 million. The State appropriation % of total pounds distributed by the SHFBM is 3% of the total lbs distributed for 11/12 fiscal year.
5) **Detailed Program Budget and list of expenditures, including positions funded and funding sources:**
   a) Program Budget included the following:

a. Food Purchases	$892,167
b. Supplies and Operating Costs	$ 70,000
Totals	$962,167

   b) No positions were funded by funds.
   c) Funding sources include: financial donations, food donations, agency contributions, NC Department of Agriculture, SC Department of Social Services and NC Department of Health and Human Services'
6) **The source and amount of any matching funds received by the entity:**
   a) The amount of matching funds equal to 10% of the State appropriates is: $96,217. The amount is matched by sources of revenue such as individual contributions, direct mail, food donations, on-line giving.

Second Harvest Food Bank of Northwest NC is a 501(c)(3) nonprofit organization, incorporated in 1981 in the State of North Carolina. Our organization is one of the over 200 Feeding America food banks across the nation.

The mission of Second Harvest Food Bank of Northwest NC is to reduce hunger and malnutrition in eighteen counties across northwest North Carolina. We are committed to acquiring and distributing food to supplement the food needs of faith and community-based organizations, advocating for the rights of hungry people, educating the public about hunger and pursuing partnerships with like-minded organizations.

To achieve our vision of *sharing the abundance so no one goes hungry*, we believe everyone has the right to the food they need to lead healthy, active lives. Hunger in our community is a solvable problem. The power of community, collaboration and shared resources can create hunger-free communities.

The Board of Directors of Second Harvest Food Bank of Northwest NC is the group legally, financially, and morally responsible for the total operation and conduct of the organization. The major function of the Board of Directors is to make sure that the organization is carrying out its mission in a manner that is ethical, effective, and fiscally accountable. The Board of Directors are the trustees of the organization and are answerable to the organization's financial contributors, the recipients of its services, and any funding source that monitors its operation. The Board of Directors consists of outstanding business, civic and religious leaders from throughout our service area.

The Second Harvest Food Bank Board of Directors consists of:

- up to forty (40) members
- four (4) officers:
  Chairman, Vice-Chairman, Treasurer, Secretary
- nine (9) standing committees plus the State Delegate to the North Carolina State Association of Feeding America Food Banks

The Board of Directors is responsible for hiring a fulltime, paid Executive Director that manages the day-to-day operations of the organization.

The organization's tax return, Form 990 and Annual Report, are posted on our website at www.hungernwnc.org. Our organization is rated as a 4-star charity by Charity Navigator.

Second Harvest Food Bank of Northwest NC is regularly monitored by USDA, FDA, NCDA, Forsyth County Health Department and Feeding America for food safety compliance.

Partner agencies of our organization are monitored by us on a regular basis for food safety, non-discriminatory practices, equality of food distribution and reporting requirements.

State Nutrition Assistance Program (SNAP) – The funding provided through the State of NC for the SNAP program allows Second Harvest Food Bank of Northwest NC to purchase and distribute food through our partner agency network to poor and needy individuals at risk of hunger in our eighteen-county service area. SNAP food products serve the homeless, unemployed, underemployed, senior citizens, children and other individuals in need of food assistance. In our 18-county service area an estimated 300,000 people live in poverty and are at risk of hunger. Over three-quarters (76%) of people served by our partner agencies are food insecure, meaning they do not always know where they will find their next meal.

By acting as a central source for food donations and distributions, Second Harvest Food Bank of Northwest NC provides a reliable, convenient and efficient source of food. For ten out of the twelve months of fiscal year 2011-2012, nutritious food was purchased for distribution through 273 partner agencies that administer direct food assistance to poor and needy clients. We seek to leverage our buying power for food products to obtain the best value with the SNAP funding. The food products purchased with SNAP funding included high quality, staple, nutritious items such as canned meats, fruits and vegetables, rice, pasta and dry beans.

Local partner agencies may pick up SNAP product at our warehouse, located at 3655 Reed Street in Winston-Salem. Partner agencies in our outlying counties are offered rural delivery service, which brings SNAP product to their communities. Eligible partner agencies will distribute the SNAP food to their clients during their normal hours and days of operations. We have developed a formula to ensure SNAP product is distributed in a fair manner based on the number of individuals served. Frequent monitoring of SNAP-eligible partner agencies ensures the proper distribution of SNAP food to those at risk of hunger. Administrative costs associated with ordering, receiving, storing, distributing and transporting of SNAP food are reimbursed as a portion of the SNAP funding allocated.

Our service area focuses on the 18 counties of northwest North Carolina of Alamance, Alexander, Alleghany, Ashe, Caldwell, Caswell, Davidson, Davie, Forsyth, Guilford, Iredell, Randolph, Rockingham, Stokes, Surry, Watauga, Wilkes and Yadkin. In our 18-county service area, an estimated 300,000 people live in poverty and are at risk of hunger. Over 256,000 people each year receive emergency food assistance from Second Harvest Food Bank of Northwest NC, through our network of food pantries, soup kitchens and shelter partner agencies.

These people represent the area's most vulnerable citizens. From the 2010 Hunger in America Study, conducted by Feeding America, among those served by Second Harvest Food Bank of Northwest NC, 32% are children under age 18 and nearly 10% are senior citizens. 64% of the adults served are women and 31% of all households served had at least one adult working. These citizens are 41% white, 43% African American and 10% Hispanic. Citizens seeking emergency food assistance are forced to make choices between food and other necessities including heating, rent, transportation and medical care.

With the SNAP funding received in fiscal year 2011-2012, 155,576 individuals were served. By applying the above-mentioned demographics, it can be estimated that of the total number of individuals served 49,784 are children under age 18 and nearly 15,558 are senior citizens. 99,569 of the adults served are women. Of the individuals served, 63,786 are white, 66,898 are African American and 15,558 are Hispanic.

With the SNAP funding of $962,166 for fiscal year 2011-2012, Second Harvest Food Bank of Northwest NC purchased and distributed 1,741,775 pounds to 273 eligible non-profit partner agencies serving individuals in crisis.

This food provided approximately 1,451,400 meals to individuals at risk of hunger in our 18-county service area.

More than 37 million people, including 14 million children and nearly 3 million seniors receive emergency food assistance each year through Feeding America food banks, the nation's largest domestic hunger-relief organization. NC food banks provide food assistance for an estimated 1.5 million different people annually (15% of the State's population). Based on data from the Hunger in America 2010 Study for Northwest NC and our partner agency network, our particular organization is serving 300,000 people annually. Food insecurity is caused by low education levels, our struggling economy and unemployment/underemployment created by loss of jobs. These factors leave individuals and families with uncertain availability to nutritious and safe food. Nutrition is critical to the growth and development of a healthy individual. Inadequate nutrition has adverse effects on physical health, behavior and mental health, child development, school readiness and achievement and economic productivity. Participation in SNAP allows Second Harvest Food Bank of Northwest NC to distribute staple, nutritious food to our eligible partner agencies that provide an improved balance of nutrition to needy individuals and expand the capacity of our partner agencies to meet the demand for food assistance.

Savings to our SNAP eligible partner agencies were approximately $2.9 million. These savings allowed our partner agencies increased capacity to expand their food assistance programs to a larger population of individuals.

With the SNAP funding of $962,166 for fiscal year 2011-2012, Second Harvest Food Bank of Northwest NC purchased and distributed 1,741,775 pounds to 273 eligible non-profit partner agencies serving individuals in crisis. This food reduced food insecurity by providing approximately 1,451,400 meals to 155,576 individuals at risk of hunger in our 18-county service area.

100% of the product purchased with SNAP funding was high quality, nutritious food obtained at the best value.

SNAP PROGRAM BUDGET

Salaries and Benefits*	$108,245
Operating Costs	
Facility Expenses	16,535
Transportation Expenses	19,153
Agency Relations Expenses	392
Food Purchases	817,841
Total Budget	$962,166

*No staff positions were funded with SNAP dollars. The above amount represents an allocation of an appropriate portion (based on the percentage of SNAP food versus all food distributed) of salaries and employee benefits for staff positions directly involved in the SNAP program including:

Truck Drivers
Receiving Staff
Distribution Staff
Inventory Control Staff
Facility Staff
Food Purchasing Staff
Finance Staff

Second Harvest Food Bank of Northwest
NC
Revenue Sources
Fiscal Year 2011-2012

	Year to Date
Interest Income-Operating	785.23
United Way of Forsyth County	169,964.00
Trusts & Foundations	185,108.68
NC Gen Fd Grant- SNAP Indirect	817,841.00
SNAP Direct	144,325.00
Churches/Religious Organizs	104,191.56
Businesses & Corporations	300,384.56
Direct Mail	576,308.34
Outside Fundraising Events	207,595.00
Civic Clubs	22,168.85
Agency Conference Income	165.25
TCK Cookbook Revenue	9,055.00
Major Gifts Donors	601,430.50
Estate Gifts	417,515.43
Food Purchase Program Income	593,361.95
Unsolicited	108,260.25
Miscellaneous Income	8,142.79
Handling Fees-Reg	663,657.29
Handling Fees-TEFAP	151,046.23
Rural Distribution	128,550.30
Total Revenues	5,209,857.21

Cumberland Community Action Program Inc.
Second Harvest Food Bank of Southeast North Carolina
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

(1) The entity's mission, purpose, and governance structure.

Mission:

To feed the hungry in Southeast North Carolina by soliciting and judiciously distributing healthy food and grocery products through a network of non-profit partners and to be an advocate that educates the community on the problems of and solutions to domestic hunger.

Purpose:

The Second Harvest Food Bank of Southeast North Carolina collects usable grocery items, largely donated, from suppliers and distributes them to approximately 240 member agencies in 7 counties in Southeast North Carolina. These partner agencies provide direct food assistance to more than 107,000 unique clients each year. In addition to general food distribution, the Food Bank engages in the "Hunger Relief for Kids" Backpack program, a program with 37 school locations in 7 counties with over 1,500 children being served each Friday during the school year. The Food Bank operates a Mobile Food Pantry Program as a direct service to those at risk of hunger in food desserts with transportation barriers to nutritious food. The Food Bank conducts over 70 distribution events throughout our service area during the year.

Governance Structure:

The Second Harvest Food Bank of Southeast North Carolina (SHFB SENC) is a division of Cumberland Community Action Program Inc. (CCAP). CCAP is a private, non-profit corporation duly incorporate under the laws of the State of North Carolina for the express purpose of "improving the education and economic opportunities, living environment and general welfare of the people". It is a recognized as a 501 (c) (3) charitable organization by the Internal Revenue Service.

The Board of Directors of CCAP served through 3 areas.

1. **Public** — Selected to served on board by a public official with a designated term assigned by said official for their term of office
2. **Private** — Serves on the board of directors for a period of 5 years unless reappointed by the organization
3. **Elected** — Elected by citizens in designated areas for a period of 5 years and then must seek reelection to the board of directors by the communities they serve

The CCAP Board of Director officers' positions are:

1. Chairman
2. Vice Chairman
3. Secretary
4. Treasurer
5. Parliamentarian
6. Chaplain

Cumberland Community Action Program Inc.
Second Harvest Food Bank of Southeast North Carolina
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

Governing Board committees include:

1. Executive
2. Finance
3. Board Development
4. Nominating
5. Audit

(2) A description of the types of programs, services, and activities funded by State appropriations.
The Second Harvest Food Bank of Southeast North Carolina utilizes SNAP funds to purchase, transport, store, and distribute food products from the Food Bank at no cost to member non-profit agencies. The products will be nutritious, wholesome food to include protein that might otherwise not be available from the Food Bank. This includes products such as canned beef stew, canned fruits, canned vegetables, frozen ground beef, frozen ground turkey, canned chicken, salmon, peanut butter, pasta, spaghetti sauce, and other desirable foods. Approximately 240 receiving agencies that operate emergency food box programs are provided SNAP purchased products free. In turn agencies will provide these products free to individual recipients in our 7-county service area. Hungry receipts in both rural and urban areas will receive benefit from this distribution.

(3) Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.

Demographic Data Item	Source	Response
Estimated number of individuals in our service area seeking food assistance at a pantry, shelter, or kitchen, within a year.	**Feeding America's Hunger In America 2010 Report – the most current comprehensive data we have on persons seeking food assistance from our network of emergency food organizations. Data collection for Hunger In America 2014 begins this spring.**	**107,000**
Estimated Demographic spread of individuals in our service area seeking food assistance at a pantry, shelter, or kitchen.		**Gender** Male: **45.6%** Female: **54.4%** **Age** <18: **34.9%** 18-64: **53.9 %** >64: **12.2%** **Ethnicity** White: **17.5%** Black: **67.6%** Hispanic: **3.5%** Native American: **10.7%** Asian/Pac. Islander: **1.2%**

Estimated Number of *MEALS* Served by SNAP Food in FY11/12

SNAP Pounds Purchased	Feeding America's lbs. to meal conversion metric	Estimated Meals provided by SNAP food purchased	SNAP % of Total Pounds Distributed by the SHFB SENC
796,698	**1 meal = 1.28 pounds**	**622,420**	**10%**

11/26/12

Cumberland Community Action Program Inc.
Second Harvest Food Bank of Southeast North Carolina
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

Second Harvest Food Bank of Southeast North Carolina's 7-County Service Area:

Bladen, Cumberland, Duplin, Harnett, Hoke, Robeson, & Sampson

(4) Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.

In FY 11-12, the Second Harvest Food Bank of Southeast North Carolina distributed 796,698 pounds or 622,420 meals of SNAP food to 204 SNAP eligible, participating member agencies in our 7-county service area. SNAP funding was used to purchase the most needed products, ones not available through industry donations in southeast North Carolina. Food product purchased include: tuna fish, green beans, rice, pinto beans, canned fruit and vegetables and peanut butter. Administrative funding for the Second Harvest Food Bank of Southeast North Carolina's SNAP program operations includes labor, warehousing, storage, refrigeration, order-picking/preparation and trucking to agencies.

(5) A detailed program budget and list of expenditures, including all positions funded and funding sources.

See separate attachment

(6) The source and amount of any matching funds.

No match was required in FY 2011/12

SECOND HARVEST FOOD BANK OF SENC	
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)	
FY 11/12 Section 10.19 (b) reporting #5	
Description	**FY 11/12 Budget**
REVENUE	
Contributions Income	
INDIVIDUALS	129,533
BUSINESS/CORPORATIONS	32,498
CIVIC ORGS/SCHOOLS/OTHER	1,020
GRANTS/ FOUNDATIONS	165,845
Contributions Income Total	**328,896**
SNAP FOOD PURCHASE INCOME	721,624
SNAP ADMINISTRATIVE REIMBURSEMENT INC.	240,542
SHARED MAINTENANCE FEE	349,148
MISCELLANEOUS Income	8,970
TOTAL INCOME	**1,649,180**
EXPENSES	

11/26/12

Cumberland Community Action Program Inc.
Second Harvest Food Bank of Southeast North Carolina
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

SALARY & FRINGES	
Director	51,683
Operations Manager	43,680
Warehouse Managers	34,382
Customer Relations Specialist	22,339
Agency Relations Manager	42,890
Food Souce Coordinator	33,300
Inventory Control Clerk	22,152
Administrative Assistant	28,974
Warehouse Asst	22,152
Truck Drivers (2.5 FTE)	72,862
SNAP Coordinator	33,300
Contract Labor	11,027
TOTAL SALARY & FRNGES	**418,741**
EMPLOYEE BENEFITS	**64,474**
PAYROLL TAXES	**38,129**
SNAP FOOD PURCHASES	**721,624**
PROFESSIONAL FEES	**80,018**
EQUIPMENT PURCHASE (federal grant)	**89,345**
EQUIPMENT MAINTENANCE & REPAIR - WAREHOUSE	**40,698**
OCCUPANCY	
Insurance, Bldg & Flood	3,821
Electricity & gas	30,151
Communications - telephones and internet	11,991
Food packing and warehouse supplies	27,210
Waste Management	6,163
Pest Control	847
Mortgage	44,670
TOTAL OCCUPANCY	**124,853**
TRANSPORTATION	
Vehicle Gas & Oil	17,877
Vehicle Repairs & Maintenance	8,452
Vehicle Lease	30,392
Vehicle Insurance	4,613
Vehicle License & permits	7,932
TOTAL TRANSPORTATION (TRUCK COSTS)	**69,266**
MISCELLANEOUS EXPENSE/WAREHOUSE	**2,032**
TOTAL EXPENSES	**1,649,180**

11/26/12

Cumberland Community Action Program Inc.
Second Harvest Food Bank of Southeast North Carolina
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

11/26/12

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS
Name of Committee

2-14-2013
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Madison Mackenzie	DOJ
Carley Ruff	NCHC
Lauren Knott	NCHC
George Smith	Nexsen Pruet
Melissa Reed	PPHS
Jennifer Hutchins	Navigant
Dave Mosley	"
DAVID MCMAHON	MYERS & STAUFFER PLLC
Ashley Capps	AARP Intern
David Blackwell	NC Board of Nursing
Megan Cassella	UNC Chapel Hill
Paul Enderson	Youth Villages
Chris McClure	Brooks Pierce

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS
Name of Committee

2-14-2013
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Heather Dunsmore	merck
Eric Hunley	SAS
[illegible]	[illegible]
TRACY COLVARD	AHHC
Melissa Robinson	HP
Kay Paksoy	NASW-NC
Johanna Tiedt	NASW-NC
Lauren Absher	NASW-NC
Jay Joiner	Soundtracs
Adam Linker	NC Justice Center
Dean Plunkett	PS
[illegible]	SEANC
Kristen Laster	SSG NC

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — **Name of Committee**

2-14-2013 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ellen Holliman	Alliance Behavioral Healthcare
Tracy Hayes	Alliance Behavioral Healthcare
Annaliese Dolph	DRNC
Mary Bethune	AARP NC
Kerra Bolton	LCA
Andy Chase	KMA
Colleen Kochanek	NCCEP
Dick Culbreth	Medfam
Butch Gunnells	NC Bev A
Jennifer Mahan	ASNC
Tony Dorsett	DRNC
Ken Melton	Bunch
Ed Turlington	Brooks House

VISITOR REGISTRATION SHEET

##5 — 2-14-13

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Doug Lassiter	NCSTA
BRUCE THOMPSON	PALCAR POC
Daniel Amburn	NERMA + the awesome bag society
JOEZ AMBER	NELSON-MULLINS
Jim Harrell	NCSA
Joyce Peters	CCS
Andy Ellen	NCRMA
Sam Taylor	NCBIO
Julia Adams	The Arc of NC
Saicel Rotheeler	BRUNSWICK ASSOCIATES

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — **Name of Committee**

2-14-2013 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
RICHARD TOPPING	CARDINAC INNOVATIONS
PAM SHIPMAN	"
A B Smith--	BridgeStone
[illegible]	NCANTCF
[illegible]	MFTS
Michelle Frazier	MFTS
Vlasta Hakes	Grifols
Sarah Wolfe	MWC LLC
DAVID STONE	The Carolinas Center for Hospice and EOL Care
Wendy Kelly	N.C. Gov Group
Caroline Cobb	Policy Consult.

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — **Name of Committee**

2-14-2013 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jud Bonn	Bonn - Assoc.
Johanna Reese	NCACC
JAY PETERS	CSS
KAREN GILLESPIE	DMS
DOUG HERON	WM
HUGH TILLOT	NCHA
JOHN THOMPSON	CCNC
DAPPA SIMPSON	SBA
DANIEL BAUM	TROUTMAN SANDERS
TOMMY SUTER	NOVARTIS

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — 2-14-2013

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lee A. Swecker	Cary,
E Nelson	NCHA
Reston Jones	Gous Office
Eric Faust	office state auditor
Clif Chioda	Office State Auditor
Jane Seo	Office of State Auditor
Annie Smith	Youth Villages
Matt Gross	NCPC
Sam Clark	NCHCFA
Bill Rustin	ACP
Missy ONeal	IBM

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — **Name of Committee**

2-14-2013 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Heather Barnett	Ward & Smith
[illegible]	MUC
Kerry Swearingen	SAS
Will Huntsberry	TNDY Week
CMS DA	[illegible]

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

February 19, 2013
Legislative Office Building - Room 643
8:30 a.m.

Representative William Brisson, Presiding	
Welcome and Introductions by Chairs	
Nonprofit Special Provision	Donnie Charleston, Committee Staff Fiscal Research Division
Nonprofit Presentations	
Food Banks Introduction	Allen Briggs, Executive Director, NC Association of Feeding America Food Banks
Food Bank of Central and Eastern N. Carolina	Peter Werbicki, CEO
Food Bank of the Albemarle	Liz Reasoner, Executive Director
Manna Food Bank	Cindy Threlkeld, Executive Director
Second Harvest of Metrolina	Kay Carter, Executive Director
Second Harvest of Northwest	Clyde Fitzgerald, Executive Director
Second Harvest of Southeast	David Griffin, Executive Director
Adjourn	
Next Meeting:	Thursday, February20th, 9:00 a.m.

Joint Committee on Appropriations on Health and Human Services
Tuesday, February 19, 2013 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations on Health and Human Services met at 8:30 AM on February 19, 2013, in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Jean Farmer-Butterfield, Carl Ford, Jim Fulghum, Beverly Earle, Mark Hollo, Verla Insko, Donny Lambeth, and Susan Martin were present, along with 5 Senate members.

Representative William Brisson presided.

Representative Brisson opened the meeting by welcoming everyone and recognizing the House Sergeants-at-Arms—Fred Hines and Charles Godwin—and the Senate Sergeants-at-Arms—Leslie Wright and Steve Wilson. He also recognized the Pages in attendance. For the House were William Jackins of Mecklenburg County, Daniel Kunath of Wake County, Erin McDonald of Mecklenburg County, and Melissa Pulley of Nash County. For the Senate were Katie Brown of Cumberland County and Libby Dotson of Johnston County.

Donnie Charleston, of Fiscal Research, spoke briefly on the Nonprofit Special Provision and welcomed Allen Briggs, Executive Director of NC Association of Feeding America Food Banks. Mr. Briggs gave a Food Banks Introduction, followed by presentations by Executive Directors of regional food banks.

The meeting adjourned at 9:51 AM

Representative William Brisson
Presiding

Susan Fanning, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 14, 2013 10:27 AM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Tuesday, February 19, 2013 at 8:30 AM - CORRECTED #1

Principal Clerk ____
Reading Clerk ____

Corrected #1:

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Tuesday	February 19, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

THE JOINT CONFERENCE COMMITTEE REPORT ON THE CONTINUATION, EXPANSION AND CAPITAL BUDGETS

(Revised Pursuant to S.L. 2012-142, Section 27.3)

S. L. 2012-142 (House Bill 950)

North Carolina General Assembly
2012 Session

July 24, 2012

As amended by S.L. 2012-145 (Senate Bill 187); S. L. 2012-74 (House Bill 1015); S.L. 2012-36 (House Bill 1025); and S.L. 2012-194 (Senate Bill 847).

Conference Report on the Continuation, Capital and Expansion Budgets

FY 12-13

25 Non-State Entity Pass-Through Funds ($9,159,699) R
Replaces $9,159,699 in recurring special appropriation (pass-through) funds for the following non-state entities with non-recurring funds: $9,159,699 NR

North Carolina Senior Games, Inc. - $121,481
ARC of North Carolina - $305,598
ARC of North Carolina – Wilmington - $51,048
Autism Society of North Carolina - $2,941,818
The Mariposa School for Children with Autism - $339,879
Easter Seals UCP of North Carolina - $76,792
Easter Seals UCP of North Carolina and Virginia - $1,542,647
ABC of North Carolina Child Development Center - $366,703
Residential Services, Inc. - $ 246,424
Oxford House, Inc. - $200,000
Brain Injury Association of North Carolina - $225,223
Food Bank of Central and Eastern North Carolina, Inc. - $333,334
Food Bank of the Albemarle - $333,334
Manna Food Bank - $333,334
Second Harvest Food Bank of Metrolina, Inc - $333,334
Second Harvest Food Bank of Northwest North Carolina, Inc. - $333,332
Prevent Blindness NC - $308,163
Second Harvest Food Bank of Southeast NC $333,332

(6.0) Division of Social Services

26 Adoption Vendor Payments ($2,025,649) R
Reduces funds for adoption vendor services through efficiencies gained by better program oversight by the Division of Social Services.

27 FMAP IV-E Child Welfare Services ($379,116) R
Increases State General Funds due to changes in the Federal Medical Assistance Percentage (FMAP). The change from 65.28% to 65.51% goes into effect in October of 2012.

28 Foster Care Efficiencies ($6,674,351) R
Reduces funds for the Foster Care Program due to a change in the case mix of foster care children in the care of the Division of Social Services.

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.

REPORTS BY NON-STATE ENTITIES RECEIVING DIRECT STATE APPROPRIATIONS

SECTION 10.19.(a) The Department of Health and Human Services shall require the following non-State entities to match ten percent (10%) of the total amount of State appropriations received each fiscal year. In addition, the Department shall direct these entities to submit a written report annually, beginning December 1, 2012, of all activities funded by State appropriations to the Joint Legislative Oversight Committee on Health and Human Services, 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:

(1) North Carolina Senior Games, Inc.
(2) ARC of North Carolina.
(3) ARC of North Carolina – Wilmington.
(4) Autism Society of North Carolina.
(5) The Mariposa School for Children with Autism.
(6) Easter Seals UCP of North Carolina.
(7) Easter Seals UCP of North Carolina and Virginia.
(8) ABC of North Carolina Child Development Center.
(9) Residential Services, Inc.
(10) Oxford House, Inc.
(11) Brain Injury Association of North Carolina.
(12) Food Bank of Central and Eastern North Carolina, Inc.
(13) Food Bank of the Albemarle.
(14) Manna Food Bank.
(15) Second Harvest Food Bank of Metrolina, Inc.
(16) Second Harvest Food Bank of Northwest North Carolina, Inc.
(17) Second Harvest Food Bank of Southeast North Carolina
(18) Prevent Blindness NC.

SECTION 10.19.(b) The report required by subsection (a) of this section shall include the following information about the fiscal year preceding the year in which the report is due:

(1) The entity's mission, purpose, and governance structure.
(2) A description of the types of programs, services, and activities funded by State appropriations.
(3) Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.
(4) Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.
(5) A detailed program budget and list of expenditures, including all positions funded and funding sources.
(6) The source and amount of any matching funds received by the entity.

REPORT ON LAPSED SALARY FUNDS

SECTION 10.20. Beginning no later than November 1, 2012, the Department of Health and Human Services shall submit quarterly reports to the Joint Legislative Oversight Committee on Health and Human Services, 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 use of lapsed salary funds by each Division within the Department. For each Division, the report shall include the following information about the preceding calendar quarter:

(1) The total amount of lapsed salary funds.
(2) The number of full-time equivalent positions comprising the lapsed salary funds.
(3) The Fund Code for each full-time equivalent position included in the number reported pursuant to subdivision (2) of this section.

Food Bank of Central & Eastern NC

Reporting Requirements Fiscal Year 11/12 – Direct State Appropriations

Section 10.19.(b)

1) **Entity's Mission:** No One Goes Hungry in Central & Eastern North Carolina.
   Purpose: Receive donated food to the Food Bank through grocery stores, food manufacturers and distributors and community food drives. The food is then sorted, collected and stored throughout the branches in Sandhills, Durham, Greenville, New Bern, Wilmington and Raleigh. It is then distributed to a network of 800 partner agencies including food pantries, soup kitchens, shelters, day care centers and elderly care programs. This allows the Food Bank to assist in meeting basic needs of the children and families who are food insecure.
   Governance Structure: The Food Bank of Central & Eastern NC (FBCENC) is an incorporated organization through the State of NC with Articles of Incorporation and by-laws. The FBCENC has an active board of directors comprised of civil and community leaders who assist the President/CEO. The FBCENC is a 501(c)3 tax-exempt organization and was granted tax exemption in January, 1981.
2) **Description of types of program, services and activities funded by the State appropriations:** The goal of the utilization of the State appropriate funding is to provide approximately 607k meals of nutritious food, purchased primarily through North Carolina suppliers, to a majority of Food Bank partner agencies in a 19,000 square mile 34-county service area. This food will reach low-income families and individuals in the service area that come to partner agencies needing emergency food supplies.
3) **Statistical and demographical information on the number of persons served by these programs, services and activities, including the counties in which services are provided.** During the 11/12 fiscal year, Food Bank partner agency pantries served 1,220,522 households and 3,210,205 individuals. Please note that these are duplicated numbers since many of our partner agencies are not able to track unduplicated numbers. Partner agencies that are provided food from the state appropriation funding also served 920,182 meals through soup kitchens and 1,195,323 through emergency shelters. Demographic Data from the "Hunger in America 2010" study (a comprehensive study of hunger conducted every four years by Feeding America and its member food banks) provides the following data on food recipients served by Food Bank of Central & Eastern North Carolina partner agencies: 22.4% non-Hispanic White, 65.1% non-Hispanic Black/African American, 8.3 % Hispanic, 0% Asian, 0% Native Hawaiian or Other Pacific Islander and 2.1% other. The percentages add up to 101% because clients interviewed for the study could identify multiple races/ethnicities.

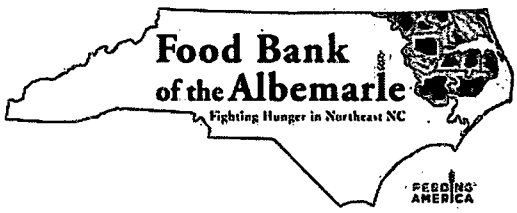
   The counties served by the Food Bank are: Brunswick, Carteret, Chatham, Columbus, Craven, Duplin, Durham, Edgecombe, Franklin, Granville, Greene, Halifax, Harnett, Johnston, Jones, Lee, Lenoir, Moore, Nash, New Hanover, Onslow, Orange, Pamlico,

Pender, Person, Pitt, Richmond, Sampson, Scotland, Vance, Wake, Warren, Wayne, and Wilson.

4) **Outcome measures that demonstrate the impact and effectiveness of the programs, services and activities.** The FBCENC purchased 727,768 lbs of food from State appropriations monies in 11/12 fiscal year, this equates to estimated meals provided of 606,473. The State appropriation % of total pounds distributed by the FBCENC is 2% of the total lbs distributed for 11/12 fiscal year.
5) **Detailed Program Budget and list of expenditures, including positions funded and funding sources:**
   a) Program Budget included the following:

a. Food Purchases	$817,842
b. Supplies and Operating Costs	$ 86,595
c. Salary and Fringes	$ 57,730
Totals	$962,167

   b) Program funds portions of: Marketing and Product Assistant/Shopping Coordinator who purchases food product, Driver – Class A, Outreach Coordinators, Director of Finance,
   c) Funding sources include: donations, food donations, agency contributions, NC Department of Agriculture, and NC Dept of Health and Human Services
6) **The source and amount of any matching funds received by the entity:**
   a) The amount of matching funds equal to 10% of the State appropriates is: $96,217. The amount is matched by sources of revenue such as individual contributions, direct mail, food donations, on-line giving.



Fighting hunger and poverty in northeast North Carolina

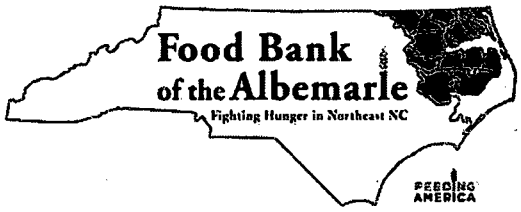
Serving Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Gates, Hertford, Hyde, Martin, Northampton, Pasquotank, Perquimans, Tyrrell and Washington Counties.

SNAP APPROPRIATION EXPENDITURE REPORT

FY 2011/2012

NOVEMBER 28, 2012

LIZ REASONER
EXECUTIVE DIRECTOR
252.335.4035 x110
lreasoner@feedingamerica.org



Fighting hunger and poverty in northeast North Carolina

Serving Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Gates, Hertford, Hyde, Martin, Northampton, Pasquotank, Perquimans, Tyrrell and Washington Counties.

The Food Bank of the Albemarle serves a fifteen county region that makes up northeast North Carolina. The mission of the Food Bank is to fight hunger and poverty in northeast North Carolina. Our vision is that our communities are hunger free. We are a regional clearinghouse for the collection and distribution of food and grocery items to non-profit and faith-based organizations for their food programs and to eligible individuals for their food needs. We are able to receive, stage, and store large quantities of food. This food is then distributed to the hungry in fifteen northeast North Carolina counties through our partner agencies. Since 1984, the Food Bank has been a member of the national network of Food Banks called Feeding America (originally America's Second Harvest).

The Food Bank of the Albemarle is a private, 501(c)3 non-profit organization incorporated in the state of North Carolina. An uncompensated Board of Directors governs the organization. Our board is comprised of civic and business leaders from throughout our service territory. The Executive Director leads the organization, oversees its activities and answers to the Board of Directors.

Across the more than 6,000 square miles served by the Food Bank of the Albemarle, we work in partnership with 130 non-profit member agencies. These agencies include food pantries, soup kitchens, day care centers, juvenile and senior citizen residential programs, and shelters. These partner agencies put the food into the hands of the hungry in our communities. Either these agencies pick up food from our warehouse in Elizabeth City or we deliver it to them for distribution to the hungry men, women, and children in their communities. In addition to these programs, we provide food to our most under- and un-served clientele via the Mobile Food Pantry. This program operates in areas where a traditional pantry is not available to help those in need of food assistance.

For Fiscal Year 2011/12, Food Bank of the Albemarle's share of the legislative appropriation was $961,666. The appropriation was larger than in years prior and the funds enabled us to provide food to even more of the hungry families and individuals throughout our fifteen county service area. Using these funds from the legislature, we were able to secure 1,285,276 pounds of food for our clients. Those pounds represent a 54% increase in SNAP product that went o hungry families here in northeast NC.. We distributed the food via our participating, partner agencies in the manner described above. Please refer to the attached table for detailed information on the breakdown of our clients served and use of state funds.

The Food Bank of the Albemarle is a member of Feeding America, the largest domestic hunger relief organization and a national network of more than 200 food banks. We, in turn, have partner agencies that distribute food to clients. Each participating agency is bound, contractually, to adhere to rigorous standards for food safety. Agencies are required to screen clients for eligibility. They also receive Federal Civil Rights training, to ensure non-discriminatory practices. Further, we inspect our agencies at regular intervals to ensure compliance with Federal, state and Feeding America standards. Noncompliance can lead to revocation of an agency's participation agreement with the Food Bank of the Albemarle.

The Food Bank of the Albemarle, in FY10/11 and FY11/12, has raised enough money in private funding to cover the 10% match required for our appropriation. Our sources include private donations received through direct contact solicitations, direct mail campaigns, private grants, United Way participation and special events. Please see the attached table for details about our revenue sources. The Food Bank also has audited financial statements and IRS Form 990's for the past two fiscal years available at your request.

Food Bank of the Albemarle

Public Support and Revenue	2011/2012 Approved	Recommended change by line	2011/2012 Amendment to Revenue
Direct Public Support			
Individual Donors	$ 94,500.00	$ -	$ 94,500.00
Business Donors	$ 13,000.00	$ -	$ 13,000.00
Church Donors	$ 17,000.00	$ -	$ 17,000.00
Organization Donors	$ 10,000.00	$ -	$ 10,000.00
Total Direct Public Support	**$ 134,500.00**	**$ -**	**$ 134,500.00**
Annual Appeals			
Thanksgiving Appeal - Direct Mail	$ 17,500.00	$ 12,400.00	$ 29,900.00
Christmas Appeal - Direct Mail	$ 60,000.00	$ (11,200.00)	$ 48,800.00
Hunger Hurts Appeal - Insert	$ 6,000.00	$ (6,000.00)	$ -
Total Annual Appeals	**$ 83,500.00**	**$ (4,800.00)**	**$ 78,700.00**
Special Events			
SE, Dine Out	$ 12,500.00	$ 1,300.00	$ 13,800.00
SE, Walk for Hunger	$ 40,000.00	$ -	$ 40,000.00
Total Special Events	**$ 52,500.00**	**$ 1,300.00**	**$ 53,800.00**
Agency Fees & Purchases			
WH Handling/Delivery/Annual Fees	$ 239,000.00	$ -	$ 239,000.00
Coop Buying/Wholesale Food Purchases	$ 121,000.00	$ -	$ 121,000.00
Total Agency Fees & Purchases	**$ 360,000.00**	**$ -**	**$ 360,000.00**
Grants & Appropriations			
Grants, Foundations	$ 87,015.00	$ 20,000.00	$ 107,015.00
Settlements (MOVED TO STATE AWARDS)		$ -	$ -
County Appropriations	$ 13,500.00	$ -	$ 13,500.00
City Grants & Appropriations	$ 5,000.00	$ -	$ 5,000.00
FNS Outreach Reimbursement	$ 15,903.00	$ (4,903.00)	$ 11,000.00
Total Grants & Appropriations	**$ 121,418.00**	**$ 15,097.00**	**$ 136,515.00**
United Way Allocations			
UW, Albemarle Area	$ 28,000.00	$ -	$ 28,000.00
UW, Martin County	$ 3,000.00	$ -	$ 3,000.00
UW, United Way of America	$ 2,470.00	$ -	$ 2,470.00
Combined Federal Campaign	$ 8,500.00	$ -	$ 8,500.00
UW, Beaufort County	$ 14,500.00	$ -	$ 14,500.00
Total United Way Allocations	**$ 56,470.00**	**$ -**	**$ 56,470.00**
Miscellanous			
Interest Income	$ 1,000.00	$ (400.00)	$ 600.00
Misc. Income	$ 1,500.00	$ (1,000.00)	$ 500.00
Sales Tax Reimbursement	$ 2,800.00	$ -	$ 2,800.00
Small Business Health Care Tax Credit	$ 10,973.00	$ (4,500.00)	$ 6,473.00
Total Miscellanous	**$ 16,273.00**	**$ (5,900.00)**	**$ 10,373.00**
Federal Awards			
Emergency Food and Shelter Program	$ 16,000.00	$ (7,262.00)	$ 8,738.00
TEFAP Commodity Distribution	$ 24,000.00	$ 32,700.00	$ 56,700.00
CACFP After School Meal Program	$ 15,000.00	$ -	$ 15,000.00
Total Federal Awards	**$ 55,000.00**	**$ 25,438.00**	**$ 80,438.00**
State Awards			
Settlement AG	$ 24,810.00	$ -	$ 24,810.00
SNAP Food Purchases	$ 333,334.00	$ 628,800.00	$ 962,134.00
Total State Awards	**$ 358,144.00**	**$ 628,800.00**	**$ 986,944.00**
Suta Debit/Transfer inot operating			
Savings debit/transfer into operating	$ 49,600.00	$ -	$ 49,600.00
TOTAL PUBLIC SUPPORT & REVENUES	**$ 1,287,405.00**	**$ 659,935.00**	**$ 1,947,340.00**

Expenses	2011/2012 Approved	net change Increased by SNAP Portion.	2011/2012 Amended Expenses Effective 1/1/12
Expenses - Staff			
Staff, Salaries	$ 416,671.00	$ 22,969.00	$ 439,640.00
Staff, Health Insurance	$ 78,002.00	$ -	$ 78,002.00
Payroll Tax Expense	$ 31,875.00	$ 1,757.00	$ 33,632.00
SUTA Tax Expense	$ 4,167.00	$ 229.00	$ 4,396.00
Staff, Workers Compensation	$ 7,500.00	$ -	$ 7,500.00
Meetings/Training	$ 4,000.00	$ 3,500.00	$ 7,500.00
Inmate Transportation	$ 12,000.00		$ 12,000.00
Mileage Reimbursement	$ 3,080.00		$ 3,080.00
Staff, Shirt & Safety Shoes	$ 2,200.00	$ 1,500.00	$ 3,700.00
Payroll Processing	$ 2,200.00	$ 330.00	$ 2,530.00
Total Expenses - Staff	**$ 561,695.00**	**$ 30,285.00**	**$ 591,980.00**
Expenses - Equipment			
OPS Equip. Repair/Maint.	$ 4,000.00	$ 1,200.00	$ 5,200.00
OPS Equip. Purchases	$ 3,000.00	$ 900.00	$ 3,900.00
IT Equip. Rental	$ 5,040.00	$ -	$ 5,040.00
IT Equip, Hardware and Software	$ 11,000.00	$ 1,000.00	$ 12,000.00
IT Equip. Repair/Maint.	$ 7,200.00	$ 900.00	$ 8,100.00
Total Expenses - Equipment	**$ 30,240.00**	**$ 4,000.00**	**$ 34,240.00**
Expenses - Vehicles			
Vehicle Insurance	$ 4,700.00	$ 1,410.00	$ 6,110.00
Vehicle License and taxes	$ 2,500.00	$ 750.00	$ 3,250.00
Vehicle Gas & Oil	$ 60,000.00	$ 8,500.00	$ 68,500.00
Vehicle Repair/Maintenance	$ 15,000.00	$ 5,000.00	$ 20,000.00
Program, Freight	$ 20,000.00	$ 25,000.00	$ 45,000.00
Vehicle Rental	$ 2,000.00		$ 2,000.00
Vehicle Purchase	$ 42,600.00		$ 42,600.00
Total Expenses - Vehicles	**$ 146,800.00**	**$ 40,660.00**	**$ 187,460.00**
Expenses - Building			
Building Loan Payment	$ 29,412.00	$ 1,788.00	$ 31,200.00
Building Maintenance	$ 13,000.00		$ 13,000.00
Building Supplies	$ 3,500.00	$ 1,050.00	$ 4,550.00
Building Insurance	$ 8,600.00	$ 1,500.00	$ 10,100.00
Building Pest Control	$ 1,500.00	$ -	$ 1,500.00
Building - Lawn Care	$ 2,000.00	$ 800.00	$ 2,800.00
Trash	$ 4,500.00	$ -	$ 4,500.00
Utilities/Propane Gas/Electric	$ 23,000.00	$ 2,300.00	$ 25,300.00
Telephone	$ 6,500.00	$ -	$ 6,500.00
Miscellaneous	$ -	$ -	$ -
Supply - Office Furnishings	$ 650.00	$ -	$ 650.00
Total Expenses - Building	**$ 92,662.00**	**$ 7,438.00**	**$ 100,100.00**
Expenses - Supplies			
Supply, Office	$ 9,000.00	$ 1,820.00	$ 10,820.00
Supply, Printing	$ 6,000.00	$ 500.00	$ 6,500.00
Supply, Postage	$ 9,000.00	$ 4,100.00	$ 13,100.00
Subscriptions	$ 500.00	$ -	$ 500.00
Supply other	$ 800.00	$ -	$ 800.00
Non-food Supply ASP	$ 250.00		$ 250.00
Total Expenses - Supplies	**$ 25,550.00**	**$ 6,420.00**	**$ 31,970.00**
Expenses - Special Event			
Special Event Advertising	$ 2,000.00	$ -	$ 2,000.00
Spec Event Supplies & Direct Cost	$ 2,500.00	$ 1,000.00	$ 3,500.00
Media (web) & Education (static displays)	$ 2,000.00	$ 1,500.00	$ 3,500.00
Total Expenses - Special Event	**$ 6,500.00**	**$ 2,500.00**	**$ 9,000.00**

Expenses - Other			
Volunteer Appreciation	$ 800.00	$ -	$ 800.00
Director & Officers Insurance	$ 1,300.00	$ -	$ 1,300.00
Sales Tax	$ 3,750.00	$ -	$ 3,750.00
Professional Fees (Audit)	$ 6,000.00	$ 350.00	$ 6,350.00
NCAFAFB	$ 12,200.00	$ 6,000.00	$ 18,200.00
Bank Service Charges, C & P, late fees	$ 750.00	$ 1,350.00	$ 2,100.00
Dues	$ 1,000.00	$ -	$ 1,000.00
Interest Expenses	$ 500.00	$ 500.00	$ 1,000.00
Feeding America Fee	$ 3,460.00	$ -	$ 3,460.00
Brokerage Fees	$ 450.00	$ -	$ 450.00
Branding		$ 15,000.00	$ 15,000.00
Property Tax	$ 300.00	$ -	$ 300.00
Total Expenses - Other	**$ 30,510.00**	**$ 23,200.00**	**$ 53,710.00**
Expenses - Food Purchases			
Food Purchases SNAP	$ 280,000.00	$ 538,094.00	$ 818,094.00
Agency Food Purchases	$ 110,000.00	$ -	$ 110,000.00
CACFP Food Purchases	$ -	$ -	$ -
VAP	$ 1,300.00	$ -	$ 1,300.00
Total Expenses - Food Purchases	**$ 391,300.00**	**$ 538,094.00**	**$ 929,394.00**
TOTAL EXPENSES	**$ 1,285,257.00**	**$ 652,597.00**	**$ 1,937,854.00**
		(deficit)/reserve	**$ 9,486.00**

SNAP DOLLARS

Racial Composition of Clients (% of State Funds)*

$ 961,666.00			
White	$	387,551.40	40.30%
African American	$	323,119.78	33.60%
Hispanic/Latino	$	197,141.53	20.50%
Native American	$	37,504.97	3.90%
Asian	$	11,539.99	1.20%
Other	$	4,808.33	0.50%
	$	**961,666.00**	**100.00%**

Age Composition of Clients (% of State Funds)*

$ 961,666.00			
17 & Under	$	360,624.75	37.50%
18 to 64	$	524,107.97	54.50%
65 & Over	$	76,933.28	8.00%
	$	**961,666.00**	**100.00%**

SNAP LBS

Racial Composition of Clients (% of SNAP LBS)*

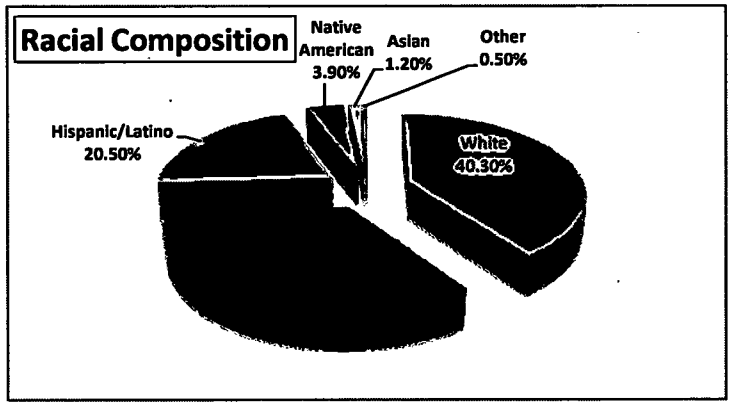
1,285,276		
White	517,966.23	40.30%
African American	431,852.74	33.60%
Hispanic/Latino	263,481.58	20.50%
Native American	50,125.76	3.90%
Asian	15,423.31	1.20%
Other	6,426.38	0.50%
	1,285,276.00	**100.00%**

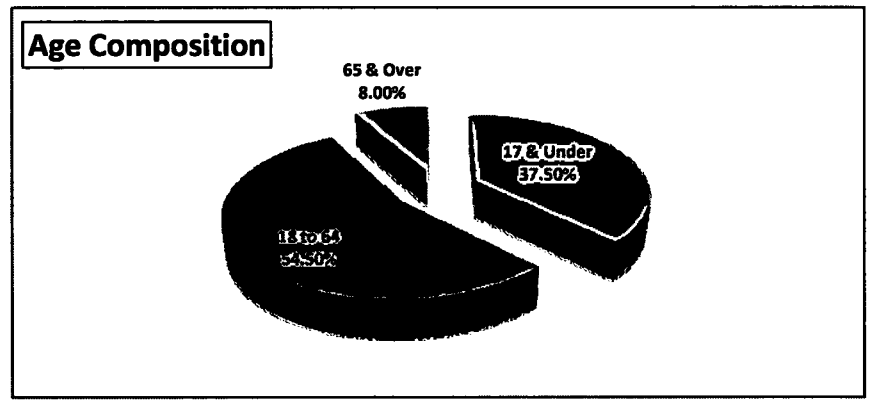
Age Composition of Clients (% of SNAP LBS)*

1,285,276		
17 & Under	481,978.50	37.50%
18 to 64	700,475.42	54.50%
65 & Over	102,822.08	8.00%
	1,285,276.00	**100.00%**

** Percentages based on the 2010 Feeding America Hunger Study*

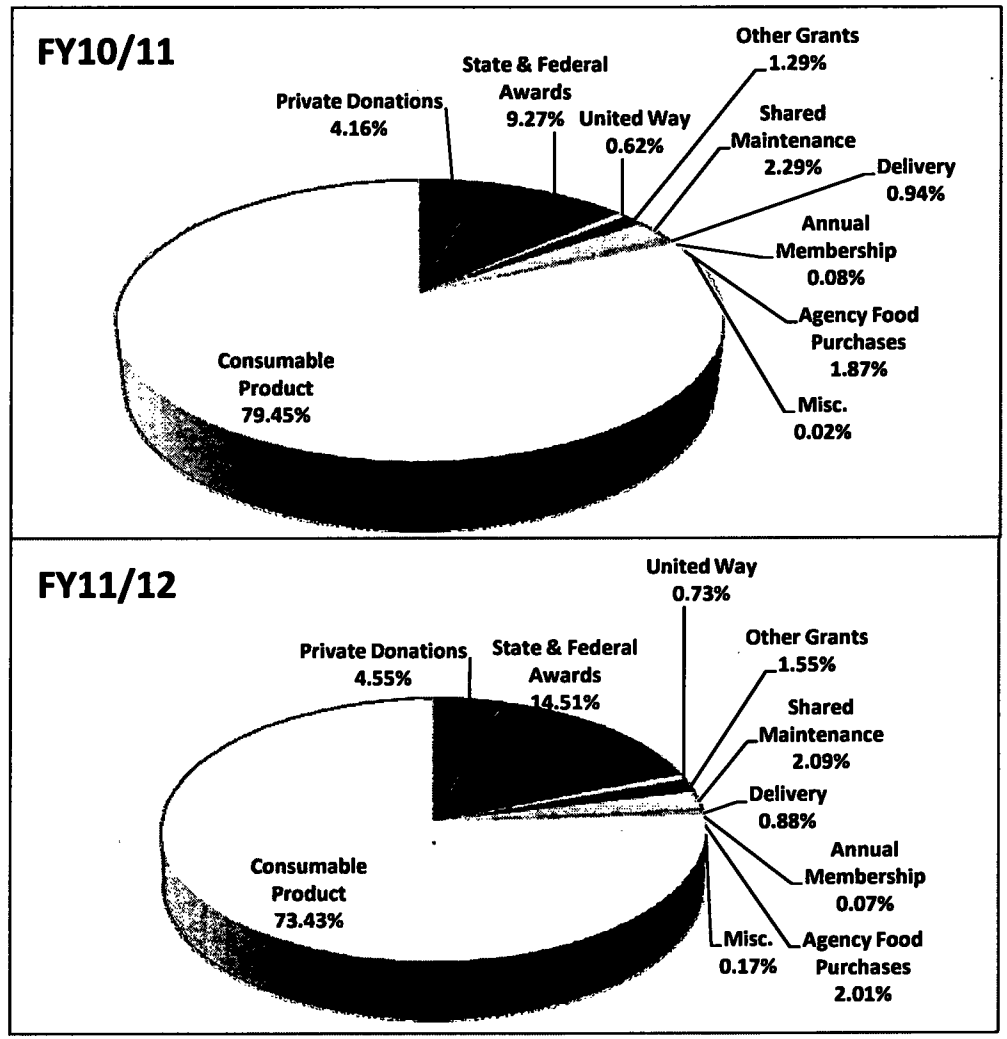
Client Race and Age Composition





Revenue Summary
FY 10/11 & 11/12

	2010/11	2011/12
Private Donations	$ 294,786.00	$ 338,914.00
State & Federal Awards	$ 657,217.00	$ 1,079,732.00
United Way	$ 44,272.00	$ 54,424.00
Other Grants	$ 91,683.00	$ 115,359.00
Shared Maintenance	$ 162,530.00	$ 155,382.00
Delivery	$ 66,874.00	$ 65,846.00
Annual Membership	$ 5,380.00	$ 5,338.00
Agency Food Purchases	$ 132,231.00	$ 149,678.00
Misc.	$ 1,756.00	$ 12,380.00
Consumable Product	$ 5,633,339.00	$ 5,464,285.00
Total Support and Revenue	**$ 7,090,068.00**	**$ 7,441,338.00**



MANNA FOOD BANK
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

(1) The entity's mission, purpose, and governance structure.

Mission: MANNA FoodBank's mission is to involve, educate and unite people in the work of ending hunger in Western North Carolina. MANNA's vision is a hunger free Western North Carolina.
Purpose: MANNA FoodBank collects usable grocery items, largely donated, from suppliers and distributes them to MANNA's approximately 255 accredited partner agencies in 16 counties in Western North Carolina. These partner agencies then provide direct food assistance to more than 106,000 unique clients each year. In addition to the general food distribution program, MANNA also engages in MANNA Packs for Kids, a program that provides a 3-5 pound bag of food to take home to more than 3,000 children each Friday during the school year; and Food and Nutrition Services outreach, which assists hundreds of clients each year to apply for FNS benefits (formerly called food stamps).
Governance Structure: MANNA was founded in 1982 and is a 501(c) (3) tax exempt, non-profit corporation doing business in the state of North Carolina. The property, affairs and business of MANNA are managed by a volunteer Board of Directors comprised of community leaders with a particular interest in hunger-related issues. The Board meets 8 times per year. Directors serve a term of three years, with no more than two terms served consecutively. MANNA's Executive Director reports directly to the Board.

The Board of Director offices are:

- President
- Vice President
- Past President
- Secretary
- Treasurer

Boards of Director Committees include:

- Executive
- Finance
- Membership & Governance
- Fundraising
- Audit

(2) A description of the types of programs, services, and activities funded by State appropriations.

MANNA FoodBank works with over 255 partner 501(c) (3) organizations, of which 149 are eligible as emergency food providers to receive and distribute SNAP-purchased food. The SNAP program enables MANNA to provide a high quality source of food to emergency food providing agencies (emergency food pantries, soup kitchens, homeless shelters, and domestic violence shelters) in our 16 county area thus providing greater food security to the citizens of Western North Carolina who are food insecure. Through SNAP funding, MANNA was able to purchase 1,294,052 pounds of food, providing an estimated 1,078,376 meals to children, adults and the elderly, living at or below the poverty line.

MANNA FOOD BANK
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

(3) Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.

Demographic Data Item	Source	Response
Estimated number of individuals in our service area seeking food assistance at a pantry, shelter, or kitchen, within a year.	Feeding America's Hunger In America 2010 Report – the most current comprehensive data we have on persons seeking food assistance from our network of emergency food organizations. Data collection for Hunger In America 2014 begins this spring.	106,600
Estimated Demographic spread of individuals in our service area seeking food assistance at a pantry, shelter, or kitchen.		**Gender** Male: 52.4% Female: 47.6 **Age** <18: 31% 18-64: 60% >64: 9% **Ethnicity** White: 70.4% Black: 14.7% Hispanic: 10.6% Native American: 3.5% Asian/Pac. Islander: <1%

Estimated Number of *MEALS* Served by SNAP Food in FY11/12

SNAP Pounds Purchased	Feeding America's lbs. to meal conversion metric	Estimated Meals provided by SNAP food purchased	SNAP % of Total Pounds Distributed by the MANNA FoodBank
1,294,052	1 meal = 1.2 pounds	1,078,376	10%

MANNA FoodBank's 16-County Service Area:
Avery County
Buncombe County
Cherokee County
Clay County
Graham County
Haywood County
Henderson County
Jackson County
Macon County
Madison County
McDowell County
Mitchell County
Polk County
Swain County
Transylvania County
Yancey County

11/26/12

MANNA FOOD BANK
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

(4) Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.

In FY 11-12, MANNA distributed 1,294,052 pounds of SNAP food to 149 SNAP eligible, participating member agencies (Emergency Food Assistance Organizations only) in our 16-county service area. SNAP funding was used to purchase the most needed products, ones not available through industry donations in WNC. Food product purchased include: tuna fish, green beans, rice, pinto beans, canned fruit and vegetables and peanut butter. Administrative funding for MANNA's SNAP program operations includes labor, warehousing, storage, refrigeration, order-picking/preparation and trucking to agencies.

(5) A detailed program budget and list of expenditures, including all positions funded and funding sources.

See separate attachment

(6) The source and amount of any matching funds.

No match was required in FY 2011/12

MANNA FOODBANK	
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)	
FY 11/12 Section 10.19 (b) reporting #5	
Description	**FY 11/12 Budget**
REVENUE	
Contributions Income	
INDIVIDUALS	465,989
CHURCHES	19,971
BUSINESS/CORPORATIONS	99,855
CIVIC ORGS/SCHOOLS/OTHER	16,642
GRANTS/ FOUNDATIONS	63,242
Contributions Income Total	**665,699**
SNAP FOOD PURCHASE INCOME	788,978
SNAP ADMINISTRATIVE REIMBURSEMENT INC.	173,190
CO-OP BUYING OVERHEAD	48,000
MISCELLANEOUS Income	8,500
TOTAL INCOME	**1,684,367**
EXPENSES	
SALARY & FRINGES	

MANNA FOOD BANK
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

Director of Operations	67,701
Warehouse Managers (1.5 FTE)	50,904
Warehouse Facilities & Safety Manager	60,469
Product Planning Coordinator (.5 FTE)	27,670
Warehouse Ordering Coordinator	37,345
Onsite Distribution Coordinator	42,896
Order Pickers (2 FTE)	64,096
Warehouse Asst (.25 FTE)	7,016
Truck Drivers (3 FTE)	123,367
Truck Driver/ Warehouse Asst (2 FTE)	78,905
Contract Labor	40,000
TOTAL SALARY & FRNGES	**600,369**
SNAP FOOD PURCHASES	**788,978**
PROFESSIONAL FEES - ANNUAL AUDIT	**13,500**
EQUIPMENT MAINTENANCE & REPAIR - WAREHOUSE	**14,800**
FOOD PACKAGING SUPPLIES	**18,000**
OCCUPANCY	
Insurance, Bldg & Flood	16,000
Electricity & gas	51,600
Water & Sewer	5,360
Food packing supplies	31,200
Propane	4,500
Waste Management	25,200
Pest Control	1,200
Franklin Warehouse utilities	1,525
Franklin Warehouse rent	4,275
TOTAL OCCUPANCY	**140,860**
TRANSPORTATION	
Vehicle Gas & Oil	60,000
Vehicle Repairs & Maintenance	15,600
Vehicle Insurance	19,660
Vehicle License & permits	5,500
Vehicle Tires	5,400
TOTAL TRANSPORTATION (TRUCK COSTS)	**106,160**
MISCELLANEOUS EXPENSE/WAREHOUSE	**1,700**
TOTAL EXPENSES	**1,684,367**

Second Harvest Food Bank of Metrolina
Reporting Requirements Fiscal Year 11/12 – Direct State Appropriations

Section 10.19.(b)

1) **Entity's Mission:** Second Harvest Food Bank of Metrolina strives through education, advocacy, and partnerships to eliminate hunger by the solicitation and distribution of food.
   Purpose: To receive donated food to the Food Bank through grocery stores, food manufacturers and distributors and community food drives. The food is then sorted, collected and stored throughout the food bank network of branches in Charlotte, Mt. Gilead, Dallas, and Hickory in NC and Spartanburg in SC. It is then distributed to a network of 550 partner agencies including food pantries, soup kitchens, shelters, day care centers and elderly care programs. This allows the Food Bank to assist in meeting basic needs of the children and families who are food insecure.
   Governance Structure: Second Harvest Food Bank of Metrolina (SHFBM) is an incorporated organization through the State of NC with Articles of Incorporation and by-laws. SHFBM has an active board of directors comprised of civil, community, and food industry leaders who assist the Executive Director. SHFBM is a 501(c) 3 tax-exempt organization and was granted tax exemption in March, 1984.
2) **Description of types of program, services and activities funded by the State appropriations:** The goal of the utilization of the State appropriate funding is to provide approximately 500,000 meals of nutritious food, purchased through North Carolina suppliers, to Food Bank partner agencies in the food bank's 14-county service area. This food will reach low-income families and individuals in the service area that come to partner agencies needing emergency food supplies.
3) **Statistical and demographical information on the number of persons served by these programs, services and activities, including the counties in which services are provided.** SHFBM serves 14 counties in NC. Listed below are the counties and their poverty population and the percentage of seniors and children living in poverty in the counties. The food purchased with SNAP funds goes to these counties to assist the food needs of the persons living in poverty.

County	Poverty Population	Percent of Population	Poverty Population over 65	Percent of Population	Poverty Population under 18	Percent of Population
Anson	5,519	22.6	634	16.5	1,894	32.3
Burke	16,377	18.7	1,846	13.5	5,167	26.6
Cabarrus	22,091	17.5	1,727	8.6	7,977	16.6
Catawba	21,950	14.5	2,134	9.8	8,405	23.3
Cleveland	20,024	20.9	2,055	14.0	7,287	32.3
Gaston	40,336	19.9	3,030	11.1	13,339	27.7
Iredell	20,998	13.3	2,453	12.0	7,139	17.9
Lincoln	11,620	15.0	976	9.7	4,165	22.9
Mecklenburg	141,435	15.6	6,489	8.0	49,261	21.3
Montgomery	6,569	24.6	816	18.7	2,261	34.3
Rowan	26,949	20.1	2,179	10.9	9,352	29.0
Rutherford	16,613	25.0	1,501	12.8	4,986	33.5
Stanly	9,038	15.4	1,093	11.5	3,025	22.4
Union	18,432	9.2	2,044	10.5	7,925	13.1

4) **Outcome measures that demonstrate the impact and effectiveness of the programs, services and activities.** SHFBM purchased 1,297,509 lbs of food from State appropriations monies in 11/12 fiscal year, this equates to estimated meals provided of 1 million. The State appropriation % of total pounds distributed by the SHFBM is 3% of the total lbs distributed for 11/12 fiscal year.
5) **Detailed Program Budget and list of expenditures, including positions funded and funding sources:**
   a) Program Budget included the following:

a. Food Purchases	$892,167
b. Supplies and Operating Costs	$ 70,000
Totals	$962,167

   b) No positions were funded by funds.
   c) Funding sources include: financial donations, food donations, agency contributions, NC Department of Agriculture, SC Department of Social Services and NC Department of Health and Human Services'
6) **The source and amount of any matching funds received by the entity:**
   a) The amount of matching funds equal to 10% of the State appropriates is: $96,217. The amount is matched by sources of revenue such as individual contributions, direct mail, food donations, on-line giving.

Second Harvest Food Bank of Northwest NC is a 501(c)(3) nonprofit organization, incorporated in 1981 in the State of North Carolina. Our organization is one of the over 200 Feeding America food banks across the nation.

The mission of Second Harvest Food Bank of Northwest NC is to reduce hunger and malnutrition in eighteen counties across northwest North Carolina. We are committed to acquiring and distributing food to supplement the food needs of faith and community-based organizations, advocating for the rights of hungry people, educating the public about hunger and pursuing partnerships with like-minded organizations.

To achieve our vision of *sharing the abundance so no one goes hungry*, we believe everyone has the right to the food they need to lead healthy, active lives. Hunger in our community is a solvable problem. The power of community, collaboration and shared resources can create hunger-free communities.

The Board of Directors of Second Harvest Food Bank of Northwest NC is the group legally, financially, and morally responsible for the total operation and conduct of the organization. The major function of the Board of Directors is to make sure that the organization is carrying out its mission in a manner that is ethical, effective, and fiscally accountable. The Board of Directors are the trustees of the organization and are answerable to the organization's financial contributors, the recipients of its services, and any funding source that monitors its operation. The Board of Directors consists of outstanding business, civic and religious leaders from throughout our service area.

The Second Harvest Food Bank Board of Directors consists of:

- up to forty (40) members
- four (4) officers:
  Chairman, Vice-Chairman, Treasurer, Secretary
- nine (9) standing committees plus the State Delegate to the North Carolina State Association of Feeding America Food Banks

The Board of Directors is responsible for hiring a fulltime, paid Executive Director that manages the day-to-day operations of the organization.

The organization's tax return, Form 990 and Annual Report, are posted on our website at www.hungernwnc.org. Our organization is rated as a 4-star charity by Charity Navigator.

Second Harvest Food Bank of Northwest NC is regularly monitored by USDA, FDA, NCDA, Forsyth County Health Department and Feeding America for food safety compliance.

Partner agencies of our organization are monitored by us on a regular basis for food safety, non-discriminatory practices, equality of food distribution and reporting requirements.

State Nutrition Assistance Program (SNAP) – The funding provided through the State of NC for the SNAP program allows Second Harvest Food Bank of Northwest NC to purchase and distribute food through our partner agency network to poor and needy individuals at risk of hunger in our eighteen-county service area. SNAP food products serve the homeless, unemployed, underemployed, senior citizens, children and other individuals in need of food assistance. In our 18-county service area an estimated 300,000 people live in poverty and are at risk of hunger. Over three-quarters (76%) of people served by our partner agencies are food insecure, meaning they do not always know where they will find their next meal.

By acting as a central source for food donations and distributions, Second Harvest Food Bank of Northwest NC provides a reliable, convenient and efficient source of food. For ten out of the twelve months of fiscal year 2011-2012, nutritious food was purchased for distribution through 273 partner agencies that administer direct food assistance to poor and needy clients. We seek to leverage our buying power for food products to obtain the best value with the SNAP funding. The food products purchased with SNAP funding included high quality, staple, nutritious items such as canned meats, fruits and vegetables, rice, pasta and dry beans.

Local partner agencies may pick up SNAP product at our warehouse, located at 3655 Reed Street in Winston-Salem. Partner agencies in our outlying counties are offered rural delivery service, which brings SNAP product to their communities. Eligible partner agencies will distribute the SNAP food to their clients during their normal hours and days of operations. We have developed a formula to ensure SNAP product is distributed in a fair manner based on the number of individuals served. Frequent monitoring of SNAP-eligible partner agencies ensures the proper distribution of SNAP food to those at risk of hunger. Administrative costs associated with ordering, receiving, storing, distributing and transporting of SNAP food are reimbursed as a portion of the SNAP funding allocated.

Our service area focuses on the 18 counties of northwest North Carolina of Alamance, Alexander, Alleghany, Ashe, Caldwell, Caswell, Davidson, Davie, Forsyth, Guilford, Iredell, Randolph, Rockingham, Stokes, Surry, Watauga, Wilkes and Yadkin. In our 18-county service area, an estimated 300,000 people live in poverty and are at risk of hunger. Over 256,000 people each year receive emergency food assistance from Second Harvest Food Bank of Northwest NC, through our network of food pantries, soup kitchens and shelter partner agencies.

These people represent the area's most vulnerable citizens. From the 2010 Hunger in America Study, conducted by Feeding America, among those served by Second Harvest Food Bank of Northwest NC, 32% are children under age 18 and nearly 10% are senior citizens. 64% of the adults served are women and 31% of all households served had at least one adult working. These citizens are 41% white, 43% African American and 10% Hispanic. Citizens seeking emergency food assistance are forced to make choices between food and other necessities including heating, rent, transportation and medical care.

With the SNAP funding received in fiscal year 2011-2012, 155,576 individuals were served. By applying the above-mentioned demographics, it can be estimated that of the total number of individuals served 49,784 are children under age 18 and nearly 15,558 are senior citizens. 99,569 of the adults served are women. Of the individuals served, 63,786 are white, 66,898 are African American and 15,558 are Hispanic.

With the SNAP funding of $962,166 for fiscal year 2011-2012, Second Harvest Food Bank of Northwest NC purchased and distributed 1,741,775 pounds to 273 eligible non-profit partner agencies serving individuals in crisis.

This food provided approximately 1,451,400 meals to individuals at risk of hunger in our 18-county service area.

More than 37 million people, including 14 million children and nearly 3 million seniors receive emergency food assistance each year through Feeding America food banks, the nation's largest domestic hunger-relief organization. NC food banks provide food assistance for an estimated 1.5 million different people annually (15% of the State's population). Based on data from the Hunger in America 2010 Study for Northwest NC and our partner agency network, our particular organization is serving 300,000 people annually. Food insecurity is caused by low education levels, our struggling economy and unemployment/underemployment created by loss of jobs. These factors leave individuals and families with uncertain availability to nutritious and safe food. Nutrition is critical to the growth and development of a healthy individual. Inadequate nutrition has adverse effects on physical health, behavior and mental health, child development, school readiness and achievement and economic productivity. Participation in SNAP allows Second Harvest Food Bank of Northwest NC to distribute staple, nutritious food to our eligible partner agencies that provide an improved balance of nutrition to needy individuals and expand the capacity of our partner agencies to meet the demand for food assistance.

Savings to our SNAP eligible partner agencies were approximately $2.9 million. These savings allowed our partner agencies increased capacity to expand their food assistance programs to a larger population of individuals.

With the SNAP funding of $962,166 for fiscal year 2011-2012, Second Harvest Food Bank of Northwest NC purchased and distributed 1,741,775 pounds to 273 eligible non-profit partner agencies serving individuals in crisis. This food reduced food insecurity by providing approximately 1,451,400 meals to 155,576 individuals at risk of hunger in our 18-county service area.

100% of the product purchased with SNAP funding was high quality, nutritious food obtained at the best value.

SNAP PROGRAM BUDGET

Salaries and Benefits*	$108,245
Operating Costs	
Facility Expenses	16,535
Transportation Expenses	19,153
Agency Relations Expenses	392
Food Purchases	817,841
Total Budget	$962,166

*No staff positions were funded with SNAP dollars. The above amount represents an allocation of an appropriate portion (based on the percentage of SNAP food versus all food distributed) of salaries and employee benefits for staff positions directly involved in the SNAP program including:

Truck Drivers
Receiving Staff
Distribution Staff
Inventory Control Staff
Facility Staff
Food Purchasing Staff
Finance Staff

Second Harvest Food Bank of Northwest NC
Revenue Sources
Fiscal Year 2011-2012

	Year to Date
Interest Income-Operating	785.23
United Way of Forsyth County	169,964.00
Trusts & Foundations	185,108.68
NC Gen Fd Grant- SNAP Indirect	817,841.00
SNAP Direct	144,325.00
Churches/Religious Organizs	104,191.56
Businesses & Corporations	300,384.56
Direct Mail	576,308.34
Outside Fundraising Events	207,595.00
Civic Clubs	22,168.85
Agency Conference Income	165.25
TCK Cookbook Revenue	9,055.00
Major Gifts Donors	601,430.50
Estate Gifts	417,515.43
Food Purchase Program Income	593,361.95
Unsolicited	108,260.25
Miscellaneous Income	8,142.79
Handling Fees-Reg	663,657.29
Handling Fees-TEFAP	151,046.23
Rural Distribution	128,550.30
Total Revenues	5,209,857.21

Cumberland Community Action Program Inc.
Second Harvest Food Bank of Southeast North Carolina
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

(1) The entity's mission, purpose, and governance structure.

Mission:

To feed the hungry in Southeast North Carolina by soliciting and judiciously distributing healthy food and grocery products through a network of non-profit partners and to be an advocate that educates the community on the problems of and solutions to domestic hunger.

Purpose:

The Second Harvest Food Bank of Southeast North Carolina collects usable grocery items, largely donated, from suppliers and distributes them to approximately 240 member agencies in 7 counties in Southeast North Carolina. These partner agencies provide direct food assistance to more than 107,000 unique clients each year. In addition to general food distribution, the Food Bank engages in the "Hunger Relief for Kids" Backpack program, a program with 37 school locations in 7 counties with over 1,500 children being served each Friday during the school year. The Food Bank operates a Mobile Food Pantry Program as a direct service to those at risk of hunger in food desserts with transportation barriers to nutritious food. The Food Bank conducts over 70 distribution events throughout our service area during the year.

Governance Structure:

The Second Harvest Food Bank of Southeast North Carolina (SHFB SENC) is a division of Cumberland Community Action Program Inc. (CCAP). CCAP is a private, non-profit corporation duly incorporate under the laws of the State of North Carolina for the express purpose of "improving the education and economic opportunities, living environment and general welfare of the people". It is a recognized as a 501 (c) (3) charitable organization by the Internal Revenue Service.

The Board of Directors of CCAP served through 3 areas.

1. **Public** — Selected to served on board by a public official with a designated term assigned by said official for their term of office
2. **Private** — Serves on the board of directors for a period of 5 years unless reappointed by the organization
3. **Elected** — Elected by citizens in designated areas for a period of 5 years and then must seek reelection to the board of directors by the communities they serve

The CCAP Board of Director officers' positions are:

1. Chairman
2. Vice Chairman
3. Secretary
4. Treasurer
5. Parliamentarian
6. Chaplain

Cumberland Community Action Program Inc.
Second Harvest Food Bank of Southeast North Carolina
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

Governing Board committees include:

1. Executive
2. Finance
3. Board Development
4. Nominating
5. Audit

(2) A description of the types of programs, services, and activities funded by State appropriations.

The Second Harvest Food Bank of Southeast North Carolina utilizes SNAP funds to purchase, transport, store, and distribute food products from the Food Bank at no cost to member non-profit agencies. The products will be nutritious, wholesome food to include protein that might otherwise not be available from the Food Bank. This includes products such as canned beef stew, canned fruits, canned vegetables, frozen ground beef, frozen ground turkey, canned chicken, salmon, peanut butter, pasta, spaghetti sauce, and other desirable foods. Approximately 240 receiving agencies that operate emergency food box programs are provided SNAP purchased products free. In turn agencies will provide these products free to individual recipients in our 7-county service area. Hungry receipts in both rural and urban areas will receive benefit from this distribution.

(3) Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.

Demographic Data Item	Source	Response
Estimated number of individuals in our service area seeking food assistance at a pantry, shelter, or kitchen, within a year.	**Feeding America's Hunger In America 2010 Report – the most current comprehensive data we have on persons seeking food assistance from our network of emergency food organizations. Data collection for Hunger In America 2014 begins this spring.**	**107,000**
Estimated Demographic spread of individuals in our service area seeking food assistance at a pantry, shelter, or kitchen.		**Gender** Male: **45.6%** Female: **54.4%** **Age** <18: **34.9%** 18-64: **53.9 %** >64: **12.2%** **Ethnicity** White: **17.5%** Black: **67.6%** Hispanic: **3.5%** Native American: **10.7%** Asian/Pac. Islander: **1.2%**

Estimated Number of *MEALS* Served by SNAP Food in FY11/12

SNAP Pounds Purchased	Feeding America's lbs. to meal conversion metric	Estimated Meals provided by SNAP food purchased	SNAP % of Total Pounds Distributed by the SHFB SENC
796,698	**1 meal = 1.28 pounds**	**622,420**	**10%**

Cumberland Community Action Program Inc.
Second Harvest Food Bank of Southeast North Carolina
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

Second Harvest Food Bank of Southeast North Carolina's 7-County Service Area:

Bladen, Cumberland, Duplin, Harnett, Hoke, Robeson, & Sampson

(4) Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.

In FY 11-12, the Second Harvest Food Bank of Southeast North Carolina distributed 796,698 pounds or 622,420 meals of SNAP food to 204 SNAP eligible, participating member agencies in our 7-county service area. SNAP funding was used to purchase the most needed products, ones not available through industry donations in southeast North Carolina. Food product purchased include: tuna fish, green beans, rice, pinto beans, canned fruit and vegetables and peanut butter. Administrative funding for the Second Harvest Food Bank of Southeast North Carolina's SNAP program operations includes labor, warehousing, storage, refrigeration, order-picking/preparation and trucking to agencies.

(5) A detailed program budget and list of expenditures, including all positions funded and funding sources.

See separate attachment

(6) The source and amount of any matching funds.

No match was required in FY 2011/12

SECOND HARVEST FOOD BANK OF SENC	
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)	
FY 11/12 Section 10.19 (b) reporting #5	
Description	**FY 11/12 Budget**
REVENUE	
Contributions Income	
INDIVIDUALS	129,533
BUSINESS/CORPORATIONS	32,498
CIVIC ORGS/SCHOOLS/OTHER	1,020
GRANTS/ FOUNDATIONS	165,845
Contributions Income Total	**328,896**
SNAP FOOD PURCHASE INCOME	721,624
SNAP ADMINISTRATIVE REIMBURSEMENT INC.	240,542
SHARED MAINTENANCE FEE	349,148
MISCELLANEOUS Income	8,970
TOTAL INCOME	**1,649,180**
EXPENSES	

Cumberland Community Action Program Inc.
Second Harvest Food Bank of Southeast North Carolina
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

SALARY & FRINGES	
Director	51,683
Operations Manager	43,680
Warehouse Managers	34,382
Customer Relations Specialist	22,339
Agency Relations Manager	42,890
Food Souce Coordinator	33,300
Inventory Control Clerk	22,152
Administrative Assistant	28,974
Warehouse Asst	22,152
Truck Drivers (2.5 FTE)	72,862
SNAP Coordinator	33,300
Contract Labor	11,027
TOTAL SALARY & FRNGES	**418,741**
EMPLOYEE BENEFITS	**64,474**
PAYROLL TAXES	**38,129**
SNAP FOOD PURCHASES	**721,624**
PROFESSIONAL FEES	**80,018**
EQUIPMENT PURCHASE (federal grant)	**89,345**
EQUIPMENT MAINTENANCE & REPAIR - WAREHOUSE	**40,698**
OCCUPANCY	
Insurance, Bldg & Flood	3,821
Electricity & gas	30,151
Communications - telephones and internet	11,991
Food packing and warehouse supplies	27,210
Waste Management	6,163
Pest Control	847
Mortgage	44,670
TOTAL OCCUPANCY	**124,853**
TRANSPORTATION	
Vehicle Gas & Oil	17,877
Vehicle Repairs & Maintenance	8,452
Vehicle Lease	30,392
Vehicle Insurance	4,613
Vehicle License & permits	7,932
TOTAL TRANSPORTATION (TRUCK COSTS)	**69,266**
MISCELLANEOUS EXPENSE/WAREHOUSE	**2,032**
TOTAL EXPENSES	**1,649,180**

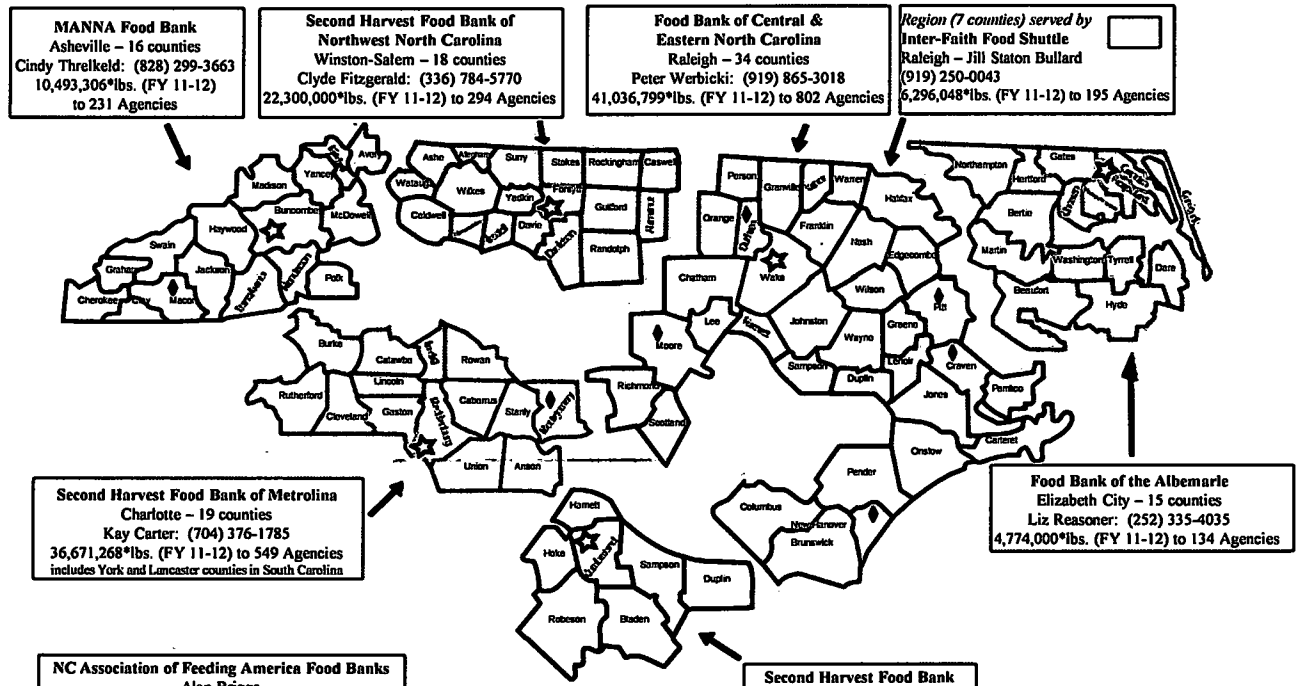
11/26/12

Cumberland Community Action Program Inc.
Second Harvest Food Bank of Southeast North Carolina
STATE NUTRITION ASSISTANCE PROGRAM (SNAP)
FY 11/12 Section 10.19(b) reporting

11/26/12

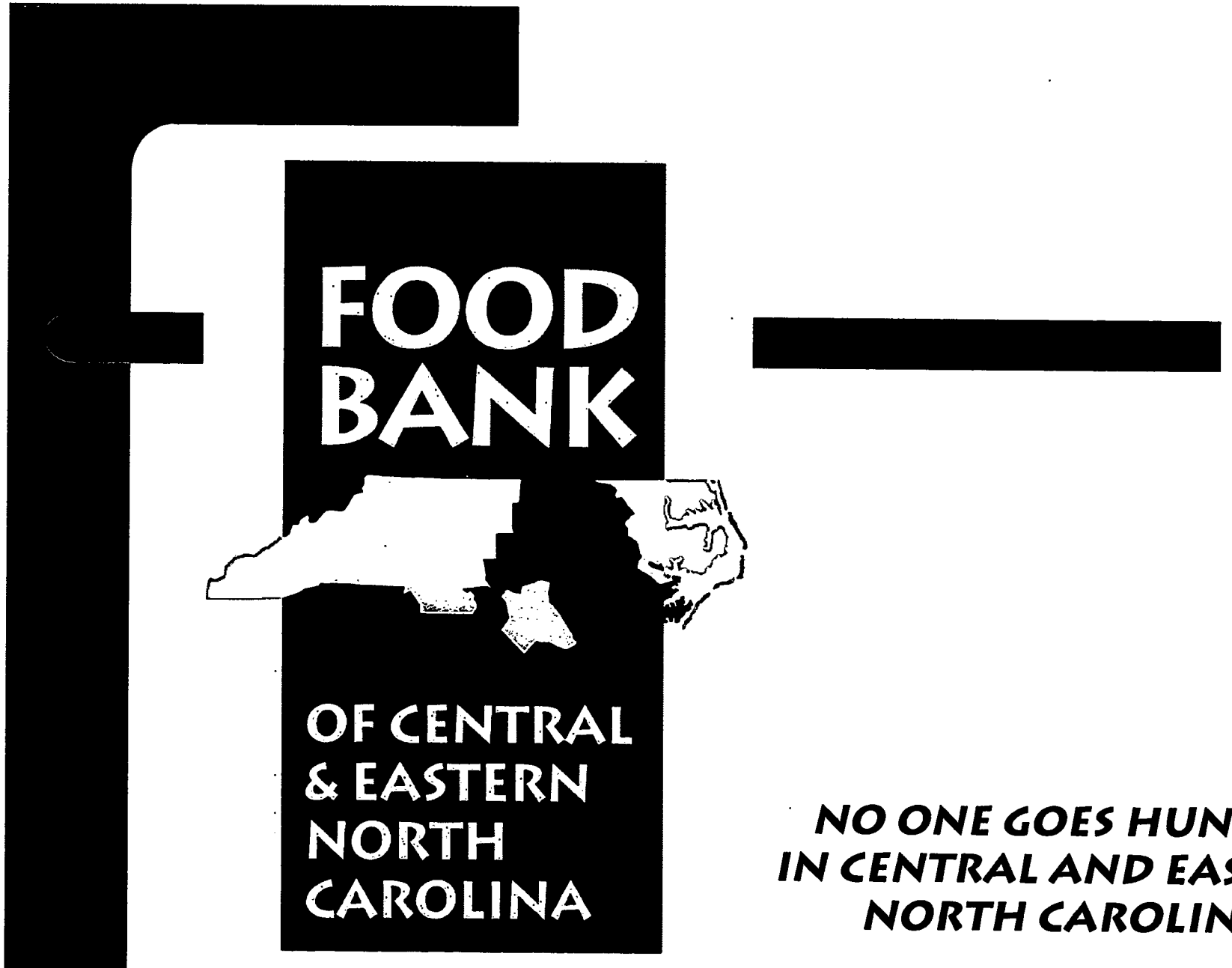
NC Association of Feeding America Members Map

NC Association of Feeding America Food Banks



updated 2/6/13

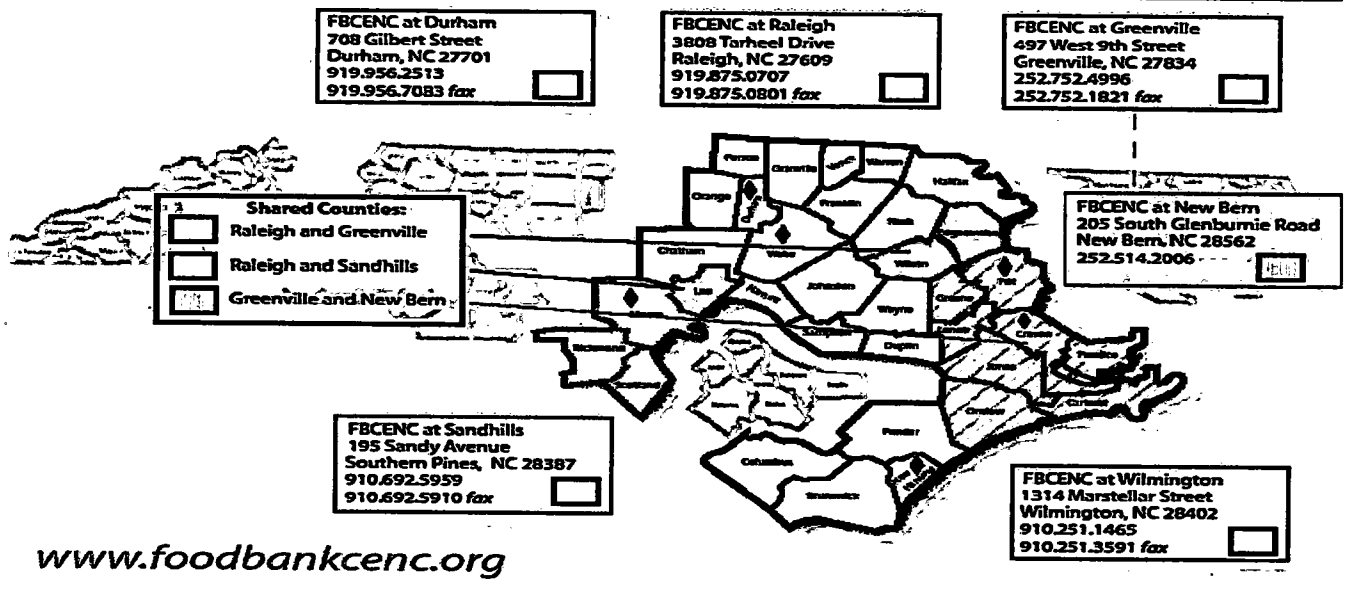
* Poundage figure indicates food distribution to agencies.



NO ONE GOES HUNGRY IN CENTRAL AND EASTERN NORTH CAROLINA

Food Bank CENC Service Area Map

FOOD BANK OF CENTRAL & EASTERN NORTH CAROLINA
BRANCH LOCATIONS - SERVING 34 COUNTIES



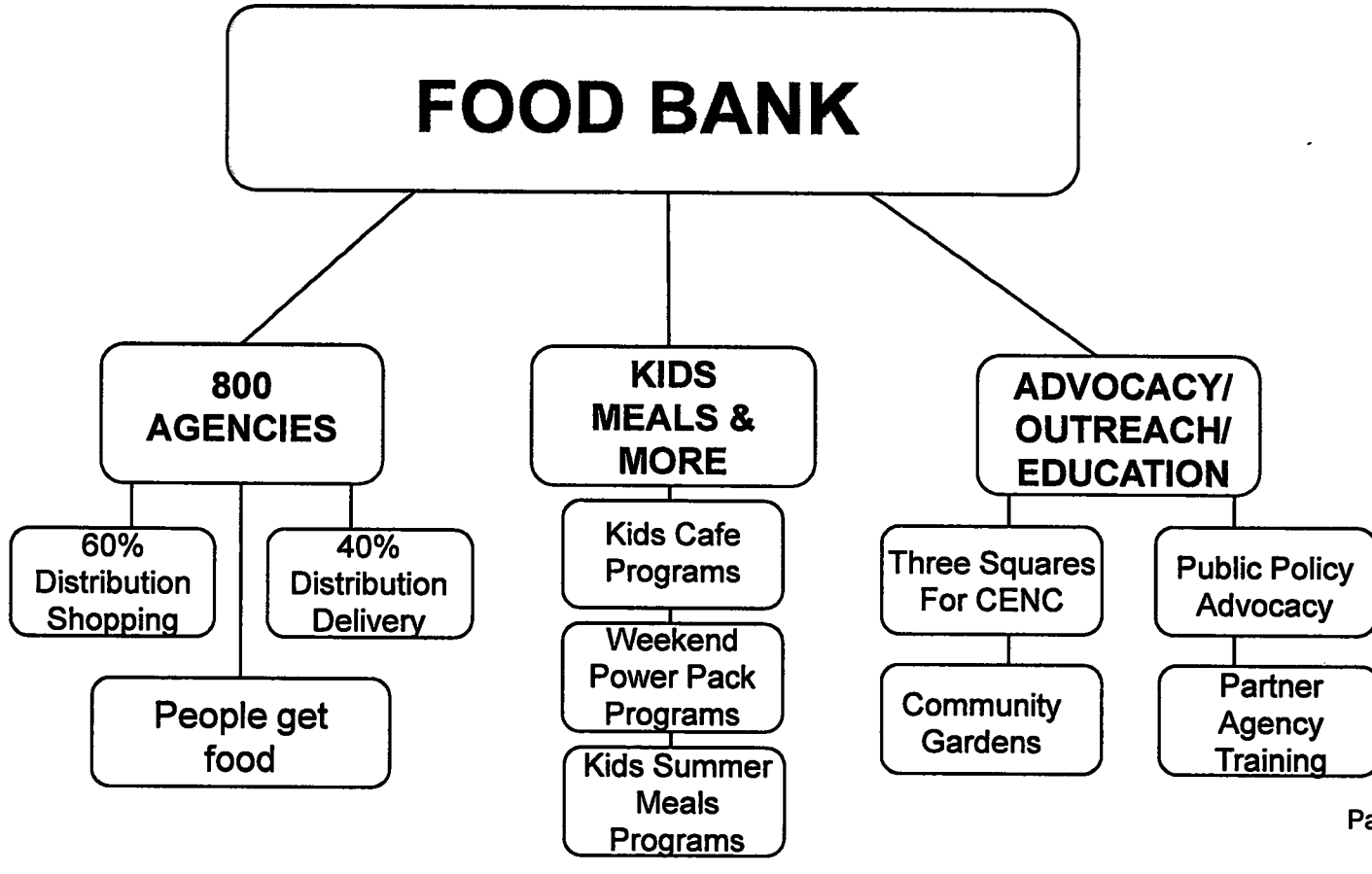
www.foodbankcenc.org

FBCENC 34 COUNTIES SERVED	Economic tier 1(a)	% Poverty Population(b)	# living below poverty level(b)	18-64 below poverty level(b)	(+)65 below poverty level(b)	0-18 children below poverty level(b)	Total Lbs Distributed FY11-12	State Appropriated Lbs Distributed FY11-12
BRUNSWICK		13%	14,494	9,019	1,267	4,208	1,359,389	30,191
CARTERET		12%	7,712	4,955	638	2,119	899,916	18,649
CHATHAM		11%	7,276	4,262	616	2,398	659,977	14,601
COLUMBUS	1	23%	13,339	7,173	1,090	5,076	931,028	14,613
CRAVEN		16%	17,111	8,822	1,713	6,576	1,121,775	29,395
DUPLIN		24%	13,991	7,014	1,814	5,163	704,782	6,489
DURHAM		15%	41,194	26,120	1,917	13,157	2,102,749	57,545
EDGECOMBE	1	22%	12,601	6,118	1,283	5,200	1,274,835	20,696
FRANKLIN		14%	8,342	4,741	854	2,747	1,100,460	21,612
GRANVILLE		12%	7,137	4,506	636	1,995	534,291	12,066
GREENE	1	15%	3,260	1,081	453	1,726	299,107	4,324
HALIFAX	1	23%	12,825	7,162	1,550	4,113	940,002	4,816
HARNETT		15%	16,832	8,695	1,818	6,319	1,118,759	19,315
JOHNSTON		16%	26,866	14,347	1,743	10,776	1,440,867	41,072
JONES	1	18%	1,850	1,043	162	682	164,938	2,011
LEE		14%	8,178	4,278	810	3,090	742,378	13,521
LENOIR	1	20%	11,890	6,289	1,249	4,352	854,540	12,538
MOORE		13%	11,632	6,381	1,124	4,127	1,207,712	25,762
NASH		14%	13,831	7,363	1,728	4,740	778,739	13,309
NEW HANOVER		16%	31,842	21,810	1,987	8,045	1,915,305	42,171
ONSLOW		12%	21,382	12,321	1,292	7,769	1,216,770	12,113
ORANGE		16%	21,666	15,683	825	5,158	632,075	18,522
PAMLICO		14%	1,882	922	277	683	361,270	3,823
PENDER		18%	9,434	5,076	1,087	3,271	975,607	5,361
PERSON		14%	5,593	2,937	660	1,996	449,685	6,660
PITT		23%	38,720	26,119	2,167	10,434	2,433,388	43,121
RICHMOND	1	27%	12,593	7,270	1,235	4,088	1,999,967	14,165
SAMPSON		21%	13,272	7,092	1,224	4,956	554,655	5,600
SCOTLAND	1	29%	10,567	6,014	683	3,870	1,047,905	15,442
VANCE	1	30%	13,620	6,400	1,176	6,044	1,252,042	17,034
WAKE		10%	90,969	56,059	5,136	29,774	6,417,632	152,906
WARREN	1	24%	5,143	3,178	543	1,422	446,307	2,766
WAYNE		19%	23,683	13,047	1,824	8,812	1,228,916	10,043
WILSON	1	21%	17,479	9,596	1,462	6,421	1,303,087	15,516
AVG/TOTALS	**11**	**15%**	**568,206**	**332,893**	**44,043**	**191,307**	40,470,855	727,768

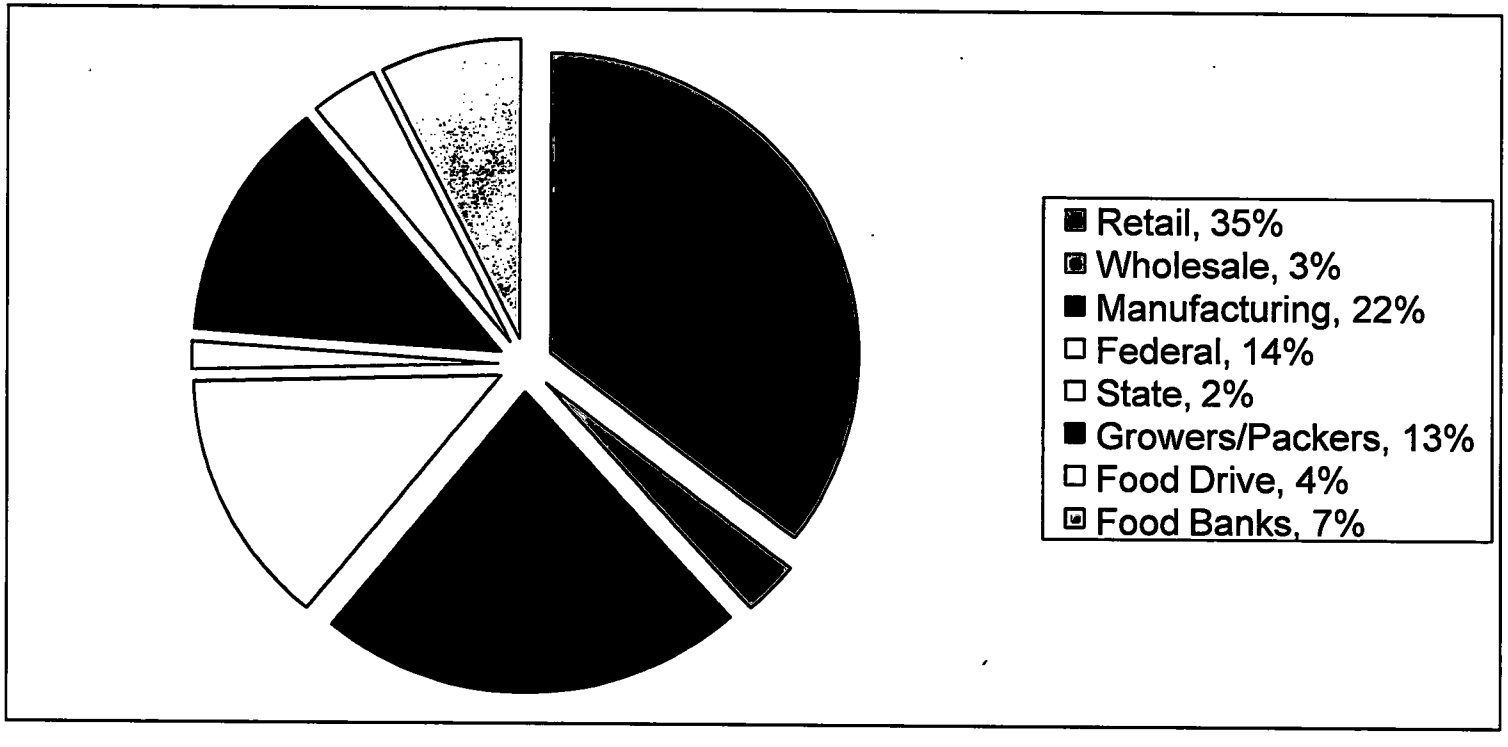
a) NC commerce

b) 2008-2010, American Community Survey

The Big Picture – How Food Goes Out

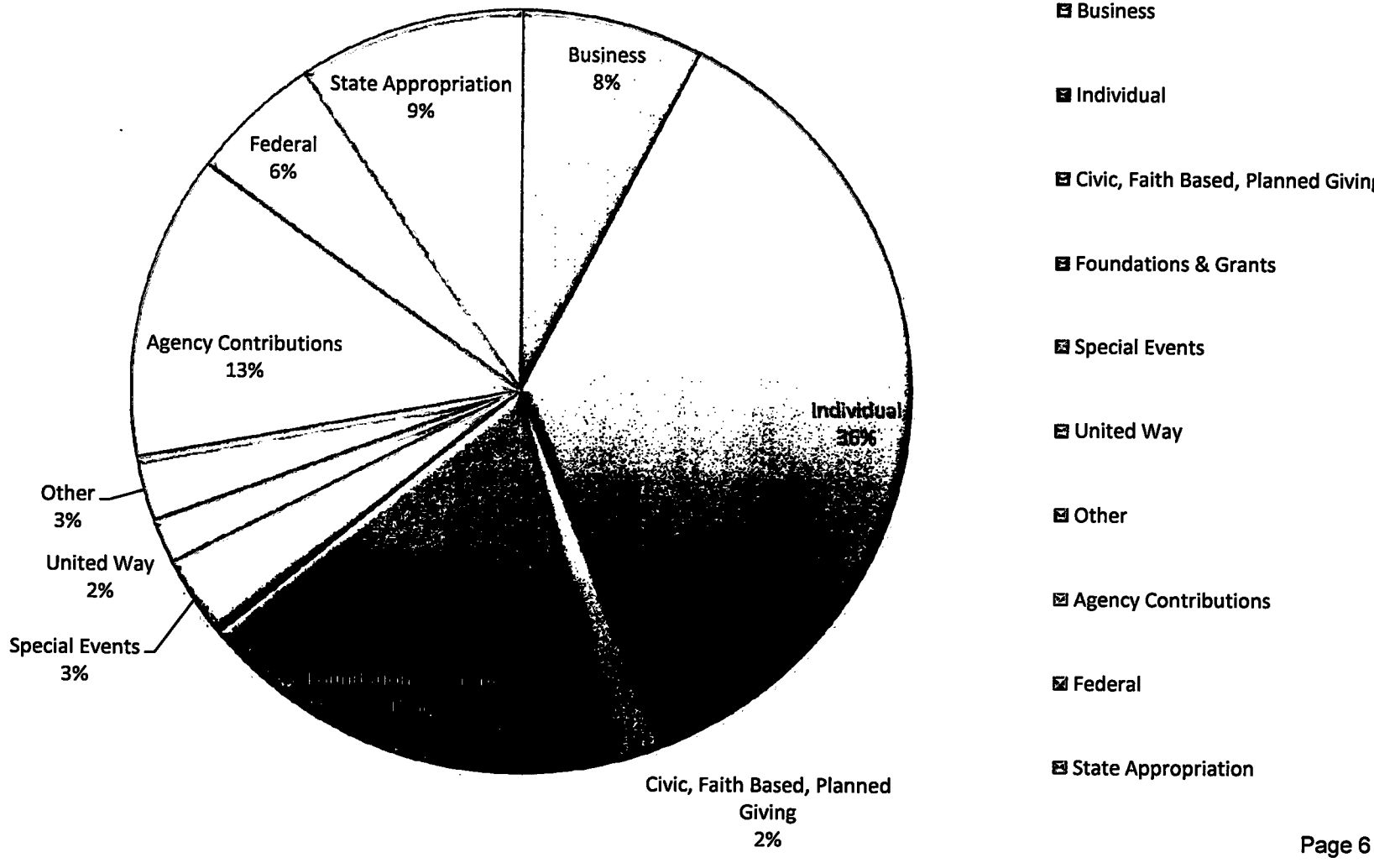


Pounds Received by Donor Type FY11-12



Food Bank of Central & Eastern NC

FY 11-12 Total Revenue Percent Categories



FOOD BANK OF CENTRAL & EASTERN NC - AGENCY DISTRIBUTION BY COUNTY, FY 11-12

Name	County	Gross Weight
Southport Oak Island	BRUNSWICK	440,393
Love of Christ Ministries	BRUNSWICK	209,500
Brunswick Island Baptist	BRUNSWICK	128,928
Victory Independent	BRUNSWICK	102,113
Pleasant Grove	BRUNSWICK	97,278
Towncreek Vision Corporation	BRUNSWICK	92,503
Dixon Chapel	BRUNSWICK	57,861
Brunswick Family Assistance	BRUNSWICK	49,278
South Brunswick Inter-Church	BRUNSWICK	47,202
St. Brendans Catholic Church	BRUNSWICK	31,055
Sonrise Independent Baptist	BRUNSWICK	18,361
Trinity Missionary Baptist	BRUNSWICK	17,537
Faith Building Missions	BRUNSWICK	10,458
Salvation and Deliverance	BRUNSWICK	8,975
Countywide C.D.C.	BRUNSWICK	8,446
Word of Life Outreach	BRUNSWICK	8,437
Inspirational House of Praise	BRUNSWICK	7,600
WPP - Supply Elementary School	BRUNSWICK	5,631
Trinity Tabernacle Full	BRUNSWICK	5,061
KC - Community Boys & Girls	BRUNSWICK	3,848
KC - Pleasant Grove	BRUNSWICK	1,715
SFSP - Word of Life Outreach	BRUNSWICK	1,633
SFSP - Pleasant Grove	BRUNSWICK	1,622
SFSP - Community Boys & Girls	BRUNSWICK	1,265
GRACEFALLS	BRUNSWICK	985
Matthew's Ministry	BRUNSWICK	847
Straightway Ministries	BRUNSWICK	492
SFSP -Strong In Grace Ministry	BRUNSWICK	365
	BRUNSWICK Total	1,359,389
Woodville Baptist Church	CARTERET	201,859
Calvary Baptist Church	CARTERET	192,424
Salvation Army Carteret Co	CARTERET	134,855
Faith Tabernacle of Praise	CARTERET	123,942
Wildwood Presbyterian Church	CARTERET	76,985
East Coast Church, Inc.	CARTERET	71,677
St. James Methodist Church	CARTERET	45,385
Martha's Mission Cupboard	CARTERET	19,709
God's City of Refuge, Inc.	CARTERET	12,827
KC - Boys & Girls Clubs of	CARTERET	12,217
SFSP - Boys & Girls Club	CARTERET	5,925
Family Promise of Carteret	CARTERET	1,261
Glad Tidings Church	CARTERET	850
	CARTERET Total	899,916
St. Julia Catholic Church	CHATHAM	109,402
Chatham Out-Reach Alliance	CHATHAM	104,275
Alston Chapel United Holy	CHATHAM	97,785
Pentecostal Victory Temple	CHATHAM	88,677
God's Helping Hand -	CHATHAM	58,890
Destiny Church of God	CHATHAM	49,826
Evergreen United Methodist	CHATHAM	40,281
Haw River Baptist Church	CHATHAM	35,163
Chatham County Group Homes 3	CHATHAM	10,984
Chatham County Group Homes	CHATHAM	9,332
Chatham County Group Homes	CHATHAM	9,275
Chatham County Group Homes	CHATHAM	9,216
Chatham County Group Homes	CHATHAM	8,784
Chatham County Group Homes 1	CHATHAM	8,609
Chatham County Group Homes 2	CHATHAM	8,213
Chatham County Group Homes	CHATHAM	5,036
Emmanuel Fellowship Church of	CHATHAM	4,695
SFSP -Chatham County Parks/Rec	CHATHAM	1,171
SFSP - Liberty Chapel Church	CHATHAM	363
	CHATHAM Total	659,977
Harvest Table	COLUMBUS	637,702
Believers Home Fellowship	COLUMBUS	169,748
Living Word Church	COLUMBUS	40,795
KC - Farmers Union CDC	COLUMBUS	17,905
Jesus Tabernacle	COLUMBUS	13,294
New Creations Ministries	COLUMBUS	11,921
WPP - Men and Women United	COLUMBUS	10,620
Dreams R Us, Inc.	COLUMBUS	6,675
Farmers Union Developmental	COLUMBUS	6,500
First Baptist Church of Lake	COLUMBUS	5,643
Southeastern Church of God	COLUMBUS	4,337
Shiloh Outreach Inc.	COLUMBUS	3,567
Bogue Community Citizens	COLUMBUS	1,239
SFSP - New Creations Ministry	COLUMBUS	936
Help Mission/Whiteville	COLUMBUS	146
	COLUMBUS Total	931,028
Religious Community Services	CRAVEN	313,876
Area Day Reporting Program for	CRAVEN	227,080
Living Bread Holiness Church	CRAVEN	186,964
Abundant Life Miracle Center	CRAVEN	129,949
Good News Outreach Church	CRAVEN	46,877
Word of God Christian Center	CRAVEN	46,305
Vanceboro Christian Help Cente	CRAVEN	32,720
Extended Hands	CRAVEN	31,255
Ephesus SDA Church	CRAVEN	22,775
Cornerstone Assembly	CRAVEN	18,438
Salvation Army-New Bern	CRAVEN	15,931
Youth Vision	CRAVEN	11,944
Havelock Cherry Point	CRAVEN	9,270
KC - After School Arts Program	CRAVEN	6,897
Coastal Women's Shelter	CRAVEN	5,974
Child #1 Group Home	CRAVEN	5,279
Vanceboro Group Home	CRAVEN	3,499
Spencer's Place Group Home	CRAVEN	3,425
Hoke Street Group Home	CRAVEN	1,524
RHA Howell Care Centers, Inc.	CRAVEN	994
SFSP - Continental Societies I	CRAVEN	698
STAFF House, Inc	CRAVEN	101
	CRAVEN Total	1,121,775
Word of Faith Ministries Food	DUPLIN	416,653
New Elders Chapel	DUPLIN	95,711
Full Gospel Deliverance Church	DUPLIN	78,318
Potter's Wheel Ministries	DUPLIN	65,568
Wallace Church of God	DUPLIN	32,583
East Duplin Christian Outreach	DUPLIN	15,000
SFSP - Outlaws Bridge Universa	DUPLIN	949
	DUPLIN Total	704,782
The River	DURHAM	174,004
CAARE, Inc.	DURHAM	159,590
Feed My Sheep of Durham Food	DURHAM	131,401
Immanuel Temple SDA Community	DURHAM	126,674
Fisher Memorial	DURHAM	125,302
TROSA	DURHAM	116,837
Durham Rescue Mission	DURHAM	96,691
Urban Ministries of Durham	DURHAM	89,992
Ministerios Guerreros de	DURHAM	87,761
Christian Assembly Emergency	DURHAM	76,056
Iglesia Presbiteriana Emanuel/	DURHAM	72,539
Calvary UMC	DURHAM	61,907
Alliance of AIDS Services-	DURHAM	60,078
Durham Spanish SDA Church	DURHAM	53,107
Southside Church of Christ	DURHAM	40,827
Durham Rescue Mission's	DURHAM	39,453
Immanuel Temple SDA Church -	DURHAM	37,283
Freedom House Durham	DURHAM	34,049
Just a Clean House	DURHAM	33,624
Seed Time & Harvest Fellowship	DURHAM	33,171
Church of God of Prophecy-	DURHAM	31,285
KC - The Ram Organization	DURHAM	30,251
Russell Memorial	DURHAM	26,313
Recovery Center of Durham	DURHAM	23,754
Feed My Sheep of Durham	DURHAM	19,017
Bethlehem Temple Apostolic-	DURHAM	17,760
Oak Grove UAFree Will Baptist	DURHAM	16,433
St. John's House of Refuge	DURHAM	15,268
New Opportunities 2nd Chance	DURHAM	13,316
Michael's Place	DURHAM	13,094
Agape Corner, Inc	DURHAM	11,426
Jonathans Outreach Network	DURHAM	11,424
Greater Emmanuel Temple	DURHAM	10,972
St. James of Durham	DURHAM	10,796

Victorious Community	DURHAM	10,703
Calvary Baptist Church/	DURHAM	10,356
Salvation Boys and Girls Club	DURHAM	10,250
West Durham Baptist Church	DURHAM	10,089
Ark of Safety Outreach --	DURHAM	9,284
RAM Organization	DURHAM	8,813
Housing for New Hope	DURHAM	8,436
WPP - Walnut Grove United	DURHAM	8,122
FTHOP	DURHAM	8,086
Durham Exchange Club	DURHAM	7,428
Henderson Towers Resident	DURHAM	5,974
Salvation Army-Durham	DURHAM	5,586
Youth Life Learning Center	DURHAM	5,579
Fitts-Powell Apts.	DURHAM	5,394
WPP - Eastway Elemen School	DURHAM	5,172
First Pentecostal Church	DURHAM	5,007
Mt. Sylvan United Methodist	DURHAM	4,849
WPP - Burton Geo-World Magnet	DURHAM	4,819
Reality Ministries	DURHAM	4,809
Nehemiah Christian Center	DURHAM	4,703
Achievement Academy of Durham	DURHAM	4,558
Mt. Zion Christian Church	DURHAM	4,362
First Calvary Baptist Church	DURHAM	4,332
Lutheran Family Services	DURHAM	3,608
Autism Services-Great Bend Dr.	DURHAM	3,562
Meals on Wheels of Durham, Inc	DURHAM	3,368
Step and Ladders	DURHAM	3,283
Autism Services/Kenwood Dr	DURHAM	3,112
Durham Crisis Response Center	DURHAM	2,628
Ar-Razzaq Islamic Center	DURHAM	2,422
Zion Temple UCC of Durham	DURHAM	2,339
Housing for New Hope/	DURHAM	2,217
Just For Us	DURHAM	1,861
SFSP - Feed My Sheep	DURHAM	1,846
Walltown Children's Theatre	DURHAM	1,841
SFSP - Walltown Childrens	DURHAM	1,702
Bethlehem United Holy Church	DURHAM	1,465
House of Refuge	DURHAM	1,397
Housing for New Hope	DURHAM	1,325
Partners For Youth	DURHAM	921
SFSP - Lakemoor	DURHAM	911
Divine Grace Fellowship	DURHAM	697
Faith Gospel Tabernacle	DURHAM	611
John Avery Boys & Girls Club	DURHAM	502
Resources for Human	DURHAM	474
El Sanctuary	DURHAM	446
South Eastern Effort Developin	DURHAM	430
Veterans Helping Veterans	DURHAM	395
Threshold-Durham Advocates	DURHAM	385
SFSP - Pendleton Apts	DURHAM	369
Durham First Assembly of God	DURHAM	340
Building Family Visions	DURHAM	116
	DURHAM Total	2,102,749
Tarboro Community Outreach	EDGECOMBE	517,236
New Jerusalem Pentecostal	EDGECOMBE	182,705
Refuge One Way Church	EDGECOMBE	113,284
Regeneration Development	EDGECOMBE	95,030
Word of Life International	EDGECOMBE	92,721
Outreach Community Center Inc.	EDGECOMBE	52,799
St. James Missionary Baptist	EDGECOMBE	52,405
New Destiny Outreach	EDGECOMBE	35,913
Adult Day Health Activity Cntr	EDGECOMBE	30,660
Living Waters Ministries of	EDGECOMBE	19,722
Christ Way Holiness Church	EDGECOMBE	13,737
Conetoe Chapel Missionary	EDGECOMBE	13,135
Positive Generation In Christ	EDGECOMBE	11,284
KC - Community Enrichment	EDGECOMBE	11,022
Holy Mission Church of God	EDGECOMBE	6,471
Fellowship of Christ Church	EDGECOMBE	5,490
Open Door Ministry of Faith	EDGECOMBE	5,431
The Wright's Center, Inc.	EDGECOMBE	5,377
The Lighthouse Home, Inc.	EDGECOMBE	5,237
Gibraltar -Church on the Rock	EDGECOMBE	2,097
Willing Workers Miracle Ti	EDGECOMBE	1,474
SFSP - Rainbow Kids Club	EDGECOMBE	989
Church of God	EDGECOMBE	516
SFSP - Living Waters	EDGECOMBE	100
Rock Church of Tarboro	EDGECOMBE	0
	EDGECOMBE Total	1,274,835
Faith Baptist Church/	FRANKLIN	199,618
Care and Share, Inc.	FRANKLIN	186,800
God's Vision Ministries	FRANKLIN	181,574
Saint's Delight United Church	FRANKLIN	125,818
Kingdom Health Care Inc.	FRANKLIN	124,270
Franklin County Volunteers In	FRANKLIN	97,183
Hands of Hope Ministry -	FRANKLIN	64,988
Glory Cloud & Fire Ministries	FRANKLIN	36,751
Union View Baptist Church	FRANKLIN	33,014
WPP - Care & Share of Franklin	FRANKLIN	24,927
New Liberty Outreach Services	FRANKLIN	14,621
Louisburg Group Home	FRANKLIN	6,483
Franklin County Group Home	FRANKLIN	4,413
	FRANKLIN Total	1,100,460
Area Congregations In Ministry	GRANVILLE	263,383
Upon This Rock Ministry	GRANVILLE	108,004
First Baptist Church-Creedmoor	GRANVILLE	65,087
Pine Grove Baptist Church	GRANVILLE	46,769
Christian Faith Center	GRANVILLE	22,562
Masonic Home for Children	GRANVILLE	11,810
Belton Creek Baptist Church	GRANVILLE	11,042
Oxford Group Home	GRANVILLE	5,634
	GRANVILLE Total	534,291
Greene County Interfaith	GREENE	160,249
Ministries of the Bread of	GREENE	84,879
Victory & Dominion World	GREENE	26,890
KC - Victory & Dominion World	GREENE	15,171
SFSP - Victory & Dominion	GREENE	6,061
Snow Hill Group Home/	GREENE	5,857
	GREENE Total	299,107
Union Mission	HALIFAX	505,045
Hobgood Citizens Group	HALIFAX	151,290
Mt. Carmel Church of God	HALIFAX	63,236
Shiloh Missionary Baptist Ch	HALIFAX	51,733
White Rock Baptist Church	HALIFAX	44,893
Hollister Reach	HALIFAX	30,822
London Missionary Baptist	HALIFAX	19,264
The Way of the Cross Outreach	HALIFAX	17,346
Concerned Citizens Of Tillery	HALIFAX	16,533
KC - Scotland Neck	HALIFAX	14,493
My Father's House	HALIFAX	14,433
Twilight Missionary Baptist	HALIFAX	3,329
Pilgrim Way of the Cross	HALIFAX	3,117
SFSP - Scotland Neck Education	HALIFAX	2,338
SFSP - Pleasant Grove Refuge	HALIFAX	1,639
SFSP - Hollister Reach Inc	HALIFAX	491
	HALIFAX Total	940,092
Recruiters for Christ Church	HARNETT	427,716
Deliverance Church	HARNETT	163,136
Angier Area Food Pantry	HARNETT	118,744
Alpha & Omega	HARNETT	116,942
TMO Foundation Inc.	HARNETT	104,446
Coats COGOP	HARNETT	41,734
The Rising Sun Church of	HARNETT	32,996
Freedom Biker Church	HARNETT	22,819
Glad Tiding Church, Inc.	HARNETT	19,732
A Sound of Abundance	HARNETT	15,916
S.A.F.E. of Harnett County	HARNETT	10,989
McKoy Grove Holiness Church	HARNETT	10,256
(PAL) City of Dunn	HARNETT	9,514
Smart Choice Outreach	HARNETT	6,040
Harnett Food Pantry -	HARNETT	5,971
KC - Think Smart Outreach	HARNETT	4,053
Elmore Blackley Fellowship	HARNETT	3,325
Salvation Army - Dunn	HARNETT	2,517
SFSP - Dunn Police Athletic	HARNETT	1,913
	HARNETT Total	1,118,759
Avery Chapel FWB Church	HOKE	392,997
ıe Chapel of Jesus Christ	HOKE	21,596

	HOKE Total	414,593
Milagros y Maravillas de Dios/	JOHNSTON	245,579
New Life Deliverance Ministry	JOHNSTON	182,298
Edgerton Memorial UMC	JOHNSTON	149,470
Flowing Waters World Outreach	JOHNSTON	145,168
Samaritan's Shelf	JOHNSTON	88,518
Shiloh Christian	JOHNSTON	80,186
D.A.P.A.A. INC.	JOHNSTON	78,714
Benson Area Ministerial	JOHNSTON	64,033
First Baptist Church of	JOHNSTON	62,765
ST. ANN CATHOLIC CHURCH	JOHNSTON	62,480
Clayton Area Ministries	JOHNSTON	43,168
Day by Day Treatment Center	JOHNSTON	27,155
Lighthouse Christian	JOHNSTON	27,115
Potter's House Outreach Center	JOHNSTON	25,268
Family Life Center, Inc.	JOHNSTON	21,046
Power of Praise Tabernacle	JOHNSTON	19,982
Johnston Community Chapel	JOHNSTON	17,786
Iglesia De Dios Cristo	JOHNSTON	16,687
Harvest Word Ministry	JOHNSTON	14,766
WPP - First Baptist Church of	JOHNSTON	13,271
Western Assembly Church of	JOHNSTON	12,286
Showers of Blessing Community	JOHNSTON	10,669
Salvation Army-Smithfield	JOHNSTON	7,115
Basic Needs Ministry	JOHNSTON	6,816
Siltrist Solutions	JOHNSTON	5,525
Harbor Inc.	JOHNSTON	3,121
Kenly Area Ministries	JOHNSTON	2,777
Christ Community United	JOHNSTON	2,459
Crossroads Church	JOHNSTON	1,314
A Touch From Above Faith	JOHNSTON	1,289
Smithfield Rescue Mission	JOHNSTON	1,253
White Oak Hill Missionary	JOHNSTON	788
	JOHNSTON Total	1,440,867
Maysville United Methodist Chu	JONES	85,373
New Hope Community Outreach	JONES	38,916
Faith Outreach Holy Ministries	JONES	19,462
Salvation Army- Maysville	JONES	10,242
Unlimited Care, Inc.	JONES	9,797
Coastal Women's Shelter	JONES	843
The House That God Built	JONES	305
	JONES Total	164,938
Christians United Outreach	LEE	325,702
Bread Basket/Sanford Soup	LEE	167,127
Ministerio Bethel, Inc	LEE	71,697
God's Fellowship Church	LEE	44,848
Christian Faith Ministries	LEE	40,402
New Life Praise Church	LEE	22,011
Salvation Army of Lee County	LEE	19,492
Hillview Christian Assembly	LEE	16,232
Bread of Life Ministries	LEE	9,168
KC - Boys & Girls Club Sanford	LEE	7,129
New Birth Non-Denominational	LEE	6,586
Body of Christ Ministry	LEE	2,257
Church of God of Prophecy/	LEE	2,107
DBR Ministries	LEE	2,044
Monarch	LEE	2,042
Faith Hope Deliverance	LEE	1,547
GET SMART, INC.	LEE	1,306
All Nations Apostolic Church	LEE	512
SFSP - KTV Alive	LEE	169
	LEE Total	742,378
St. Mark Church Ministries	LENOIR	353,093
Freedom Family Foundation, Inc	LENOIR	226,460
Alpha and Omega Church	LENOIR	130,346
Greater St. Peter Church	LENOIR	36,551
River Of Life Christian/	LENOIR	28,310
Herring Grove F.W.B. Church	LENOIR	22,038
The Bible Church of Christ	LENOIR	15,177
Apostolic Deliverance	LENOIR	12,974
Kennedy Baptist Children's	LENOIR	12,805
Community Development Resource	LENOIR	7,417
KC - St. Mark's Church Hands	LENOIR	4,558
Flynn Christian Fellowship	LENOIR	3,039
...iloch Free Will Baptist Ch	LENOIR	1,122
Rey de Reyes Pentecostal	LENOIR	456
S.A.F.E. Lenoir County	LENOIR	194
	LENOIR Total	854,540
Montgomery Churches In Action/	MONTGOMERY	151,351
	MONTGOMERY Total	151,351
West End United Methodist Men	MOORE	135,873
Page United Methodist Church	MOORE	122,999
Word of Truth Christian Center	MOORE	91,618
Carthage United Methodist Ch.	MOORE	85,759
Christian Mission Center	MOORE	63,394
Pinebluff United Methodist Men	MOORE	62,144
Pentecostal Assembly	MOORE	58,667
New Zion AME Zion Church	MOORE	48,767
WPP - St. Joseph of the Pines	MOORE	47,281
KC - Boys & Girls Club of	MOORE	43,072
Wesleyan Methodist Church	MOORE	33,122
Sandhills - Moore Coalition	MOORE	32,792
Aberdeen Community Club, Inc.	MOORE	31,471
Southern Pines UMC	MOORE	31,290
New Beginnings Holiness Church	MOORE	29,113
High Falls United Methodist	MOORE	28,520
Monarch	MOORE	25,966
Cameron Boys' Camp / Baptist	MOORE	25,158
Sandhills Children's Center	MOORE	21,903
First Missionary Baptist	MOORE	21,778
Solid Rock Community Church	MOORE	18,826
SNAK PAK PALS	MOORE	17,869
Mission Agape	MOORE	15,164
Carthage Church of God	MOORE	14,535
Bethesda Presbyterian Church	MOORE	12,810
Bethesda, Inc.	MOORE	12,391
Northern Moore Resource Center	MOORE	10,690
Robbins Area Christian	MOORE	10,561
St. Anthony's Cath Church	MOORE	7,873
Southside Baptist Church	MOORE	7,600
Linden Lodge Foundation, INC	MOORE	7,149
MANNA	MOORE	6,915
SFSP - Boys & Girls Club	MOORE	4,018
Port Human Services	MOORE	3,797
SFSP - Northern Moore Family	MOORE	3,647
Page United Methodist Soup Kit	MOORE	2,897
The Academy of Moore County	MOORE	2,826
SFSP - Aberdeen Recreation	MOORE	2,252
Occoneechee Council/BSA-	MOORE	2,075
The Arc of Moore, Inc.	MOORE	1,088
SFSP - The Worship Center	MOORE	855
Friend to Friend	MOORE	675
Right Start	MOORE	251
FirstHealth Hospice	MOORE	170
Moore Buddies	MOORE	90
SFSP - The Academy of Moore	MOORE	1
	MOORE Total	1,207,712
Greater Joy Missionary Baptist	NASH	146,166
Fountain of Hope	NASH	112,524
Gregg Court Apartments	NASH	100,039
Apostolic Faith Church	NASH	98,451
St. Paul Missionary Baptist	NASH	96,120
Baker Family Ministry	NASH	75,694
Christian Fellowship Homes	NASH	47,737
Community Chapel Church	NASH	30,991
United Community Ministries	NASH	26,177
Salvation Army-Rocky Mount	NASH	10,596
Evangel Christian Fellowship	NASH	10,004
Crosspointe Ministries, Inc.	NASH	6,797
SFSP - Boys & Girls Club Nash/	NASH	4,845
Rocky Mount Church of the	NASH	4,838
KC - Boys & Girls Clubs Nash	NASH	4,685
Lifeline Christian Center	NASH	2,395
Faith Christian Ministries of	NASH	430
SFSP - The Salvation Army of	NASH	250
The Helping Hand Food Pantry	NASH	0
	NASH Total	778,739
First Fruit Ministries	NEWHANOVER	379,741

Good Shepherd Center	NEWHANOVER	257,035
The Lord's Church	NEWHANOVER	199,929
Mother Hubbard's Cupboard	NEWHANOVER	188,446
BATH	NEWHANOVER	88,012
Community Boys & Girls Club	NEWHANOVER	69,493
Wrightsboro United Methodist	NEWHANOVER	68,961
Bethesda Christian Life Church	NEWHANOVER	67,843
Holy Grounds Coffee House	NEWHANOVER	57,090
Tileston Outreach	NEWHANOVER	52,413
Full Circle Ministry	NEWHANOVER	49,259
Helping Hands/St Stanislaus	NEWHANOVER	46,508
Upper Room Praise &	NEWHANOVER	43,413
Nourish NC	NEWHANOVER	39,757
First In Famuilies/The ARC of	NEWHANOVER	37,512
Salvation Army-Wilmington	NEWHANOVER	35,380
KC - Wilmington Residential	NEWHANOVER	25,842
New Covenant Holiness Church	NEWHANOVER	22,566
Wilmington Branch TEFAP	NEWHANOVER	20,134
Ashley Center	NEWHANOVER	19,613
Brigade Boys and Girls Club	NEWHANOVER	14,834
St Peter The Fisherman Church	NEWHANOVER	14,250
First Baptist Church	NEWHANOVER	12,518
Stepping Stone Manor	NEWHANOVER	12,267
Myrtle Grove SDA Church	NEWHANOVER	10,290
St. Jude's Metropolitan	NEWHANOVER	7,852
CIS Wire Program	NEWHANOVER	7,787
The Love Center Church, Inc.	NEWHANOVER	7,167
Bread for Life -	NEWHANOVER	6,777
SFSP - Wilmington Family	NEWHANOVER	6,225
Step Up for Soldiers	NEWHANOVER	5,760
SFSP - YWCA of the Lower	NEWHANOVER	4,201
Coastal Horizons	NEWHANOVER	4,065
Wilmington Family YMCA	NEWHANOVER	3,987
The Rock of Wilmington	NEWHANOVER	3,942
Weekend Meals on Wheels	NEWHANOVER	3,599
Cape Fear Christian Church	NEWHANOVER	3,211
WPP - Communities In Schools	NEWHANOVER	3,022
Federal Point Help Center, Inc	NEWHANOVER	2,612
LINC	NEWHANOVER	1,879
Ambassadors for Christ Called	NEWHANOVER	1,576
Phoenix Mission Connections	NEWHANOVER	1,476
Child Advocacy Commission	NEWHANOVER	1,332
SFSP - The Village	NEWHANOVER	1,256
Immaculate Conception Church	NEWHANOVER	1,042
SFSP - WRAAP, Inc.	NEWHANOVER	801
Kids Making It, Inc.	NEWHANOVER	772
YWCA of the Lower Cape Fear	NEWHANOVER	602
SFSP - Warsaw Middle	NEWHANOVER	479
Domestic Violence Shelter and	NEWHANOVER	368
Philippians 3: Ministries, Inc	NEWHANOVER	187
Catholic Charities	NEWHANOVER	149
SEARISE	NEWHANOVER	73
	NEW HANOVER Total	1,915,305
Mt. Carmel, Inc. HELPS	ONSLOW	316,003
Onslow Community Ministries	ONSLOW	264,214
Richlands Community Outreach	ONSLOW	169,814
White Oak Ecumenical	ONSLOW	158,393
Salvation Army-Jacksonville	ONSLOW	110,438
First United Methodist Church	ONSLOW	109,730
Second Chance Mission Of Hope	ONSLOW	40,350
Open Door Management, Inc.	ONSLOW	15,771
ALCC-Nehemiah Christian Center	ONSLOW	11,442
Snead's Ferry Presbyterian	ONSLOW	11,036
KC - Mt. Carmel Inc. - HELPS	ONSLOW	5,881
Holly Ridge Church of God	ONSLOW	1,978
SFSP - Mount Carmel	ONSLOW	1,400
SFSP - Heatherton Park	ONSLOW	320
	ONSLOW Total	1,216,770
St. Joseph CME Outreach–	ORANGE	119,351
Chapel Hill Training Outreach-	ORANGE	109,319
Friends of Orange County DSS	ORANGE	108,837
Inter-Faith Council/	ORANGE	102,134
Hunter's Chapel A.M.E. Church	ORANGE	43,009
Grace and Peace Tabernac	ORANGE	40,341
Palmers Grove United Methodist	ORANGE	27,180
Orange Congregations Mission	ORANGE	25,271
Cedar Grove Mt. Zion AME	ORANGE	19,012
WPP - Chapel Hill Carrboro	ORANGE	15,059
KC - Friends of Chapel Hill	ORANGE	7,178
Source Force	ORANGE	7,107
Friends of Chapel Hill Parks &	ORANGE	3,386
Freedom House/Chapel Hill	ORANGE	1,693
Orange Co Head Start/Early HS	ORANGE	1,460
Orange County Disability	ORANGE	1,099
OE Enterprises	ORANGE	639
	ORANGE Total	692,075
Pamlico County Fishes & Loaves	PAMLICO	321,310
Youth Empowerment Organization	PAMLICO	17,160
KC - Heartworks Children's	PAMLICO	16,299
Pamlico County Group Home	PAMLICO	3,651
SFSP - HeartWorks Children's	PAMLICO	2,850
	PAMLICO Total	361,270
Burgaw PFWB	PENDER	621,790
Livingstones Tabernacle	PENDER	156,103
Pender County Christian	PENDER	90,021
St. Joseph Parish Outreach	PENDER	41,669
Faith Harbor UMC	PENDER	16,090
Pike Rocky Point Presbyterian	PENDER	15,929
KC - The Holmes Movement	PENDER	7,479
Pender Adult Services, Inc.	PENDER	6,538
WPP - Cape Fear Elementary	PENDER	5,684
We Care 4 You Foundation, Inc.	PENDER	4,198
SFSP - Safe Holmes Movement	PENDER	2,789
The Well Community Development	PENDER	2,375
SFSP - Communities In Schools	PENDER	1,607
TAFF, Inc.	PENDER	1,093
SFSP - Camp Kirkwood	PENDER	899
KC - Community Boys & Girls	PENDER	714
New Beginnings Community Ch	PENDER	629
	PENDER Total	975,607
Word of Life Christian Center	PERSON	363,782
Christian Help Center	PERSON	49,385
Jonathans Outreach Network	PERSON	16,402
Roxboro Church of God	PERSON	9,420
Person County Group Homes	PERSON	8,746
Oak Grove Community	PERSON	1,700
Excess SFSP Inventory	PERSON	250
	PERSON Total	449,685
Freedom Family Foundation, Inc	PITT	233,638
Philippi Church of Christ	PITT	225,127
Pentecostal Temple	PITT	214,361
The Anointed Ones Church	PITT	168,506
First Born Comm. Dev. Ctr.	PITT	163,221
Project Anna, Inc.	PITT	161,197
Ayden Christian Care Center	PITT	131,587
Koinonia Christian Center	PITT	118,966
Antioch United Holy Church	PITT	114,321
Churches Outreach Network	PITT	107,328
Hope of Glory Ministries, Inc.	PITT	106,525
Salvation Army-Greenville	PITT	98,929
Bread of Life/Grifton	PITT	98,508
Christ Temple Holiness Church	PITT	85,719
Memorial Baptist Church	PITT	82,736
Holy Temple Church	PITT	68,918
St. Paul's Episcopal Church	PITT	60,192
St. Peter Catholic Church	PITT	38,679
Operation Sunshine, Inc	PITT	19,733
Love Ministries Church (LMC)	PITT	14,400
Brown's New Approach To Living	PITT	12,627
South Greenville Church	PITT	11,380
Emmanuel Community FWB, Inc.	PITT	11,140
Zion Chapel Senior Food Serv	PITT	9,225
Saints Delight Church of God	PITT	8,993
Mount Calvary Grace & Mercy	PITT	7,893
Joseph Provisions	PITT	7,553
Building Hope Community Life	PITT	6,883
[illegible]ndra's Tons of Love	PITT	6,300
[illegible]ston Mill Road Community	PITT	6,264

Darden Enlightenment Cen	PITT	6,060
SFSP - Armor of God Christian	PITT	5,918
Selvia Chapel F.W.B. Church	PITT	5,453
Victory Christian Assembly	PITT	4,811
KC - Armor of God Christian	PITT	2,487
SFSP - Community Fellowship	PITT	2,139
SFSP - MCCC Greater Beginnings	PITT	1,602
SFSP - Lil Willie Center	PITT	1,593
Armor of God Christian Church	PITT	1,190
SFSP - Joy Kitchen	PITT	668
New Mt. Moriah United	PITT	496
New Foundations Group Home	PITT	122
	PITT Total	2,433,388
Helping Hands of Hamlet	RICHMOND	730,446
Tabernacle Full Gospel	RICHMOND	283,485
Our Daily Bread Christian Food	RICHMOND	166,144
Emmanuel Ministries Church	RICHMOND	134,546
Prayer and Faith Temple Church	RICHMOND	119,419
Tabernacle of Faith PHC	RICHMOND	102,182
House of Prayer/Feed My People	RICHMOND	80,365
Rockingham Spanish SDA Church	RICHMOND	78,506
King's Gate Church Internation	RICHMOND	52,570
Victory Deliverance Church of	RICHMOND	47,030
Outreach for Jesus	RICHMOND	35,495
Foundation of Jesus Christ	RICHMOND	31,763
St. Paul Lutheran- Hamlet	RICHMOND	20,347
Southern Mission Ministries	RICHMOND	19,578
Jesus is Justice Mission, Inc	RICHMOND	15,294
Greater Diggs	RICHMOND	12,790
KC - Leak Street Inc.	RICHMOND	12,336
Mt. Zion UCC/Rockingham	RICHMOND	10,804
Pee Dee Baptist Association	RICHMOND	9,716
Richmond County Enrichment	RICHMOND	6,955
SFSP - Leak Street	RICHMOND	5,466
Church of God of Prophecy --	RICHMOND	5,245
Community Mentor Program	RICHMOND	3,401
First Presbyterian Church	RICHMOND	3,121
Monarch - Cauthen Group Home	RICHMOND	2,982
Monarch - Richmond Adult Group	RICHMOND	2,509
Monarch - Mallard Lane	RICHMOND	1,778
Monarch - Pence Place	RICHMOND	1,339
New Horizons	RICHMOND	1,243
SFSP - Philadelphia UMC	RICHMOND	1,188
SFSP - Faith Assembly	RICHMOND	1,027
SFSP - Sinai Kingdom Summer	RICHMOND	831
SFSP - Hamlet Housing	RICHMOND	141
SFSP - Sidney Grove Church	RICHMOND	-75
	RICHMOND Total	1,999,967
Jackson Grove Bible Church of	SAMPSON	360,116
Rock Ministry Inc.	SAMPSON	99,555
Revival Deliverance Ctr, Inc	SAMPSON	87,210
New Vision Christian Church	SAMPSON	7,163
Harvest House/TCCHC	SAMPSON	611
	SAMPSON Total	554,655
Missions Ministries	SCOTLAND	238,943
Laurinburg Hope In Christ	SCOTLAND	238,512
Restoring Hope Center	SCOTLAND	117,549
FIRST Thessalonian Baptist	SCOTLAND	84,654
New Covenant Christian Ctr.	SCOTLAND	78,384
St. John's Emergency Food	SCOTLAND	58,202
Rockingham District	SCOTLAND	51,976
Spring Hill Baptist	SCOTLAND	51,760
Unionville Missionary Baptist	SCOTLAND	39,403
Church Community Services	SCOTLAND	26,994
Agape Buchanan Featherstone	SCOTLAND	18,084
Higher Dimensions Ministries	SCOTLAND	16,986
St. Luke United Methodist	SCOTLAND	8,445
Jerusalem United Methodist	SCOTLAND	8,042
WPP - IE Johnson Elemen PTO	SCOTLAND	2,995
SFSP - Restoring Hope	SCOTLAND	2,922
First United Methodist Church	SCOTLAND	2,447
RHA Health Services, Inc.	SCOTLAND	819
Domestic Violence Ctr.Scotland	SCOTLAND	788
	SCOTLAND Total	1,047,905

...eline Outreach, INC.	VANCE	323,312
Young Memorial United Holy	VANCE	171,994
Cotton Memorial Presbyterian	VANCE	123,305
Holy Faith Temple, C.F.A.P	VANCE	95,164
Big Ruin Creek Baptist	VANCE	72,088
Shiloh Baptist Church	VANCE	69,727
Mt. Zion Christian Church/	VANCE	60,346
Brookston Baptist Church	VANCE	59,032
Cokesbury United Methodist	VANCE	49,179
Salvation Army-Henderson	VANCE	32,478
Positive Directions-	VANCE	27,963
Addiction Recovery Center	VANCE	27,917
Greater Ransom Way Of The	VANCE	24,712
Kittrell Shiloh Missionary	VANCE	20,180
Spirit of Life Kings	VANCE	19,521
Calvary Temple Holy Church	VANCE	19,161
Boys & Girls Club of NCNC	VANCE	10,930
Alliance Rehabilitative Care	VANCE	9,851
Alliance Rehabilitative Care--	VANCE	7,234
William Hawkins Yth Ministries	VANCE	6,954
Vance-Adult Group Home	VANCE	5,431
Roanoke Ave. Group Home	VANCE	5,411
Graham Ave. Group Home	VANCE	4,904
SFSP - Room at the Cross	VANCE	3,056
ACTS/Henderson	VANCE	1,190
Recovery Innovations of NC	VANCE	553
SFSP - TA Byrd Youth	VANCE	449
	VANCE Total	1,252,042
Catholic Parish Outreach	WAKE	856,392
Community Helpers Service	WAKE	647,748
Upper Room Church of God	WAKE	459,852
Emmanuel Hispanic Pentecostal	WAKE	419,131
With Love From Jesus Ministry	WAKE	371,528
Comunidad Christiana Hosanna	WAKE	371,095
Bread of Life	WAKE	264,216
Gethsemane 7th Day	WAKE	165,062
Fuquay-Varina Emergency	WAKE	151,249
Tri-Area Ministry	WAKE	149,745
White Oak Foundation	WAKE	128,914
Lifepointe Church	WAKE	127,205
Urban Ministries of Wake	WAKE	117,062
N.C.A. Philip Randolph Inst.	WAKE	108,361
Church Of God Of Prophecy	WAKE	106,170
North Haven Church	WAKE	98,052
Cathedral De Jesus	WAKE	93,352
Faith Missionary Baptist	WAKE	91,318
Raleigh Vineyard Christian	WAKE	83,042
The Healing Place of Wake	WAKE	74,599
Mission Raleigh of Mt. Vernon	WAKE	73,278
Pleasant Grove Missionary	WAKE	69,611
Western Wake Crisis Ministry	WAKE	65,842
Poplar Springs Christian	WAKE	64,533
Brown Bag Ministry	WAKE	55,141
Child Evangelism Fellowship	WAKE	49,694
New Providence Missionary	WAKE	45,120
Salvation Army-Raleigh	WAKE	44,876
Longview United Methodist	WAKE	41,025
Greater Pentecostal F. D.	WAKE	39,000
Jesucristo Fuente De Amory	WAKE	36,614
Cristo La Solucion	WAKE	35,675
Straightway Temple	WAKE	34,390
UMOJA Central SDA Church	WAKE	33,656
Islamic Association of Raleigh	WAKE	33,068
Knightdale Church of God	WAKE	31,523
Reaching Your Goals Inc.	WAKE	31,352
Progressive Teamwork Outreach	WAKE	30,998
Alliance of AIDS Services	WAKE	29,205
Habakkuk Outreach Center/	WAKE	28,581
Riley Hill Family Life Center	WAKE	28,291
Raleigh Rescue Mission	WAKE	27,204
Triangle Vineyard Christian	WAKE	26,690
Corinth United	WAKE	26,617
Brooks Ave. Church Of Christ	WAKE	25,687
Davie St Presbyterian	WAKE	25,541

Trinity United Faith Center	WAKE	25,059
Church of God-Sermon del Monte	WAKE	24,589
Mt. Zion United Holy Church	WAKE	22,077
The Light of Life Ministry	WAKE	21,083
Iglesia Cristiana Casa de	WAKE	18,176
The Healing Place Wake County	WAKE	17,747
St. Anna Freewill Baptist	WAKE	17,644
Universal Outreach	WAKE	17,000
Christian Fellowship Home-	WAKE	16,772
Praise Worship Tabernacle	WAKE	16,436
J. T. Locke Resource Center	WAKE	16,035
Community of Hope Ministries	WAKE	15,155
Overflow Outreach	WAKE	13,445
Martin Street Baptist Church	WAKE	12,118
Capital Pentacostal Church	WAKE	11,119
Caring Hearts Outreach	WAKE	11,063
Joseph's Hand	WAKE	10,829
First Born Church of	WAKE	10,172
Word of God Fellowship	WAKE	9,510
Shiloh Temple Tabernacle of	WAKE	9,358
Break Through Temple	WAKE	8,034
Passage Home/Matthew House	WAKE	8,003
New Life Community Church	WAKE	7,896
Zina Christian Center	WAKE	7,056
Ernest Myatt Child Development	WAKE	6,963
The Women's Center of Wake Co.	WAKE	6,958
Autism Services /	WAKE	6,509
Resources For Seniors	WAKE	6,389
Lutheran Family Services	WAKE	6,095
KC - Homework Haven	WAKE	5,650
WPP - Lincoln Heights	WAKE	5,606
Southlight Supervised	WAKE	5,453
Resources For Seniors	WAKE	5,121
Cary Church of God	WAKE	5,074
Millbrook United Methodist	WAKE	4,923
WPP - Reedy Creek	WAKE	4,902
Haven House-Second Round Youth	WAKE	4,646
Emmaus House	WAKE	4,483
Transplant Recipient	WAKE	4,327
Hearts For Children	WAKE	4,196
Resources For Seniors	WAKE	3,473
St. Mary A.M.E. Church -	WAKE	3,201
Resources For Seniors/NWSC	WAKE	3,129
BAREUP/Community Healing	WAKE	3,079
Pullen Memorial Baptist Church	WAKE	2,958
SFSP - Homework Haven	WAKE	2,865
ICC- Glenwood Towers	WAKE	2,846
New Life Christian Church	WAKE	2,632
Family Circle Elder Care	WAKE	2,576
Alexander Family YMCA	WAKE	2,569
Haven House	WAKE	2,529
Better Life Development Center	WAKE	2,484
WPP - Hodge Road Elementary	WAKE	2,270
SFSP - Cedar Moor Apartments	WAKE	1,921
Dorcas Ministries	WAKE	1,887
Wendell United Methodist	WAKE	1,748
Holly Springs Food Cupboard	WAKE	1,708
SFSP - OASIS Foundation	WAKE	1,668
Better Days Ministies	WAKE	1,655
Autism Services/Glenn Forest	WAKE	1,596
Shepherd's Table Soup Kitchen	WAKE	1,503
Mt. Moriah	WAKE	1,499
Temple Baptist Church	WAKE	1,360
The Stone Chapel	WAKE	1,359
Inter-Community Council	WAKE	1,218
Living Waters CDC	WAKE	1,216
Burning Bush Ministries, Inc	WAKE	998
PLM Families Together Inc.	WAKE	965
Resources for Seniors	WAKE	947
KC - AventWest at Avent Ferry	WAKE	939
SFSP - Walnut Ridge Apts	WAKE	849
Bethlehem Baptist Church	WAKE	775
Interact	WAKE	749
SFSP - Little Believers	WAKE	728
WPP - NE Wake Backpack Buddies	WAKE	720
Christian Life Home	WAKE	566
Iglesia Nueva Esperonza	WAKE	431
Capital Towers	WAKE	370
SFSP - PLM Families Together	WAKE	256
Resources For Seniors-TLC	WAKE	213
New Life Camp -	WAKE	201
	WAKE Total	6,417,692
Loaves and Fishes	WARREN	308,575
Citizens Against Domestic	WARREN	68,448
Lake Gaston Baptist Church	WARREN	49,544
Warren Street Group Home	WARREN	14,931
Warren County Group Home	WARREN	4,809
	WARREN Total	446,307
Blessing and Giving	WAYNE	347,490
House of Fordham	WAYNE	343,721
Pete Norris Ministries Inc.	WAYNE	227,705
Stanley Chapel FWB Church	WAYNE	81,175
New St. Delight United Holy Ch	WAYNE	45,456
St. Mark Church of Christ	WAYNE	32,701
God's Way Ministries	WAYNE	28,803
Park East Church of God	WAYNE	23,507
Abundant Grace Church	WAYNE	17,968
Blood of the Lamb Church	WAYNE	11,643
First Assembly of God Church	WAYNE	11,602
Salvation Army-Goldsboro	WAYNE	8,949
Renu Life	WAYNE	7,482
Dillard Academy	WAYNE	7,445
The Original Tabernacle of	WAYNE	6,374
St. Andrews Christian Church	WAYNE	5,703
KC - Rebuilding Broken Places	WAYNE	5,623
Flynn Home Of Goldsboro	WAYNE	4,990
Eagles Nest Worship Center	WAYNE	3,136
Help and Hope Ministries	WAYNE	1,964
SFSP - Dillard Academy	WAYNE	1,791
Rebuilding Broken Places	WAYNE	1,610
Jacob House/Rachel House	WAYNE	1,322
Alice Graham New Horizons, Inc	WAYNE	756
	WAYNE Total	1,228,916
NC Love in Action (LIA)	WILSON	197,552
Glad Tidings Gospel Church	WILSON	183,960
Kenly Church of God	WILSON	163,512
St. Paul Church of Christ/	WILSON	128,595
Wilson Praise & Worship Church	WILSON	105,353
Wilson County Interfaith	WILSON	99,074
St. Marks'/La Guadalupana	WILSON	94,151
Pathway Outreach Center Inc.	WILSON	92,380
Christ Delivrance Tabernacle	WILSON	75,552
Branch Memorial Tabernacle	WILSON	54,789
New Christian Food Pantry &	WILSON	27,611
KC - Salvation Army B&G Club	WILSON	22,094
The Word Became Flesh	WILSON	13,703
WRAI Outreach Ministries	WILSON	12,827
Wilson County Senior Center	WILSON	8,622
Mt. Hebron Seventh Day	WILSON	8,453
Salvation Army-Wilson	WILSON	7,022
SFSP - Salvation Army B&GC	WILSON	2,617
Abundant Life Church	WILSON	1,671
Mental Health Association	WILSON	837
Community Missions/New	WILSON	705
The Wilson Youth United Inc	WILSON	631
SFSP - Summer Place	WILSON	518
Shiloh Pentecostal Holiness	WILSON	457
St. Timothy Community	WILSON	401
	WILSON Total	1,303,087
	Grand Total	41,036,799

NO ONE GOES HUNGRY

Fighting Hunger In Lee, Moore, Richmond, and Scotland Counties.

FOOD BANK OF CENTRAL & EASTERN NORTH CAROLINA AT SANDHILLS

2012-2013

195 Sandy Avenue
Southern Pines, NC 28387
910.692.5959
Sandhills.FoodBankCENC.org

★★★★
Charity Navigator
4-Star Rating

A Member of FEEDING AMERICA

Sandhills Fast Facts 101

- In fiscal year 2011–12, the Food Bank of Central & Eastern North Carolina at Sandhills distributed a record 5.037 million pounds to 107 partner agencies (including food pantries, shelters, soup kitchens, and group ho
- The Sandhills Branch has experienced a 55% growth in distribution over the last four years.

The need in the Sandhills Branch service area:

- In the four counties served by the Food Bank of Central & Eastern North Carolina at Sandhills, 34,792 individuals are at risk of hunger.
- 3,042 are 65 years and older.
- 12,085 are children.

How you can help:

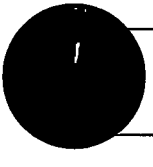
- Donate money: For every $1 donated, 5 meals, or 10 dollars of food are provided.
- Donate time: Volunteer as an individual or with a group.
- Donate food: Hold a food drive.

Programs:

- Food Recovery
  (Fresh Produce, Retail Recovery, Salvage)
- Kids Meals & More
  (Kids Cafe, Back Pack Pals, Kids Summer Meals)
- Three Squares for CENC
  (Food Nutrition Services Outreach)

Efficiency

97% of every dollar goes to Food and Food Programs.



Sandhills.FoodBankCENC.org

Cover photo: Hannah Sharpe, *The Pilot*

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

February 19, 2013
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Matt Viohl	CN Consulting
Andy Chase	KMA
Bill Rustin	AGP
Joel Maynard	GPM & Assoc
[illegible]	BSK
[illegible]	NCLHCA
Erica Nelson	NCHA
[illegible]	BCBS
Cody Hand	NCHA
John DelGiorno	Brubaker / Assoc.
Sarah Rothecker	Brubaker & Assoc.
[illegible]	BCBS NC
Doug Heron	WM
Hugh Wilson	NCMX
[illegible]	RMOIC Medical
[illegible] McCanee	Carolinas HealthCare
[illegible]	Rob Lemme + Associates

Ken Melton   K.M.A.

09-21-201

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

February 19, 2013
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	Eastern Seal UCP
David L. Brown	Second Harvest Food Bank of Metrolina
Heather Densmore	Merck
Andy Willard	UNC-CH
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	The Policy Group
Bryant Murphy	UNC School of Medicine
KAREN GILLESPIE	BMS
JAY PETERS	CSS
[illegible]	NCANTCF
Bob Hedrick	NCPC
Kristen Laster	SSGNC
Wendy Kelly	Policy Group
Daniel Ambuin	NCRMA
Andy Ellen	NCRMA
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

2-19-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Annaliese Dolph	DHHS
Penny Crumpler	Caswell Family Medical Center Yanceyville, NC
Barbara Montague	Caswell Family Medical Cntr, Yanceyville, NC.
Susanna Davis	Williams Mullen
[signature]	SEANC
Alexandra Harris	NCCHCA
Colleen Kachmele	NCCEP
Rebecca Whitaker	NCCHCA
[signature]	American Heart-ASSW
Elizabeth Wurhel	NASW Intern
Gail Lane	NCNA Halifax Regional Med. Ct - Roanoke Rapids, NC
Al Lane	HRMC
[signature]	NCACC
JEFF HUX	NC VALUES COALITION

09-21-201

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

2-19-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jay Joiner	Soundtrack
Sherry Bradshaw	DHHS
Joan Otto	DHHS
Madison Mackenzie	DOJ
Sarah Wolfe	MWC LLC
Asheley Cooper	AARP-NC
Mary Bethea	AARP-NC
Kay Paksy	NASW-NC
George Smith	Nexlen Pruet
Adam Sholar	DHHS
Sally Cameron	NC Psychological
[illegible]	MWC
Joe Coletti	OSBM
[illegible]	[illegible]
Coryl Dunn	DRNC
Matt Gross	NCPC
Daniel VanLiere	Vidant Health

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

February 20, 2013
Legislative Office Building - Room 643
9:00 a.m.

Senator Louis Pate, Presiding

Welcome and Introductions by Chairs

North Carolina Senior Games	Brad Allen, President
ABC of NC Child Development Center	Selene Johnson, Executive Director
Residential Services, Inc.	Dennis Bradshaw, Director
Oxford House	Cindy Threlkeld, Executive Director
Brain Injury Association of NC	Sandra Farmer, President

Adjourn

Next Meeting: Thursday, February21st, 8:30 a.m.

Joint Committee on Appropriations on Health and Human Services
Wednesday, February 20, 2013 at 9:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations on Health and Human Services met at 9:00 AM on February 20, 2013, in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Jean Farmer-Butterfield, Carl Ford, Jim Fulghum, Beverly Earle, Mark Hollo, Verla Insko, Donny Lambeth, and Tom Murry were present, along with 4 Senate members.

Senator Pate presided.

Senator Pate opened the meeting by welcoming everyone and recognizing the House Sergeants-at-Arms—Joe Crook and Charles Godwin—and the Senate Sergeants-at-Arms—Leslie Wright and Steve Wilson. He also recognized the Pages in attendance. For the House were Mackenzie Fiss of Mecklenburg County, Anna Freeman of Wake County, Kayla Hawkins of Vance County, and Jason Howe of Wilson County. For the Senate were Marwan Lavoie of Guilford County and Cole Williams of Guilford County.

The following presented their respective organizations to the committee and answered questions from committee members: President and Executive Director of North Carolina Senior Games, Brad Allen; Executive Director of ABC of NC Child Development Center, Selene Johnson; Director of Residential Services, Inc., Dennis Bradshaw; and Executive Director of Oxford House, Kathleen Gibson [corrected from Agenda].

Due to time constraints, President Sandra Farmer's presentation of Brain Injury Association of NC was rescheduled for the next meeting of this committee—February 21, 2013.

The meeting adjourned at 10:00 AM

Senator Louis Pate
Presiding

Susan Fanning, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Monday, February 18, 2013 02:06 PM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Wednesday, February 20, 2013 at 9:00 AM - CORRECTED #1

Principal Clerk _____
Reading Clerk _____

Corrected #1: Start Time is 9:00 a.m. instead of 8:30 a.m.

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	February 20, 2013	9:00 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 14, 2013 10:22 AM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Wednesday, February 20, 2013 at 8:30 AM

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	February 20, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

NORTH CAROLINA
Senior Games

December 2012

Mark Trogdon
Director, Fiscal Research Division
Legislative Office Building Suite 619

Mr. Trogdon,

Please find enclosed the Annual Report required by House Bill 590 from North Carolina Senior Games, Inc. If you have questions or need additional information please contact me at 919-851-5456 or brad@ncseniorgames.org.

Respectfully,

Brad

Brad Allen
President, Executive Director
North Carolina Senior Games, Inc.

NORTH CAROLINA
Senior Games

2011-12 Annual Report

North Carolina Senior Games, Inc.

Report Due Date: December 1, 2012

Person Responsible: Brad Allen, President and Executive Director

4603 Western Boulevard, Raleigh, NC 27606

Phone: (919) 851-5456 Email: brad@ncseniorgames.org

As required by House Bill 590, North Carolina Senior Games is submitting a written annual report to:

North Carolina Division of Aging and Adult Services

Joint Legislative Oversight Committee on Health and Human Services

Senate Appropriations Committee on Health and Human Services

House of Representatives Appropriations Subcommittee on Health and Human Services

Fiscal Research Division

As outlined, attachments include the following:

Mission Statement, Purpose and Governance Structure (A)

Description of Programs, Services and Activities (B)

Statistical and Demographic Information (Including Number of Persons Served and Counties) (C)

Detailed Program Budget and List of Expenditures

Including All Positions Funded and Funding Sources (D)

Source and Amount of Any Matching Funds (Included in D)

Mission Statement, Purpose and Governance Structure

North Carolina Senior Games, Inc. (A)

It is the mission of North Carolina Senior Games, Inc. to create and implement a year-round health promotion and education program for adults 55 years of age and better. In 2012, North Carolina has the largest Senior Games program in the nation, with 53 Local Games that serve all 100 counties in our state through a variety of athletic, artistic and wellness education activities and programs.

A private, non-profit 501(c)(3) entity, NCSG is governed by a volunteer Board of Directors. North Carolina Senior Games is in compliance with all state laws and has a conflict of interest policy, as presented to DHHS. Board member names are listed below:

Officers
Lisa Lauffer, Chair, Raleigh
Alice Keene, Vice-Chair, Greenville
Jack Duncan, Vice-Chair, Raleigh
Louise Gooche, Secretary, Durham
Betty Rising, Treasurer, Lumberton
Beth Wilson, Past Chair, Wilmington

Members
Jackie Allison, Youngsville
Edith Bailey, Winston Salem
Larry Bailey, Clayton
Sue Bent, Murphy
Mary Bethel, Raleigh
Tracy Davis, Fayetteville
Mary Henderson, Cary
Lee Perry, Manteo
Keron Poteat, Boone
Brandi Rheubottom, Manteo
Lee Riddick, Gatesville
Rita Roy, Greenville
Rex Smith, Raleigh
Dick Taylor, Lumberton

Ex Officio Board Members
Dorothy Anderson, Raleigh
Audrey Edmisten, Raleigh
Diane Sauer, Raleigh
Michelle Wells, Raleigh

Honorary Board
Joan Debruin, West End
Ray Funkhouser, White Stone, VA
Roman Gabriel, Castle Hayne
Waltye Rasulala, West End

Description of Programs, Service and Activities (B)

Through the Local Senior Games and State Finals, NCSG provides health promotion programs for persons 55 and better in all 100 counties of North Carolina. A descriptive flyer of all the programs and services of NCSG is attached.

Additionally, North Carolina Senior Games measures the impact of its' programs upon the health status of older persons. In 2011-12, NCSG conducted evidence-based research on a statewide level and in 5 Local Senior Games through North Carolina State University. This research measured the impact of Senior Games in improving the activity level and health status of participants. See attached research summaries.

NORTH CAROLINA

SENIOR GAMES 2012

North Carolina Senior Games began in 1983 with a vision to create a year-round health Promotion and education program for adults 55 years of age and better.

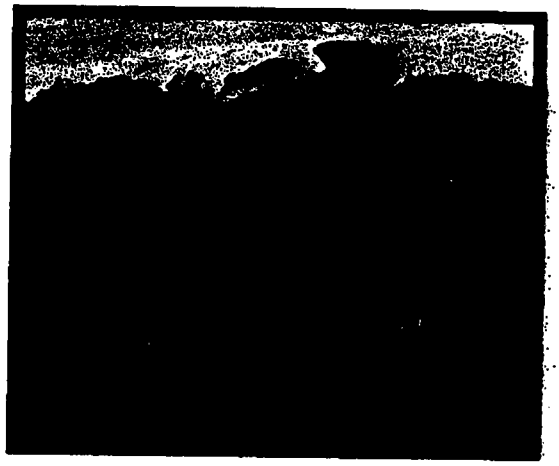
LOCAL SENIOR GAMES
There are over 60,000 participants statewide in 53 Local Games that serve all 100 counties across the state.

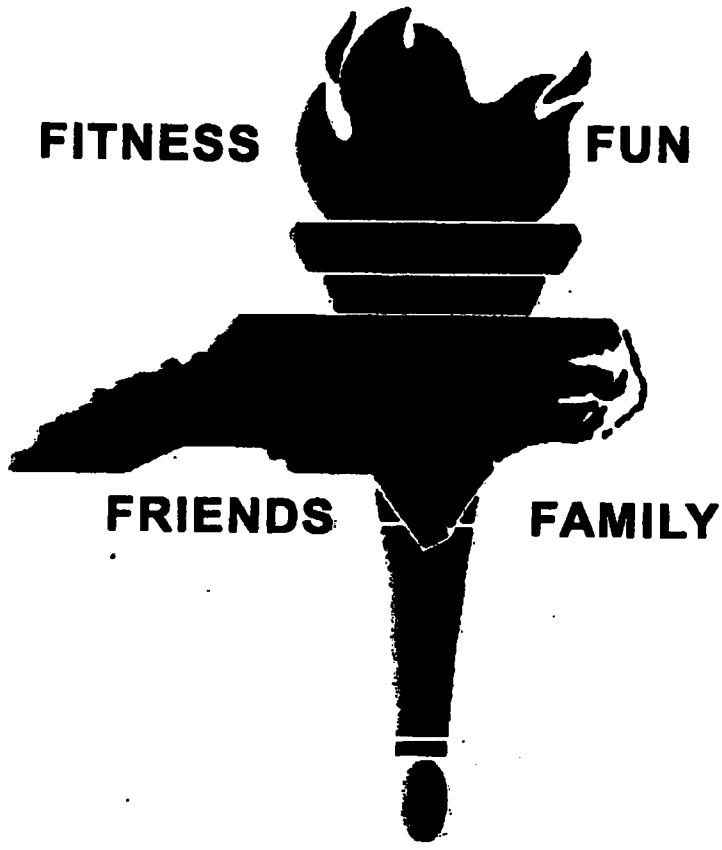
SILVERARTS
NCSG's Heritage, Visual, Performing, Literary Arts and Cheerleader programs.

SILVERSTRIDERS
NCSG's national award winning walking program

SILVER CLASSIC
NCSG's special events program

Senior Games is a wellness and prevention program to keep the body, mind and spirit fit while enjoying the company of friends, family, spectators and volunteers.





Softball Tournament
Walnut Creek Softball Complex, Raleigh
September 10-13

Bocce & Cornhole Tournaments
October 9-11, Clayton

Golf Tournament
October 9-10, Winston-Salem

Basketball Tournament
October 19-21
East Carolina University, Greenville

GRAND PATRON

daas
NORTH CAROLINA
Division of Aging and Adult Services

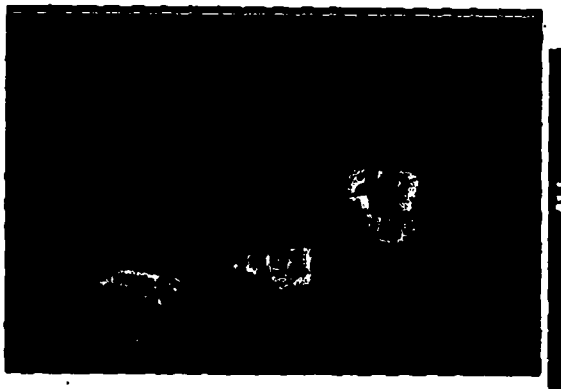
STATE FINALS PLATINUM

BlueCross BlueShield of North Carolina

4603 Western Blvd. Raleigh, NC 27606 (919)851-5456 www.ncseniorgames.org

SPORTS

Individuals compete for awards in their own SEX and AGE CATEGORY within five year increments. (55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94, 95-99, 100+).



Archery - Badminton - Basketball Shooting
Basketball Tournament - Billiards - Bocce - Bowling -Cornhole
Croquet - Cycling - Field Events - Football Throw - Golf - Horseshoes
Racquetball - Shuffleboard - Softball Throw - Softball Tournament
Spin Casting - Swimming - Table Tennis - Tennis - Track Events

The *2012 NCSG Official Rules Book* is available on our website or from your Local Coordinator.

Each year, over 60,000 seniors across the state of North Carolina enjoy participating in a **LOCAL SENIOR GAME.** Those who qualify at their Local Game are invited to attend **STATE FINALS** each fall. State Finals Entry Forms are available on our web site and from Local Games Coordinators and must be received by NCSG by August 1st.

Every two years, some State Finals winners qualify to represent North Carolina at the **NATIONAL SENIOR GAMES.**

State Finals 2012, will be a qualifying event for the 2013 National Senior Games in Cleveland, Ohio.

Local Senior Games

State Finals

National Senior Games Association

National Senior Games

CHEERLEADERS

Were you a cheerleader in your younger days or did you want to be? Don't let your pom-poms gather dust in the closet - come out and get people excited about Senior Games! Cheer on your local participants all the way to State Finals and perform at the Cheerleader Showcase.

SilverStriders

SilverStriders is N.C.'s national award winning walking program for people 50 years of age and better. Participants receive a log book for tracking progress, gifts and awards. Most Local Games offer a *SilverStriders* Fun Walk which qualifies participants for the State Finals Fun Walk. Contact NCSG or your Local Coordinator for a FREE log book.

Visit www.ncseniorgames.org for:

Details on each Local Games * Results & Records * Rules Book * State Finals Information * NCSG Ambassadors * NCSG Staff & Board of Directors * Sponsors & Contributor Information * Coordinating & Endorsing Agency links and much more!

SilverArts

A Celebration of the Creative Spirit

LITERARY ARTS

Essays... Short Stories (fiction)...
Life Experiences... Poetry

PERFORMING ARTS

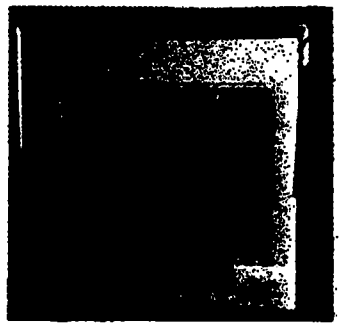
Comedy/Drama... Dance...Vocal...
Instrumental...Line Dance

VISUAL ARTS

Acrylics... Drawing... Mixed Media...
Oil... Pastels... Photography...
Sculpture... Watercolor

HERITAGE ARTS

Basketweaving...China Painting...Crocheting...Jewelry...
Knitting... Needlework...Pottery (thrown & hand built)...
Quilting (hand & machine)... Rugs (hooked, braided,woven)...
Stained Glass...Tole/Decorative Painting...Tatting & Needlelace...
Weaving...Woodcarving...Woodturning...Woodworking



SILVERARTS BOOKLET

A copy of the *2012 SilverArts Booklet* (with details and rules) is available on our web site or from your Local Coordinator.

GRAND PATRON

daas
NORTH CAROLINA
Division of Aging and Adult Services

STATE FINALS PLATNIUM SPONSOR

BlueCross BlueShield of North Carolina

STATE FINALS GOLD SPONSOR

Humana.

State Finals Silver Sponsors

Harrah's Cherokee Casino & Hotel
UNC HEALTH CARE

State Finals Bronze Sponsor

[redacted]

PREMIER HOST AGENCY

Raleigh Parks & Recreation Department

PLATINUM HOST AGENCY

Cary Parks, Recreation & Cultural Resources Dept.

COORDINATING AGENCIES

N.C. Recreation and Park Association
NCSU Dept. of Parks, Recreation and Tourism Management
N.C. Association on Aging
N.C. Association of Area Agencies on Aging
Pope Army Air Field
AARP North Carolina

ENDORSING AGENCIES

Be Active NC • N.C. Arts Council • N.C. Medical Society • UNC Institute on Aging • N.C. Division of Public Health • N.C. Academy of Family Physicians • N.C. Alliance for Health, Physical Education, Recreation & Dance • N.C. Association of Senior Citizens Clubs • N.C. Cooperative Extension Service • President's Council on Physical Fitness and Sports • Carolinas Center for Medical Excellence • National Recreation & Parks Association • N.C. Division of Parks & Recreation • N.C. DPI Division of Communication & Information • N.C. Extension & Community Association, Inc. • N.C. Retired Governmental Employees' Association • NCSU Division of Continuing Studies • Seniors Health Insurance Information Program (SHIIP) • N.C. Dental Hygiene Association • N.C. Dental Society Committee on Aging

Volunteer for a Local Game or State Finals!

Invite your family and friends to join you cheering, scoring, timing or giving awards. Our volunteers report that they have a great time and are inspired to be more healthy!

Visit our web site to volunteer today www.ncseniorgames.org

2012 LOCAL SENIOR GAMES

Contact the Local Coordinator in your area to find out how you can be a part of Senior Games. Email addresses and other Local Games details are at www.ncseniorgames.org.

LOCAL GAME	LOCATION	DATES	LOCAL COORDINATOR	TELEPHONE #
**Alamance Burlington Sr Games	Burlington	April 11-May 5	Jane Smith	336-222-5135
Albemarle Sr Games	Hertford, Eliza Cty,Pasqtnk & Prqmns	TBA	Lynne Raisor	252-426-5753
Asheville-Buncombe Sr Games	Asheville	May 14-19	Dee Black	828-350-2051
Blue Ridge Sr Games	N. Wilkesboro	April-May	Heather Barnes	336-838-3991
Brunswick Co Gator Sr Games & SilverArts	Brunswick Co.	April 11-May 10	Khrystye Haselden	910-253-2677
Cabarrus Sr Games	Concord	April 7-May 19	Mike Murphy	704-920-3484
Carteret Co Sr Games	Morehead City	April 12- May 4	Darlene Austin	252-504-4263
Caswell Senior Games	Yanceyville	May 8-30	Donna Kopec	336-694-7447
Charlotte-Mecklenburg Sr Games	Charlotte	April 10-June 2	H C Woody Woodward	704-365-1014
Chatham Co Sr Games	Pittsboro, Siler City	April 19-27	Lindsay Hickling	919-542-4512
*Cherokee Co Sr Games	Cherokee Co	May 6-9	Jim Bent	828-835-3202
*Cleveland Co Sr Games	Cleveland Co.	April 16-20	Lisa Abernethy	704-484-5491
Davie Co Sr Games	Mocksville	April	Sandra Boyette	336-751-2325
Down East Sr Games	Wilson	April 30-May 11	Lesia Davis	252-399-2286
*Durham Co Sr Games	Durham	April 14-28	Jonathan Embler	919-354-2710
Gaston Co SR Games	Dallas	March 19-April 16	Mike Hotze	704-922-2163
Greater Greensboro Sr Games	Greensboro	April 1-May 11	Don Tilley	336-375-2237
Greater High Point Sr. Games	High Point	April 30-May 22	Tina Boston	336-883-3584
**Greenville-Pitt Co Sr Games	Greenville	April 10-May3	Alice Keene	252-902-1984
**Four Seasons Sr Games	Hendersonville	May 1-15	Bridgette Galloway	828-697-4884
Haywood Co Sr Games	Waynesville	May 7-25	Scot Worley	828-452-6789
High Country Sr Games	Boone	May 18-June 9	Holly Gates	828-264-9511
**Iredell Sr Games	Statesville	May 11-26	Daniel Lewis	704-878-3429
**Johnston Co Sr Games	Johnston Co.	April 16-27	Larry Bailey	919-553-5777
Land Of Waterfalls Sr Games	Brevard	April 24-May 14	Rick Pangle	828-884-3156
Lumber River Sr Games	Pembroke	April 23-May 1	Kristen Locklear	910-272-5060
acon Co Sr Games	Franklin	April 20-May 19	Sarah Richardson	828-349-2090
ilison Co Sr Games	Mars Hill	April 14-11	John Hough	828-689-5728
cDowell Co Sr Games	Marion	April 17-May 17	Cheryl Woody	828-652-8953
Mid Carolina Sr Games	Fayetteville	April 11-26	Tracy Davis	910-323-4191
*Neuse River Sr Games	New Bern	April 18-April 27	Johanne Pryor	252-745-5252
**Onslow Sr Games	Jacksonville	April 10-28	Rick Perry	910-347-5332
Orange Co Sr Games	Orange Co.	March 31-May16	Corina Riley	919-968-2080
Piedmont Plus Sr Games	Winston Salem	April 12-20	Chuck Vestal	336-727-2325
**Raleigh Wake Sr Games	Raleigh, Cary, Garner	April 2-18	Steve White	919-831-6851
Randolph Co Sr Games	Asheboro	April 14-May 17	Jonathan Sermon	336-626-1240
*Region K Sr Games	Frnkln,Grnvle, Prsn,Vnc, Wrn	March 29-May 17	Shaaron Reynolds	252-492-8623
Rockingham Co Sr Games	Rockingham Co.	April 26-May 11	Cheryl Albrecht	336-548-9572
Rutherford Co Sr Games	Rutherford	April 16-30	Barbara Hill	828-287-6413
Salisbury Rowan Sr Games	Salisbury	April 16-May 8	Phyllis Loflin-Kluttz	704-216-7780
*Scotland Co Sr Games	Laurinburg	April 27-May 11	Kisha Williams	910-369-0686
Smoky Mountain Sr Games	Sylva	April 30-May 18	Dora Caldwell	828-293-3053
Sr Games & Silverarts Of Lee Co	Sanford	May 15-25	Jimmy Solomon	919-776-0501
Sr Games by the Sea	New Hanover & Brunswick Co	April 16-May 4	John Rancke	910-343-3682
**Sr Games In The Pines	Moore Co.	April 20-May 12	Rynet Oxendine	910-692-7376
Sr Games of Richmond Co	Richmond Co	April 16-May 3	Pete Wheeler	910-206-2224
**Thom Dav Lexington Sr Games	Thomasville, Lexington	April 16-27	Rodney Queen	336-474-2755
**Unifour Senior Games	Hkry, Lenoir, Mrgnton,Tylrsvle	April 20-May 18	Steve Jones	828-324-1200
**United Senior Games	Monroe	May 1-25	Hank Baucom	704-2824657
Uwharrie Sr Games	Albemarle, Troy	April 28-May 18	Oliver Webster	704-984-9562
**Wayne Co Sr Games	Goldsboro	April 30-May 4	Stasia Fields	919-739-7486
Yadkin Valley Sr Games	Surry/Yadkin	May	Celena Watson	336-401-8477

**Indicates "Determined on a case by case basis" as to geographical eligibility. *Indicates Closed Game - only accepts participants from their geographical area.

North Carolina Senior Games
4603 Western Blvd, Raleigh, NC 27606
(919) 851-5456
www.ncseniorgames.org

For Information about your Local Senior Games:

Senior Games—Better than EVER!

2011

NORTH CAROLINA Senior Games

North Carolina Senior Games is the oldest, largest, and arguably best health promotion organization for adults 55 years of age and better in the country. In the fall of 2010, a random sample was conducted by mailing and emailing 1,127 surveys to Local Senior Games participants in North Carolina, which resulted in a 36% response rate with 408 usable surveys. This report describes who the respondents were, why they participated, and what they believed the outcomes of their involvement were. The purpose of the evaluative research, conducted in partnership with the Department of Parks, Recreation, and Tourism Management at North Carolina State University, was to assist Local Games and the statewide Senior Games program with information to enhance program development and marketing.

Outcomes

Ways that people identified changing as a result of participation in North were considered outcomes.

- Almost 79% indicated that training and preparation for participation in Senior Games is part of their regular weekly activity.
- 67% indicated that their participation in Senior Games has *motivated them to be more* physically active and 66% more socially active.

Respondents indicated the extent to which their experience with Senior Games changed them in the following ways (% indicates *Increased Some* or *Increased A Lot)*

Meet More People	86%
Good Feelings About Life	78%
Self-Esteem	71%
Energy Level	64%
Physical Strength	57%
Heart and Lung Functioning	55%
Shape/Physique	50%

In Comparison to Previous Years:

Similar studies were conducted in 2003 and in 2007. Results indicated that the demographic profile of respondents has remained similar throughout the years.

- Since 2003, even fewer respondents have ever thought about stopping their participation in Senior Games (16% in 2003 and only 12% 2011).
- In 2011 more respondents (79%) indicated training and preparation for Senior Games is part of their weekly activity than in 2007 (73%).
- Finally, Senior Games is motivating respondents to be more physically active (67% said so in 2011 and 61% in 2007)!

66% of NCSG respondents said that in general their health is Excellent or Very Good.

The health of NCSG respondents was much better than the state average! This question was compared to the National Center for Chronic Disease Prevention and Health Promotion (Behavioral Risk Factor Surveillance System—BRFSS) data. These data reported 2009 health status for all adults including a 55-64 age group and a 65+ age group. The question was, "Would you say that in general your health is..."

Age	Excellent	Very Good	Good	Fair	Poor
Senior Games: 55-94 years	**20.6%**	**45.7%**	29.2%	4.2%	0.3%
BRFSS: 55-64 years	17.1%	33.1%	30%	13.4%	5.3%
BRFSS: 65+ years	11.6%	27.9%	34.7%	17.7%	7%

88% have never thought about stopping their participation in Senior Games!

Reasons for thinking about stopping participation mostly related to health reasons such as memory loss, arthritis, emphysema, loss of energy, injuries, and other medical conditions.

98% would recommend participating in Senior Games to friends and family!

Demographics of Respondents

- Age of respondents ranged from 55 year to 94 years, with an average of **71.6** years.
- 51% were female and 49% were male.
- A majority of respondents were retired (79%) with 12% full-time employed, and 9% part-time employed.
- 46% were college graduates and 30% completed some college including community college, Jr. college, or technical school, 20% were high school graduates, 4% completed less than high school.
- 81% identified themselves as White, 12% and as Black or African American, 3% as American Indian or Alaska Native and less than 1% as Asian American. Less than 1% were of Hispanic or Latino origin.
- 74% were married/partnered, 14% were widowed, 7% were single, and 5% were divorced.

Participation Information

Respondents got information about Senior Games from:	
Senior Center	61%
Recreation Dept.	39%
E-mail from Senior Games	38%
Friend/Family member	36%
Senior Games Web-site	27%
Newspaper	17%
Senior Games Ambassador	17%
Council on Aging	8%
Senior Club	8%
Facebook	1%

Other responses included: YMCA, assisted living activities' center director, word of mouth, coach/ teacher, senior living magazines

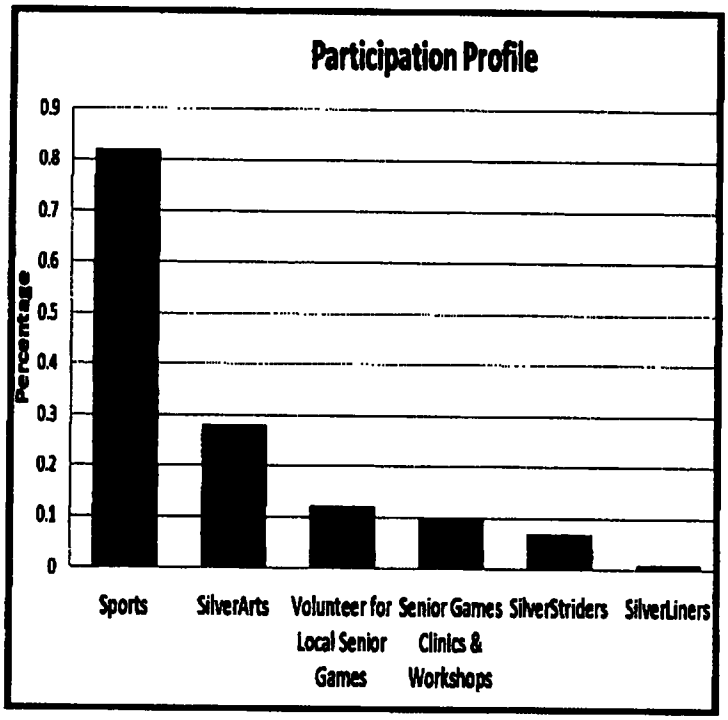
Percentage Indicating IMPORTANT Reasons for Participating in Senior Games	
Fun	98%
Keep Active	97%
Fitness	91%
Friendships	90%
Improving Health	87%
Feel Younger	87%
Fellowship/Social Opportunities	86%
Live Longer	85%
Competition	85%
Self-Esteem	84%
Creative Expression	64%
Doctor's Recommendation	40%

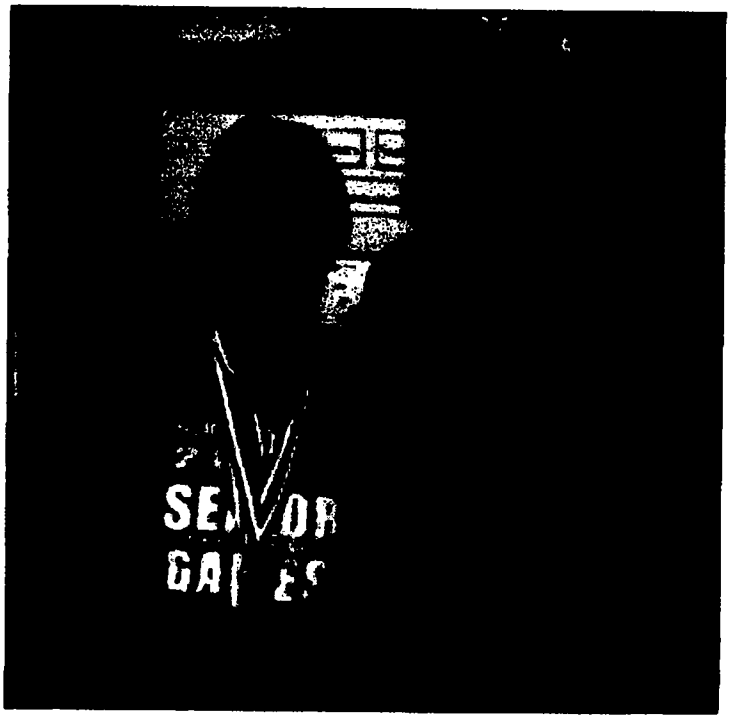
"Senior Games has kept me involved in sports which I have enjoyed all my life. The games have also afforded me the opportunity to meet people from all over the state. To meet as well as watch the participants is most heart warming, enjoyable, and inspiring."

~Anonymous

"It's an exciting opportunity for an amateur watercolorist to be able to compete with others who have my same interests. It also has encouraged me to participate in other aspects of the Senior Games. It revived my enthusiasm for my painting."

~Anonymous





Conclusions

- The majority of NCSG respondents were in **good to excellent health.** Although the cause and effect between participation and health cannot be made, all research would suggest that the more physically and socially active individuals are, the more successful the aging process. **The NCSG respondents reported their health status was better than that of the general NC population of older adults.** Respondents attributed about 5 hours each week to physical activity associated with training for NCSG. This amount of activity is **DOUBLE** the recommendations given by the Centers for Disease Control for optimal health.

- Respondents who said that training and preparation for Senior Games is a **regular weekly activity** and those who said that NCSG helped them be both socially and physically active saw greater benefits and outcomes. These findings emphasize the value of the **year round community-based** nature of NCSG.

- About 3 out of 4 (75%) respondents said that meeting more people, feeling good about life, and self-esteem were increased because of involvement in Senior Games. Three out of 4 respondents also said that training and preparing for Senior Games is a **regular weekly activity.**

- The number one reason why respondents participated in NCSG is for **FUN!** Ninety-eight out of 100 respondents agreed. This reason was followed closely by keeping active and fit and for social friendships. These reasons have been consistently expressed in previous studies.

- North Carolina Senior Games is "better than ever" regarding the important reasons and outcomes that older adults attributed to their involvement in sports, physical activity, and cultural arts. Data collected in 2010 were similar to the high satisfaction found in the previous surveys. Further, almost all respondents would **recommend** NCSG to others.

- About half the respondents were **women.** Many women of Senior Games age did not have opportunities for sport participation in their younger years. Therefore, NCSG provides a special, healthy opportunity for women's physical involvement. Women indicated that social, health, doctor's recommendation, and creative expression were more important to them than men indicated. Competition was much more important as a reason for participation for men than women.

- Respondents with a **high school education or less** said that the reasons were more important and outcomes were greater than for any other respondents with some college or a college degree. NCSG is an important opportunity for people who may not have had the opportunities to develop leisure skills that higher education often brings.

- Four out of 5 (80%)respondents in NCSG were involved with sports. Over a quarter were involved in SilverArts. A number of respondents did sports as well as other activities such as SilverArts, Silver-Striders, Silverliners, volunteering for Senior Games, and attending NCSG sponsored clinics and workshops. Individuals who did sports PLUS another activity had higher scores on reasons for participating as well as outcomes than did individuals who did sports only. NCSG appears to meet many interests and needs of older adults.

Prepared by Karla Henderson and Liana Dern. North Carolina State University Department of Parks, Recreation, and Tourism Management
This research funded by a grant from the Blue Cross and Blue Shield of North Carolina Foundation

North Carolina Senior Games

North Carolina Senior Games
Summary Statistics-May 2012
(475 Participants from 5 Games Responded)

Reasons for Participating in NC Senior Games

	Average[1]	Standard Deviation[2]	Percent that said *Important* or *Very Important*
Keep Active	4.86	.432	99%
Fun	4.85	.410	99%
Friendships	4.76	.536	98%
Fitness	4.76	.538	98%
Improving Health	4.76	.560	97%
Feel Younger	4.73	.631	96%
Live Longer	4.72	.638	95%
Fellowship/Social Opportunities	4.69	.611	97%
Self-Esteem	4.58	.795	93%
Competition	4.48	.887	91%
Creative Expression	4.40	.934	87%
Doctors' Recommendation	3.94	1.231	71%

[1]Based on 5-point scale with 5=Very Important to 1=Very Unimportant
[2]Standard deviation is an indication of the spread of scores. The closer to .00 the more agreement among answers based on this scale.

Motivation and Participation

- 86% said that training and preparing for NC Senior Games was a **part of their weekly activities.**
- 84% said that their participation in NC Senior Games motivated them to be **more physically active.**
- Over half said they were active at least **4.5 hours** a day BECAUSE of NC Senior Games.
- 90% said that participating in NC Senior Games motivated them to be **more socially active.**

Perceived Change BECAUSE of NC Senior Games

	Average[1]	Standard Deviation	Percent that said had *increased a lot* or *increased some*
Met More People	3.68	.574	93%
My Good Feelings about my Life	3.54	.682	90%
My Energy Level	3.47	.716	88%
My Self-Esteem	3.43	.739	86%
My Health	3.35	.787	85%
My Heart and Lung Functioning	3.38	.761	84%
Less Tension and/or Stress	3.34	.816	83%
My Physical Strength	3.32	.755	84%
My Stress Physique	3.26	.785	81%

[1]Based on 4-point scale with 4=increased a lot, 3=increased some, 2-did not increase or decrease, 1=decreased

Characteristics of the Respondents

- The **average number** of years that respondents had participated in NC Senior Games was 7 years.
- The **average age** of respondents was 70 years.
- The respondents were **63%** women and **37%** men.
- The respondents included **51%** White **45%** African American, **3%** American Indian, **.5%** Hispanic, and **.5%** Asian American

Health of Respondents

- 52% considered their health to be *very good* or *excellent.*
- 38% considered their health to be *good.*
- 10% considered their health to be *poor* or *fair.*

Prepared by Kelly McFadden & Karla Henderson, North Carolina State University

North Carolina Senior Games

Albemarle Senior Games
Summary Statistics—May 2012
(105 Participants Responded)

Reasons for Participating in NC Senior Games

	Average[1]	Standard Deviation[2]	Percent that said *Important* or *Very Important*
Fun	4.89	.409	99%
Keep Active	4.87	.334	100%
Friendships	4.85	.387	99%
Fitness	4.79	.457	98%
Fellowship/Social Opportunities	4.77	.595	97%
Feel Younger	4.76	.586	97%
Improving Health	4.75	.516	96%
Live Longer	4.72	.709	92%
Self-Esteem	4.66	.697	94%
Competition	4.63	.784	93%
Creative Expression	4.60	.731	92%
Doctors' Recommendation	4.08	1.285	77%

[1] Based on 5-point scale with 5=Very Important to 1=Very Unimportant
[2]Standard deviation is an indication of the spread of scores. The closer to .00 the more agreement among answers based on this scale.

Motivation and Participation

- 83% said that training and preparing for NC Senior Games was a **part of their weekly activities.**
- 82% said that their participation in NC Senior Games motivated them to be **more physically active.**
- Over half said they were active at least **5 hours** a day BECAUSE of NC Senior Games.
- 96% said that participating in NC Senior Games motivated them to be **more socially active.**

Perceived Change BECAUSE of NC Senior Games

	Average[1]	Standard Deviation	Percent that said had *Increased a lot* or *Increased some*
Met More People	3.74	.545	93%
My Good Feelings about my Life	3.67	.571	95%
My Energy Level	3.55	.624	93%
My Self-Esteem	3.52	.659	91%
Less Tension and/or Stress	3.48	.717	91%
My Heart and Lung Functioning	3.44	.715	89%
My Physical Strength	3.44	.704	90%
My Health	3.39	.709	87%
My Sleep/Insomnia	3.34	.758	87%

[1] Based on 4-point scale with 4=increased a lot, 3=increased some, 2-did not increase or decrease, 1=decreased

Characteristics of the Respondents

- The **average number** of years that respondents had participated in NC Senior Games was 7 years.
- The **average age** of respondents was 72 years.
- The respondents included **66%** women **and 34%** men.
- The respondents included **60%** White, **38%** African American, **1%** Hispanic, and **1%** Asian American.

Health of Respondents

- 45% considered their health to be *very good* or *excellent.*
- 43% considered their health to be *good.*
- 12% considered their health to be *poor* or *fair.*

Prepared by Kelly McFadden & Karla Henderson, North Carolina State University

North Carolina Senior Games

Durham Senior Games
Summary Statistics—May 2012
(26 Participants Responded)

Reasons for Participating in NC Senior Games

	Average[1]	Standard Deviation[2]	Percent that said *Important* or *Very Important*
Keep Active	4.96	.204	100%
Fun	4.92	.277	100%
Live Longer	4.89	.381	100%
Doctors' Recommendation	3.82	1.368	73%
Improving Health	4.75	.737	92%
Creative Expression	4.73	.533	96%
Friendships	4.73	.458	100%
Feel Younger	4.72	.542	96%
Fitness	4.67	.761	92%
Self-Esteem	4.62	.752	93%
Fellowship/Social Opportunities	4.60	.577	96%
Competition	4.58	.902	93%

[1] Based on 5-point scale with 5=Very Important to 1=Very Unimportant

[2] Standard deviation is an indication of the spread of scores. The closer to .00 the more agreement among answers based on this scale.

Motivation and Participation

- 96% said that training and preparing for NC Senior Games was a **part of their weekly activities.**
- 75% said that their participation in NC Senior Games motivated them to be **more physically active.**
- Over half said they were active at least **8 hours** a day BECAUSE of NC Senior Games.
- 83% said that participating in NC Senior Games motivated them to be **more socially active.**

Perceived Change BECAUSE of NC Senior Games

	Average[1]	Standard Deviation	Percent that said had *Increased a lot* or *Increased some*
Met More People	3.65	.573	95%
My Energy Level	3.55	.671	93%
My Heart and Lung Functioning	3.50	.673	89%
Less Tension and/or Stress	3.45	.671	91%
My Physical Strength	3.41	.796	90%
My Good Feelings about my Life	3.38	.824	95%
My Health	3.41	.796	87%
My Self-Esteem	3.35	.885	91%
My Shape/Physique	3.32	.839	87%

[1] Based on 4-point scale with 4=increased a lot, 3=increased some, 2-did not increase or decrease, 1=decreased

Characteristics of the Respondents

- The **average number** of years that respondents had participated in NC Senior Games was 7 years.
- The **average age** of respondents was 70 years.
- The respondents included **65%** women and **35%** men.
- The respondents included **60%** White, **38%** African American, **1%** Hispanic, and **1%** Asian American.

Health of Respondents

- 34% considered their health to be *very good* or *excellent.*
- 62% considered their health to be *good.*
- 4% considered their health to be *poor* or *fair.*

Prepared by Kelly McFadden & Karla Henderson, North Carolina State University

North Carolina Senior Games

Greenville-Pitt County Senior Games
Summary Statistics--May 2012
(113 Participants Responded)

Reasons for Participating in NC Senior Games

	Average[1]	Standard Deviation[2]	Percent that said *Important* or *Very Important*
Fun	4.88	.328	100%
Keep Active	4.87	.333	100%
Friendships	4.83	.405	99%
Fitness	4.80	.403	100%
Live Longer	4.75	.549	97%
Improving Health	4.73	.524	96%
Feel Younger	4.72	.860	97%
Fellowship/Social Opportunities	4.69	.653	95%
Self-Esteem	4.55	.800	93%
Competition	4.51	.810	93%
Creative Expression	4.22	1.064	80%
Doctors' Recommendation	3.74	1.229	57%

[1] Based on 5-point scale with 5=Very Important to 1=Very Unimportant
[2]Standard deviation is an indication of the spread of scores. The closer to .00 the more agreement among answers based on this scale.

Motivation and Participation

- 84% said that training and preparing for NC Senior Games was a **part of their weekly activities.**
- 87% said that their participation in NC Senior Games motivated them to be **more physically active.**
- Over half said they were active at least **5 hours** a day BECAUSE of NC Senior Games.
- 94% said that participating in NC Senior Games motivated them to be **more socially active.**

Perceived Change BECAUSE of NC Senior Games

	Average[1]	Standard Deviation	Percent that said had *Increased a lot* or *Increased some*
[illegible]	[illegible]	[illegible]	[illegible]
My Good Feelings about my Life	3.49	.686	90%
[illegible]	[illegible]	[illegible]	[illegible]
My Energy Level	3.34	.770	84%
[illegible]	[illegible]	[illegible]	[illegible]
My Heart and Lung Functioning	3.27	.834	81%
[illegible]	[illegible]	[illegible]	[illegible]
My Physical Strength	3.20	.809	81%
[illegible]	[illegible]	[illegible]	[illegible]

[1] Based on 4-point scale with 4=increased a lot, 3=increased some, 2-did not increase or decrease, 1=decreased

Characteristics of the Respondents

- The **average number** of years that respondents had participated in NC Senior Games was 8 years.
- The **average age** of respondents was 70.5 years.
- The respondents were equally divided between **men and women.**
- The respondents included **70%** White and **30 %** African American.

Health of Respondents

- 59% considered their health to be *very good* or *excellent.*
- 33% considered their health to be *good.*
- 8% considered their health to be *poor* or *fair.*

Prepared by Kelly McFadden & Karla Henderson, North Carolina State University

North Carolina Senior Games

Mid-Carolina Senior Games
Summary Statistics—May 2012
(142 Participants Responded)

Reasons for Participating in NC Senior Games

	Average	Standard Deviation	Percent that said *Important* or *Very Important*
Fun	4.85	.466	99%
Keep Active	4.84	.478	99%
Improving Health	4.77	.584	97%
Fitness	4.74	.619	97%
Feel Younger	4.69	.690	94%
Friendships	4.68	.687	96%
Fellowship/Social Opportunities	4.67	.661	97%
Live Longer	4.67	.713	93%
Self Esteem	4.49	.905	90%
Competition	4.47	.952	90%
Creative Expression	4.28	1.043	82%
Doctors' Recommendation	3.87	1.278	69%

[1] Based on 5-point scale with 5=Very Important to 1=Very Unimportant
[2]Standard deviation is an indication of the spread of scores. The closer to .00 the more agreement among answers based on this scale.

Motivation and Participation

- 84% said that training and preparing for NC Senior Games was a **part of their weekly activities.**
- 83% said that their participation in NC Senior Games motivated them to be **more physically active.**
- Over half said they were active at least **5 hours** a day BECAUSE of NC Senior Games.
- 86% said that participating in NC Senior Games motivated them to be **more socially active.**

Perceived Change BECAUSE of NC Senior Games

	Average[1]	Standard Deviation	Percent that said had *increased a lot* or *increased some*
Met More People	3.62	.579	95%
My Good Feelings about my Life	3.54	.690	90%
My Energy Level	3.45	.694	88%
My Heart and Lung Functioning	3.40	.717	87%
My Self-Esteem	3.39	.740	86%
My Health	3.35	.699	87%
Less Tension and/or Stress	3.32	.812	81%
My Physical Strength	3.30	.761	82%
My Shape/Physique	3.25	.807	77%

[1] Based on 4-point scale with 4=increased a lot, 3=increased some, 2-did not increase or decrease, 1=decreased

Characteristics of the Respondents

- The **average number** of years that respondents had participated in NC Senior Games was 7 years.
- The **average age** of respondents was 70 years.
- The respondents were **57%** women and **43%** men.
- The respondents included **46%** White, **40%** African American, **10%** American Indian, **2%** Hispanic, and **2%** Asian American.

Health of Respondents

- 53% considered their health to be *very good* or *excellent.*
- 34% considered their health to be *good.*
- 13% considered their health to be *poor* or *fair.*

Prepared by Kelly McFadden & Karla Henderson, North Carolina State University

North Carolina Senior Games

Region K Senior Games
Summary Statistics-May 2012
(89 Participants Responded)

Reasons for Participating in NC Senior Games

	Average[1]	Standard Deviation[2]	Percent that said *Important* or *Very Important*
Keep Active	4.80	.609	98%
Improving Health	4.77	.588	98%
Feel Younger	4.75	.641	98%
Live Longer	4.75	.643	98%
Fitness	4.73	.563	99%
Fun	4.72	.450	100%
Friendships	4.72	.586	98%
Fellowship/Social Opportunities	4.61	.626	97%
Self Esteem	4.58	.725	96%
Creative Expression	4.40	.846	92%
Competition	4.25	.931	89%
Doctors' Recommendation	4.19	.972	79%

[1]Based on 5-point scale with 5=Very Important to 1=Very Unimportant
[2]Standard deviation is an indication of the spread of scores. The closer to .00 the more agreement among answers based on this scale.

Motivation and Participation

- 92% said that training and preparing for NC Senior Games was a **part of their weekly activities.**
- 84% said that their participation in NC Senior Games motivated them to be **more physically active.**
- Over half said they were active at least **3 hours** a day BECAUSE of NC Senior Games.
- 92% said that participating in NC Senior Games motivated them to be **more socially active.**

Perceived Change BECAUSE of NC Senior Games

	Average[1]	Standard Deviation	Percent that said had *increased a lot* or *increased some*
Met More People	3.74	.640	92%
My Energy Level	3.51	.805	85%
My Good Feelings about my Life	3.50	.745	86%
My Self-Esteem	3.49	.766	84%
My Health	3.38	.775	84%
My Physical Strength	3.36	.737	86%
Less Tension and/or Stress	3.35	.783	81%
My Heart and Lung Functioning	3.35	.812	80%
My Sleep Patterns	3.25	.811	78%

[1]Based on 4-point scale with 4=increased a lot, 3=increased some, 2-did not increase or decrease, 1=decreased

Characteristics of the Respondents

- The **average number** of years that respondents had participated in NC Senior Games was 5 years.
- The **average age** of respondents was 69.5 years.
- The respondents were **80%** women and **20%** men.
- The respondents included **61%** African American, **35%** White, **2%** American Indian, and **1%** Biracial.

Health of Respondents

- 47% considered their health to be *very good* or *excellent.*
- 35% considered their health to be *good.*
- 8% considered their health to be *poor* or *fair.*

Prepared by Kelly McFadden & Karla Henderson, North Carolina State University

Statistical and Demographic Information (Including Number of Persons Served and Counties) (C)

There are 53 Local Senior Games programs (some are multi-county entities) that serve all 100 counties in our state. This is the largest program of its' type in the United States. Some of the Local Games are very small, while others are very large and offer exercise classes, practice events and SilverArts competitions all year long. Below is a summary of year-round participation:

Alamance-Burlington Senior Games:	875
Albemarle Senior Games:	672
Asheville Buncombe Senior Games:	303
Blue Ridge Senior Games:	405
Brunswick Gator Senior Games:	953
Cabarrus County Senior Games:	2356
Carteret County Senior Games:	589
Caswell County Senior Games:	166
Charlotte Mecklenburg Senior Games:	1634
Chatham County Senior Games:	172
Cherokee County Senior Games:	566
Cleveland County Senior Games:	488
Davie County Senior Games:	418
Down East Senior Games:	1277
Durham Senior Games:	1368
Four Season Senior Games:	338
Gaston County Senior Games:	348
Greater Greensboro Sr. Games:	1375
Greater High Point Sr. Games:	542
Greenville-Pitt Senior Games:	5338
Haywood County Senior Games:	1182

High Country Senior Games:	602
Iredell County Senior Games:	361
Johnston County Senior Games:	369
Land of Waterfalls Senior Games:	1443
Lumber River Senior Games:	1203
Macon County Senior Games:	651
Madison County Senior Games:	43
McDowell County Senior Games:	537
Mid-Carolina Senior Games:	1958
Neuse River Senior Games:	5763
Onslow County Senior Games:	422
Orange County Senior Games:	551
Outer Banks Senior Games:	1318
Piedmont Plus Senior Games:	1396
Raleigh-Wake Senior Games:	3028
Randolph County Senior Games:	838
Region K Senior Games:	876
Rockingham County Senior Games:	1598
Rutherford County Senior Games:	1693
Salisbury-Rowan Senior Gams:	5750
Scotland County Senior Games:	388
Senior Games By the Sea:	715
Senior Games in the Pines:	316
Senior Games of Lee Co.:	3599
Senior Games of Richmond Co.:	1171

Smoky Mountain Senior Games:	418
Thomasville-Davidson-Lexington:	505
Unifour Senior Games:	1605
United Senior Games:	821
Uwharrie Senior Games:	973
Wayne Co. Senior Games:	2156
Yadkin Valley Senior Games:	1088

Detailed Program Budget and List of Expenditures

Including All Positions Funded and Funded Sources

And Matching Resources (D)

The attached document (D) outlines all budgeted line items for North Carolina Senior Games and the matching resources for each category. A full audit is available upon request.

2012 NCSG Budget (D)

	Revenue Categories	**436,405**	
	Individual Contributions	**20,000**	
	Sponsor Contributions	**100,000**	
	Legislative Appropriation	**121,000**	
	Program Fees	**190,000**	
	Reimbursements	**3,000**	
	Investment Interest	**1,405**	
	Merchandise Sales	**1,000**	
	Expense Categories	**436,405**	
Personnel (Salaries/Wages):		**254,095**	
	President/Executive Director	70,380	
	Associate Director	57,371	
	Sports/IT Coordinator	46,332	
	Special Project Consultant	38,352	
	Administrative Coordinator	33,660	
	Part-Time	8,000	
Employee Benefits:		**36,344**	
	Health Insurance:	**17,980**	
	President/Exec Director	3,192	
	Associate Director	4,972	
	Sports/IT Coordinator	2,532	
	Special Project Consultant	7,284	
	Other Benefits:	**18,364**	
	Life/Disability	1,000	
	SEP (4%)	10,164	
	HSA Benefit	7,200	
Employer Taxes		**17,400**	
Office		**18,800**	
	Telephone	3,500	
	Maintenance	400	
	Supplies	500	
	Printing/Copying	0	
	Accounting	3,100	
	Fees	6,000	
	Postage	100	
	Furniture and Equipment	500	
	Insurance	1,800	
	Utilities	2,900	
Board of Directors		**800**	
Public Relations		**100**	
Local Games		**34,200**	
	Games Allowance	19,000	
	Travel	1,000	
	Gifts/Recognitions	500	
	Food	750	
	Telephone	1,000	
	Lodging	300	
	Supplies	500	
	Fees/Memberships	1,000	

	Printing/Copying	6,000	
	Publications/Videos	400	
	Postage	250	
	Contractual Services	3,500	
	Furniture and Equipment	0	
State Finals		**74,666**	
	SF Awards	**7,200**	
	Postage	200	
	Supplies	7,000	
	SF Ceremonies	**700**	
	SF Coordination	**6,100**	
	Telephone	0	
	Postage	0	
	Food	50	
	Gifts/Awards	250	
	Insurance	4,800	
	Printing/Copying	0	
	Travel	600	
	Lodging	0	
	Supplies	400	
	SF Events	**36,016**	
	Postage	0	
	Printing/Copying	1,200	
	Travel	700	
	Lodging	1,000	
	Food	2,066	
	Supplies	1,800	
	Rent	24,000	
	Gifts/Awards	250	
	Contract Services	5,000	
	Equipment	0	
	SF Facilities	**1,900**	
	Travel	200	
	Lodging	400	
	Food	100	
	Supplies	200	
	Rent	1,000	
	Printing/Copying	0	
	SF Hospitality	**2,000**	
	SF Medical Services	**1,000**	
	SF Registration	**9,900**	
	Telephone	0	
	Postage	2,000	
	Printing/Copying	1,700	
	Supplies	2,000	
	Refunds	4,100	
	Insurance	100	

	SF SilverArts	**4,900**	
	Printing/Copying	200	
	Food	50	
	Supplies	50	
	Rent	4,100	
	Gifts/Awards	300	
	Travel/Lodging	200	
	SF Support Services	**5,000**	

NORTH CAROLINA

SENIOR GAMES 2013

North Carolina Senior Games began in 1983 with a vision to create a year-round health promotion and wellness education program for adults 55 years of age and better. Senior Games is a program to keep the body, mind and spirit fit while enjoying the company of friends, family, spectators and volunteers.

FITNESS

FAMILY

FELLOWSHIP

FUN

FRIENDS

LOCAL SENIOR GAMES

There are over 60,000 participants statewide in 53 Local Games that serve all 100 counties across the state.

SILVERARTS

NCSG's Heritage, Visual, Performing, Literary Arts and Cheerleader programs

SILVERSTRIDERS

NCSG's national award winning walking program

SILVERLEGACIES

NCSG's planned giving and endowment program

GRAND PATRON

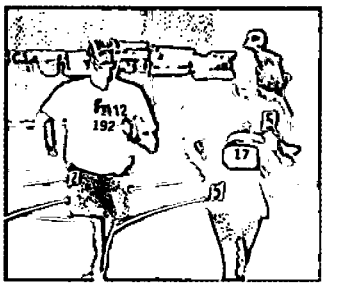
daas
NORTH CAROLINA
Division of Aging and Adult Services

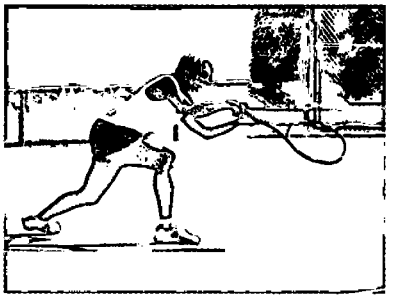
STATE FINALS PLATINUM SPONSOR

BlueCross BlueShield of North Carolina

4603 Western Blvd., Raleigh, NC 27606 (919)851-5456 www.ncseniorgames.org

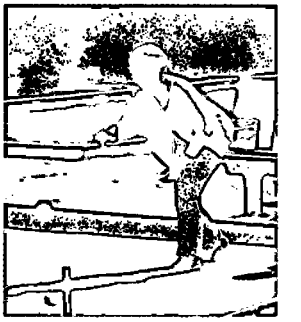
SPORTS

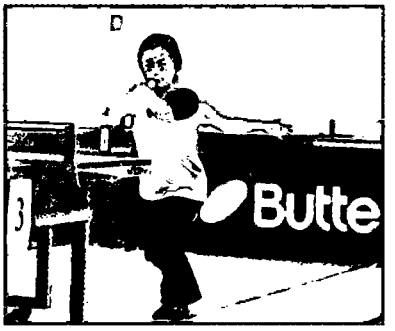




Archery, Badminton, Basketball Shooting, Basketball Tournament, Billiards, Bocce, Bowling, Cornhole, Croquet, Cycling, Shot Put, Discus, Standing and Running Long Jumps, Football Throw, Golf, Horseshoes, Racquetball, Shuffleboard, Softball Throw, Softball Tournament, Spin Casting, Swimming, Table Tennis, Tennis, Track Events

Individuals compete for awards in their own gender and age category within five year increments (55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94, 95-99, 100+). The 2013 *NCSG Official Rules Book* is available on our website or from your Local Coordinator.





SENIOR GAMES STATE FINALS

each fall is for qualifiers from 53 Local Games who register by August 1st.

September 23-29, 2013
Cary/Raleigh

Softball Tournament
September 9-12
Walnut Creek Softball Complex, Raleigh

Bocce & Cornhole Tournaments
October 8-9, Clayton

Golf Tournament
October 8-9, Winston-Salem

Basketball Tournament
TBD, East Carolina University, Greenville

LOCAL SENIOR GAMES

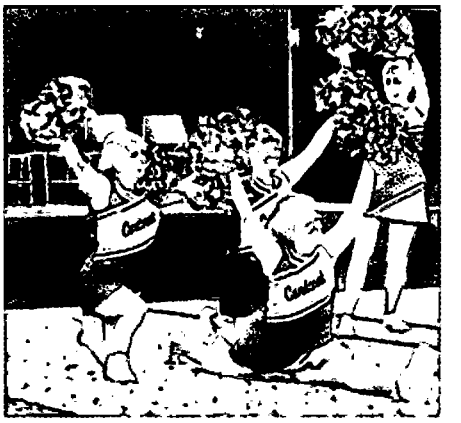
Participants compete in 53 Local Games programs each spring.

NATIONAL SENIOR GAMES

is offered every two years for State Finals qualifiers. State Finals 2012 was the qualifying event for the 2013 National Senior Games in Cleveland, Ohio.

CHEERLEADERS

Have fun and motivate others! Come out and get people excited about Senior Games! Cheer on your local participants all the way to State Finals and compete at the State Finals Cheerleader Showcase!



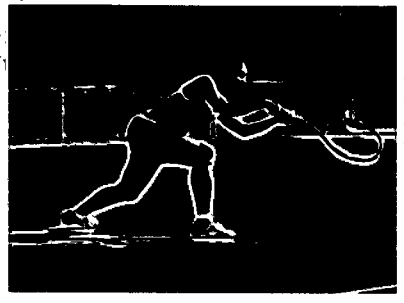
VOLUNTEER for a Local Games or State Finals and enjoy the fun, fitness, family and fellowship that is Senior Games. Visit our website for more details.

North Carolina Senior Games

Our Mission:
To create a year round health promotion and education program for adults 55 years of age and better.

NCSG, Inc. 4603 Western Blvd Raleigh NC 27606 www.ncseniorgames.org

PROGRAM IMPACT



- Through 53 Local Games serving all 100 counties in our state – the largest number of Local Games programs in the nation – over 60,000 participants actively pursued "healthy aging" in the year-round programs.

- In a statewide survey, funded by the Blue Cross Blue Shield of North Carolina Foundation, participants reported that Senior Games is "better than ever" regarding the social and physical outcomes of participation. Senior Games continues to motivate regular weekly physical activity.

- Findings from research on Senior Games grandchildren's perception of aging completed in 2011 support the need for community based intergenerational programs that foster meaningful relationships between generations through joint participation in physical and leisure activities. More specifically, how children perceived older adults primarily in terms of personality, physical characteristics, and activities. Children perceived their own aging as similar to their grandparent's current lifestyle instead of media and cultural stereotypes when influenced by a Senior Games participant.

- Research data from the 2009 State Finals volunteers showed that individuals value their investment of time in Senior Games. Volunteers had been volunteering an average of 7 years, although 1/3 were volunteering for the first time. Respondents indicated they had spent an average of almost 13 hours volunteering for State Finals.

- People of all ages and backgrounds continue to benefit from the "Fun, Fitness, Family, Fellowship and Friends" of Senior Games! Over 5,000 volunteers helped to support the statewide network of Local Games and State Finals.

Bill Finch in 800m Run

- William "Bill" Finch (101 yrs old), Greenville, says he uses Senior Games, "to keep my weight down. Someone else my age (101!) might weigh over 200 lbs., but I run and play badminton every week because of Senior Games and have been able to stay in good shape." At State Finals 2012, Finch established the gold standard in the 1500 Meter Run in the 100+ age group with a time of 17:11.75 and earned a Gold Medal in Badminton Singles.

- Judy Barton of the Wake County Fabulous 70's women's basketball team explains, "We practice every week. We play in the Local Games, State Finals and Nationals. And in between that, we play in tournaments. We've traveled all over the United States." The Fabulous 70's not only challenge the perception of the elderly, but also stand as a testament to the underlying fact that females are interested in sports and they can thrive in athletics.

- The Hoopers 80+ women's basketball team from Sampson Co. have won 6 consecutive state titles and been to the National Senior Games on several occasions. They can be found every Tuesday and Wednesday in Clinton, working out and practicing their skills on the court.

- When asked what Senior Games means to her Greenville participant Jessie McDonald, said "I look forward to participating every day. Senior Games has kept me in good shape and kept me healthy. I never thought I would live this long."

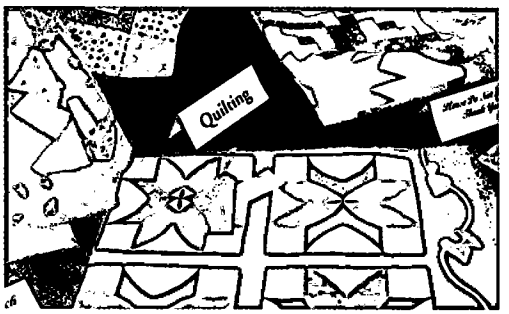
- Nance Mize, long time volunteer from ECU, describes her involvement with Senior Games as "a wonderful journey into health, fitness, commitment and mentoring from thousands of older adults as competitors, as well as hundreds of caring and giving people throughout the state as volunteers. This journey continues for me, now in my fourth year as a competitor, and I sincerely hope that I can give back as much to this program as it continues to give to me and my life."

"I thought to myself, I don't have time to be sick. I have so many things left to do and so many people that I want to help get active and healthy that I just have to beat this thing! Senior Games was the ultimate prescription for my recovery. I knew I had to return to our cheerleading group with vigor and energy...And I did, too!"
Dr. Louise Gooche after receiving a cancer diagnosis

- Sheila Rademacher, Auxiliary Programs Coordinator from Raleigh said "Senior Games puts things in perspective. Regardless of how old we get, it's not something to fear, you can grow old gracefully and still truly be as active as you want to be. A participant told me 'winning the race was not the greatest accomplishment of the day, it was living to be his age so that he could compete in the race.'"

Silver Arts℠

A Celebration of the Creative Spirit



VISUAL ARTS
Acrylics
Drawing
Mixed Media
Oil
Pastels
Photography
Sculpture
Watercolor

PERFORMING ARTS
Comedy/Drama
Dance
Vocal
Instrumental
Line Dance

LITERARY ARTS
Essays
Short Stories (fiction)
Life Experiences
Poetry

HERITAGE ARTS
Basketweaving
China Painting
Crocheting
Jewelry
Knitting
Needlework
Pottery (thrown & hand built)
Quilting (hand & machine)
Rugs (hooked, braided; woven)
Stained Glass
Tole/Decorative Painting
Tatting & Needlelace
Weaving
Woodcarving
Woodturning
Woodworking

SILVERARTS BOOKLET with details and rules is available on our website or from your Local Coordinator.

STATEWIDE PARTNERS

Gold Sponsor

Humana

Silver Sponsors

Harrah's Cherokee Casino & Hotel

REX Unc Health Care

Bronze Sponsor

Genworth Financial

Platinum Host Agencies:

Cary Parks, Recreation & Cultural Resources Dept.

Raleigh Parks & Recreation Dept.

Coordinating Agencies

NC Recreation & Park Association
NCSU Department of Parks, Recreation & Tourism Management
NC Association on Aging
NC Association of Area Agencies on Aging
AARP North Carolina

Endorsing Agencies

NC Arts Council ~ NC Medical Society ~ UNC Institute on Aging ~ NC Division of Public Health ~ NC Academy of Family Physicians ~ NC Alliance for Health, Physical Education, Recreation & Dance ~ NC Association of Senior Citizens Clubs ~ NC Cooperative Extension Service ~ President's Council on Physical Fitness & Sports ~ Carolina's Center for Medical Excellence ~ National Recreation & Parks Association ~ NC Division of Parks & Recreation ~ NC DPI Division of Communication & Information ~ NC Extension & Community Association, Inc. ~ NC Retired Governmental Employees' Association ~ NCSU Division of Continuing Studies ~ Seniors' Health Insurance Information Program (SHIIP) ~ NC Dental Hygiene Association ~ NC Dental Society Committee on Aging

VISIT www.ncseniorgames.org for Local Games details, Results & Records, & more!!

2013 LOCAL SENIOR GAMES

Contact the Local Coordinator in your area to find out how you can be a part of Senior Games. Email addresses and other Local Games details are at www.ncseniorgames.org.

GAME	LOCATION	DATES	COORDINATOR	TELEPHONE
*Alamance Burlington Sr Games	Burlington	April 8-May 9	Jane Smith	336-222-5135
Albemarle Sr Games	Elizabeth City, Hertford, Camden	April 9-12	Lynne Raisor	252-426-5753
Asheville-Buncombe Sr Games	Asheville	May 21-25	Dee Black	828-259-5809
Blue Ridge Sr Games	Wilkesboro	May	Heather Barnes	336-838-3991
Brunswick Co Gator Sr Games & SilverArts	Bolivia, Shallotte, Supply, Southport, Winnabow, Ocean Isle	April 3-May 10	Khrystye Haselden	910-253-2677
**Cabarrus Sr Games	Concord, Kannapolis, Harrisburg, Mt. Pleasant	March 11-18	Susan Donaldson	704-920-3484
Carteret Co Sr Games	Morehead City	April 12-May 3	Darlene Austin	252-504-4263
*Caswell Senior Games	Yanceyville	April 30-May 21	Donna Kopec	336-694-7447
Charlotte Meck Sr Games	Charlotte	April 20-May 10	Jennifer Honaker	704-889-2255
Chatham Co Sr Games	Pittsboro, Siler City	April 16-26	Lindsay Hickling	919-542-4512
*Cherokee Co Sr Games	Murphy, Andrews	May 11-25	Jim Bent	828-835-3202
*Cleveland Co Sr Games	Boiling Springs, Shelby	April 15-19	Sharon Robbs	704-484-5491
Davie Co Sr Games	Mocksville	April	Sandra Boyette	336-751-2325
Down East Sr Games	Rocky Mount	April 29-May10	Julie Watson	252-972-1564
*Durham Co Sr Games	Durham	April 15-26	Jonathan Embler	919-560-4296
**Four Seasons Sr Games	Hendersonville	May 6-19	Bridgette Galloway	828-697-4884
**Gaston Co Sr Games	Gastonia	March 12- April 20	Mike Hotze	704-922-2163
*Greater Greensboro Senior Games	Greensboro	April 2-May 9	Jennie Matkins	336-375-2237
**Greater High Point Sr. Games	High Point	April 29-May 21	Tina Boston	336-883-3584
**Greenville-Pitt Co Sr Games	Greenville	April 9-24	Alice Keene	252-902-1984
Haywood Co Sr Games	Waynesville	May 6-21	Scot Worley	828-452-6789
High Country Sr Games	Boone	May 6-June 9	Holly Gates	828-264-9511
**Iredell Sr Games	Statesville	April 29-May 11	Daniel Lewis	704-878-3429
**Johnston Co Sr Games	Clayton, Selma, Benson, Smithfield	April 8-9	Larry Bailey	919-553-5777
Land of Waterfalls Sr Games	Brevard	April 24- May 17	Rick Pangle	828-884-3156
Lumber River Sr Games	Pembroke, Lumberton	April 22- May 3	Kristen Elk Maynor	910-272-5060
*Macon Co Sr Games	Franklin	April 22-May 14	Sarah Overton	828-349-2090
Madison Co Sr Games	Mars Hill	April 13	John Hough	828-689-5728
McDowell Co Sr Games	Marion	April 23-May 23	Cheryl Woody	828-652-8953
Mid Carolina Sr Games	Fayetteville	April 10-25	Tracy Davis	910-323-4191
*Neuse River Sr Games	New Bern	April 17-26	Johanne Pryor	252-745-5252
**Onslow Sr Games	Jacksonville	April 8-27	Rick Perry	910-347-5332
Orange Co Sr Games	Chapel Hill, Hillsborough, Carrboro	March 23-April 6	Dana Hughes	919-918-7372
*Outer Banks Sr Games	Kill Devil Hills	April 15-27	Brandi Rheubottom	252-475-5636
Piedmont Plus Sr Games	Winston-Salem	April 16-27	Chuck Vestal	336-727-2325
**Raleigh Wake Sr Games	Raleigh, Cary, Apex, Garner	April 1-20	Jody Jameson	919-469-4081
Randolph Co Sr Games	Asheboro	April 8-May 2	Jonathan Sermon	336-626-1240
*Region K Sr Games	Henderson	March 28-May 16	Shaaron Reynolds	252-492-8623
Rockingham Co Sr Games	Mayodan-Madison, Eden, Reidsville, Stoneville, Wentworth	April 23-May 10	Cheryl Albrecht	336-548-9572
Rutherford Co Sr Games	Spindale	April 12-26	Barbara Hill	828-287-6413
Salisbury Rowan Sr Games	Salisbury	April 10-May 9	Phyllis Loflin-Kluttz	704-216-7780
*Scotland Co Sr Games	Laurinburg	April 26-May 9	Kisha Williams	910-369-0686
Smoky Mountain Sr Games	Cullowhee	April 29-May 10	Dora Caldwell	828-293-3053
Sr Games & Silverarts Of Lee Co	Sanford	May 14-24	Jimmy Solomon	919-776-0501
Sr Games by the Sea	Wilmington	April 2-May 20	John Rancke	910-343-3682
**Sr Games in the Pines	Southern Pines, Aberdeen, Pinehurst	April 15-May 4	Leigh Baggs	910-944-7275
Sr Games of Richmond Co	Hamlet, Rockingham	April 15-May 2	Pete Wheeler	910-206-2224
**Thom Dav Lexington Sr Games	Thomasville, Lexington	April 22-26	Rodney Queen	336-474-2755
**Unifour Senior Games	Hickory, Morganton, Taylorsville, Lenoir	April1 19-May 17	Steve Jones	828-324-1200
**United Senior Games	Monroe	April 15-May 24	Hank Baucom	704-2824657
Uwharrie Sr Games	Albemarle, Troy	April 278-May 17	Oliver Webster	704-984-9562
**Wayne Co Sr Games	Goldsboro	April 30-May 4	Stasia Fields	919-739-7486
Yadkin Valley Sr Games	Elkin, Mt. Airy, Dobson, Pilot Mountain, Yadkinville	May 6-31	Celena Watson	336-401-8477

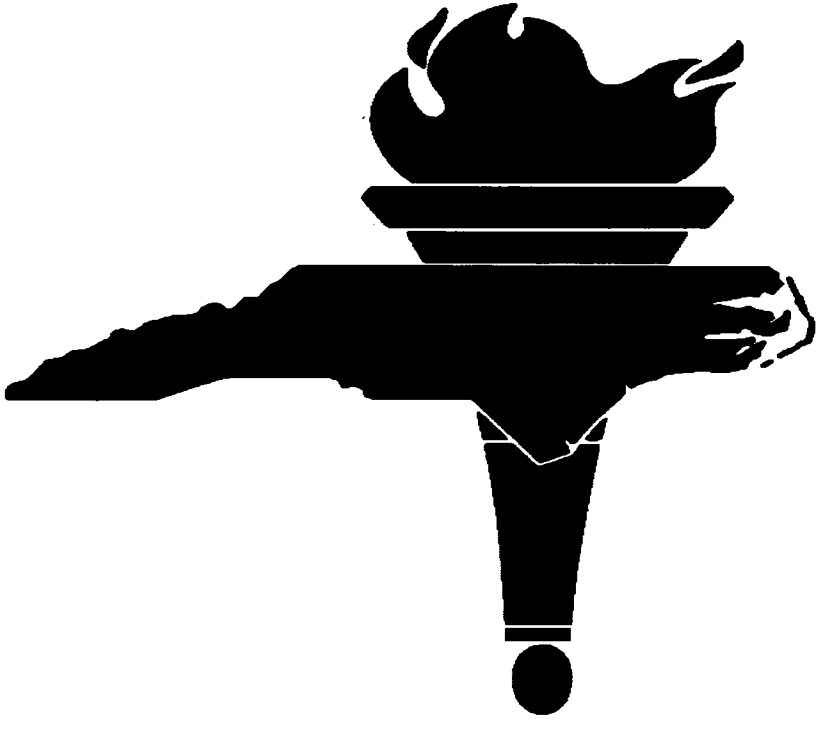
*Indicates closed game - only accepts participants from their geographical area. **Indicates determined on a case-by-case basis as to geographical eligibility.

North Carolina Senior Games
4603 Western Blvd., Raleigh, NC 27606
919-851-5456
www.ncseniorgames.org

For information about your Local Senior Games:

Joint House and Senate HHS Appropriations Subcommittee

NORTH CAROLINA
Senior Games



Services and Target Population

- Founded in 1983 as an extension of the Division of Aging's statewide effort to provide health promotion and disease prevention services for persons 55 and better;
- Consumer-directed, year-round health and wellness programs in 53 Local Senior Games serving all 100 counties in North Carolina;
- Year-round programs include exercise classes, walking clubs, wellness workshops, individual and team athletic events and the SilverArts.

Public-Private Partnership

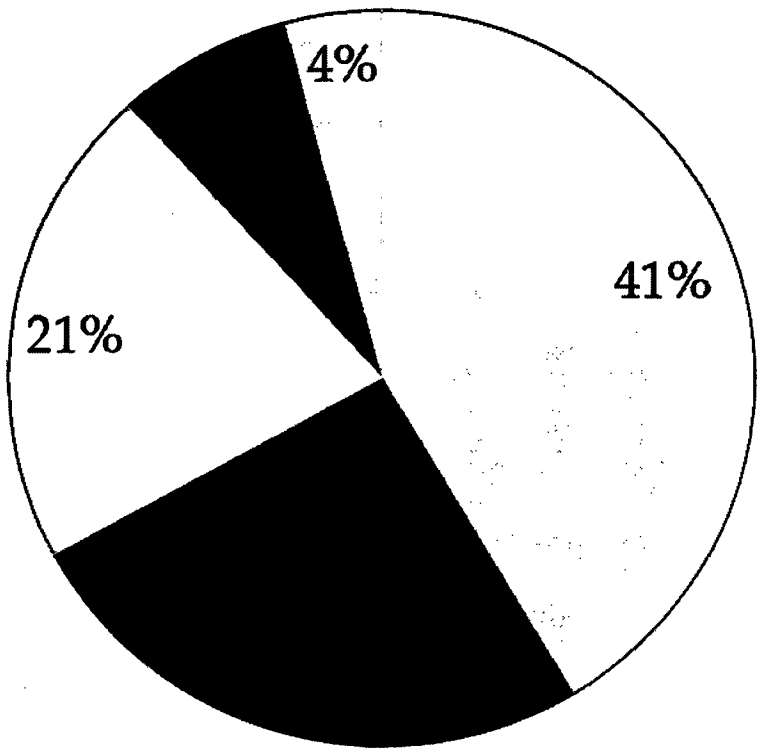
- North Carolina Senior Games is the largest health promotion program of its' type in the United States and has received national recognition for programming and service for older adults;

- There are six (6) major coordinating agencies, twenty-two (22) endorsing agencies, fifty-three (53) local host agencies and over 5,000 volunteers statewide;

- In 2012, Senior Games served 65,520 persons, ranging in age from 55 to 104. 45% Men, 55% Women.

Total Operating Budget

Total: $473,405



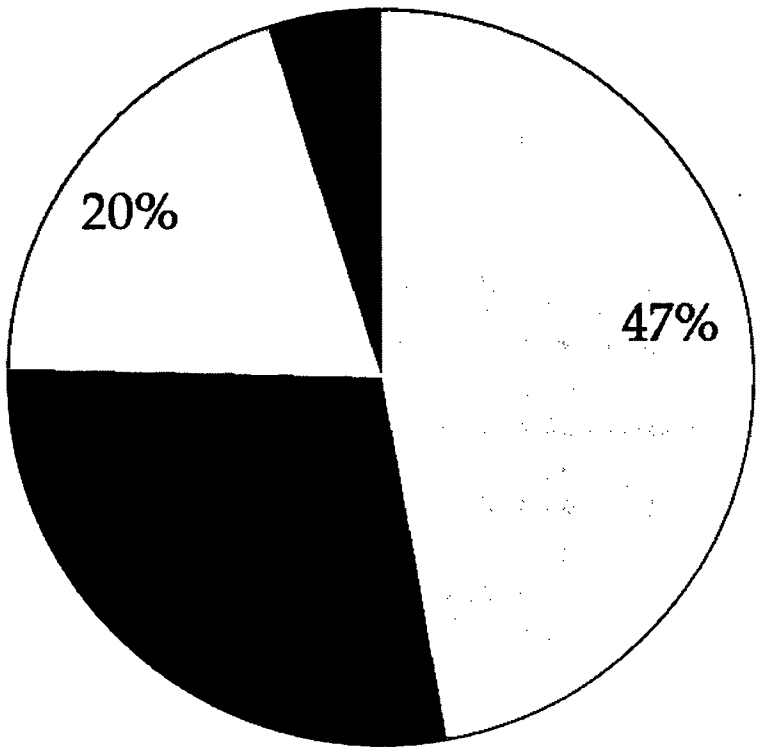
- Program Fees (195,924)
- Legislative Appropriation (121,481)
- Corporate Sponsorship (100,000)
- In-Kind Contributions (36,000)
- Individual Contributions (20,000)

Stewardship of Resources

- Local Senior Games programs generated $380,520 in 2012;
- Across the state, with the investment of $121,481 of state funds, Senior Games leveraged an additional $732,444;
- In summary, for every single dollar that the state invested, Senior Games leveraged $6 of additional resources.

Legislative Appropriation

Total: $121,481



- Local Games Training & Support (57,371)
- Local Games Programs (34,200)
- State Finals Programs (23,910)
- Administration (6,000)

Research and Outcomes

- Researchers at NC State University have conducted evaluative research of perceived benefits and outcomes of Senior Games participation for over a decade;
- In 2011 and 2012, **80%** of participants indicated that training and preparation for participation in Senior Games is **part of their regular weekly activity**;
- **67%** indicated that their participation in Senior Games has motivated them to be more **physically active**;
- **66%** revealed that Senior Games helps them to be more socially active.

Research and Outcomes

- The population of North Carolina is aging at a significant pace, as we all know;
- A comparison of studies in 2007 and 2011 reveals that more respondents in 2011(79%) indicated training and preparation for Senior Games is part of their weekly activity than in 2007 (73%);
- Further, the research reveals that Senior Games is providing an important service that motivates respondents to be more physically active (67% in 2011 and 61% in 2007)!

Comparative Analysis

- The average annual cost of housing one (1) person in a skilled nursing facility is $69,360;

- $121,481 provides funding for 1.75 persons in a skilled facility for one year;

- For the same amount of funding, North Carolina Senior Games provides 65,520 consumers age 55 and greater a better opportunity to maintain a healthy, active lifestyle.

Additional Information

A full audit and/or additional information are available upon request:

Brad Allen, President and Executive Director
North Carolina Senior Games, Inc.
4603 Western Boulevard, Raleigh, NC 27606
(919) 851-5456
brad@ncseniorgames.org

ABC of NC Child Development Center

Mark Trogdon, Director
Fiscal Research Division
Suite 619, Legislative Office Building
Raleigh, North Carolina 27603

November 19, 2012

Dear Mr. Trogdon,

The enclosed report is being submitted to you based on instructions from our Contract Manager, Jalaine Moore. According to Ms. Moore, Session Law 2012-142, Section 10.19, states that we are required to submit our report directly to the NC General Assembly. The enclosed report details the activities of ABC of NC (Contract # 2030, Amendment 1) during the 2011/12 fiscal year.

Please contact me if you have any questions.

Sincerely,

Selene Johnson, M.Ed., BCBA
Executive Director

Encl.

CC: Jalaine Moore, Contract Manager
Sandy Ellsworth, Contract Administrator
The Honorable Louis Pate
The Honorable Marilyn Avila
The Honorable Justin Burr
The Honorable Nelson Dollar
The Honorable Harris Blake
The Honorable Stan Bingham
The Honorable Ralph Hise

ABC of NC Child Development Center
3904 Old Vineyard Road
Winston Salem, NC 27104
(336)251-1180 (o)
(336)251-1181 (f)

ABC of NC Child Development Center
(ABC of NC)
Program Summary FYE 06.30.12

Mission
ABC of NC is committed to providing quality individualized educational services based on evidence-based practices in the field of autism treatment to children with autism spectrum disorders and their families. We are committed to seeking funding from a variety of sources so that we can provide services to families from any economic background. We support each student in developing the skills and motivation necessary to be able to learn and thrive in the least restrictive setting possible.

Vision
The vision of ABC of NC is that all children with autism spectrum disorder reach their full potential through effective teaching.

Governance Structure
ABC of NC is governed by an unpaid board of directors which meets four times per year. The board of directors approves the annual budget; offers guidance on programmatic and development projects; and provides strategic planning oversight. The finance committee, a committee comprised of board members, guides the annual budgeting process and accounting policies and procedures. The executive director provides both administrative and programming oversight and reports directly to the chair of the board of directors. See the attached organizational chart.

Purpose
The purpose of the early intervention program is to provide early and intensive treatment/education to young children with or at risk for developing autism spectrum disorders and to transition them to less intensive and less restrictive programs, where they are more independent learners who require fewer supports.

Programs and Services
Each student enrolled in the early intervention program has an individualized education plan (IEP) in place by their second week of enrollment. Each IEP is based on pre-program assessments, the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), the Pictorial Infant Communication Scale (PICS), the Structured Play Assessment, developmental norms, and parent goals/concerns. IEPs includ measureable goals from a variety of skill domains, including: communication, social, and self-help/adaptive living.

During the 2011/12 fiscal year, the following programs and services were provided as part of the state-funded early intervention autism program:

1. *Intensive 1:1 instruction* (4 hours per day)
   These services are provided to students who are very early learners, either very young or having had little to no prior intervention. These students generally have significant delays in communication, play, and social skills, and may engage in aggressive, destructive, or self-injurious behaviors. Services are provided throughout the school year and the summer.
2. *Preschool inclusion class* (3 hours per day) plus intensive 1:1 instruction (1 hour per day)
   These services are provided to students who have early communication and play skills and need specialized instruction for social and group skill development, continued emphasis on language/communication goals, and ongoing focus on developing adaptive/coping skills. Children with neuro-typical development (i.e. students without developmental delays) are included in the class to provide appropriate peer models for language and play skills and to ensure opportunities for facilitation of social interaction/development of friendships.
3. *Self-contained group instruction* (6 hours per day)
   These services are provided to students who have transitioned into a self-contained classroom to continue focus on communication, group skills, and adaptive behaviors. These students are often more severely affected by autism and will likely transition into self-contained special education classrooms when they enter the public schools.
4. *Inclusive readiness class* (6 hours per day)
   These services are provided to students who have more advanced language/communication, play, and social goals, and whose behaviors are generally well managed. Children with neuro-typical development (i.e. students without developmental delays) are included in the class to provide appropriate peer models for language and play skills and to ensure opportunities for facilitation of social interaction/development of friendships. These students will likely transition into a typical preschool, readiness, or Kindergarten classroom upon exiting from the ABC of NC program.
5. *Inclusive summer program* (6 hours per day)
   All early intervention students, with the exception of those receiving 1:1 intensive instruction, attend the full summer program, which is an 8-week intensive program, which is also inclusive of neuro-typical peers.
6. *Step-down program* (weekly or monthly services)
   These low-intensity/low-frequency services are provided to students who are ready to transition from ABC of NC's more intensive services to their regular community-based schools. Students may receive services in a weekly after-school "Buddy Club," which focuses on more advanced social and communication skill development. They may also receive consultative services in a) the new school, for aiding in the transition, or b) in the home, with a focus on ongoing communication, social, or behavioral challenges.

As part of the early intervention program and in an effort to achieve best outcomes, parents/caregivers are heavily encouraged to participate in a variety of activities designed to promote their child's progress:

1. *Weekly parent education classes*
   On average, once per week, ABC of NC lead teachers and/or program supervisors led classes on a variety of topics such as "Reducing Problem Behaviors," "Toilet Training," "Increasing Vocalizations in Non-Vocal Children," etc. Classes were taught in small group format at a variety of times throughout the day in order to make it convenient for families to attend. Several classes were taught during the time that the students were in school so that the parent(s) had child care. Parents were encouraged to attend at least one class per month, but could attend as many classes as they wanted for no additional charges.
2. *Monthly parent observations*
   Parents were strongly encouraged to observe their child in school once per month. Parents could observe their child at school any time it was convenient and as often as they desired.
3. *Team meetings/home visits*
   Each student had a quarterly team meeting or home visit. During team meetings, the student's program supervisor and teaching team provided progress updates, presented analyzed data, updated IEP goals, and developed strategies for increasing the student's learning rate. Parent(s) were encouraged, but not required to attend. During home visits, the program supervisor and some members of the teaching team, worked with primary caregivers in the home to address communication, social, and behavioral issues. Parent(s) also had access to program supervisors and teachers via phone, e-mail, and face-to-face meetings.
4. *Parent-Teacher Collaborative (PTC)*
   Parents were encouraged to attend meetings of the PTC in order to have opportunities to network with each other and to meet and greet staff during after-school hours. Additionally, the president of the PTC hosted a Yahoo!-based list-serv for parents to post questions, comments, celebrations, and challenges to other parents and staff who were members of the PTC.
5. *Parent newsletter*
   At least six times throughout the year, parents received a parent newsletter updating them on happenings at ABC of NC. Included in the newsletter were reminders about parent education classes and dates, student celebrations, reports on ongoing staff training/conference attendance and explanations of ABC of NC teaching methods and strategies.
6. *Parent "Homework"*
   Parents were encouraged to work with their child on IEP goals at home and in the community in order to generalize the skills to other environments.

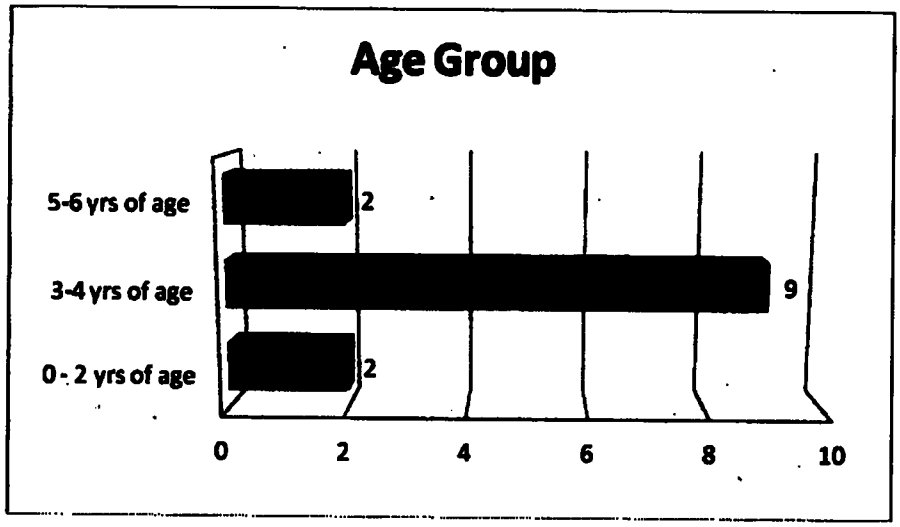
ABC of NC incorporates a variety of effective teaching strategies that are based on evidence-based practices as identified by the National Autism Center's National Standards Report and the National Professional Development Center on Autism as well

as "best practices" as identified by the 2001 National Research Council report on educating children with autism. Teaching strategies included, but were not limited to:

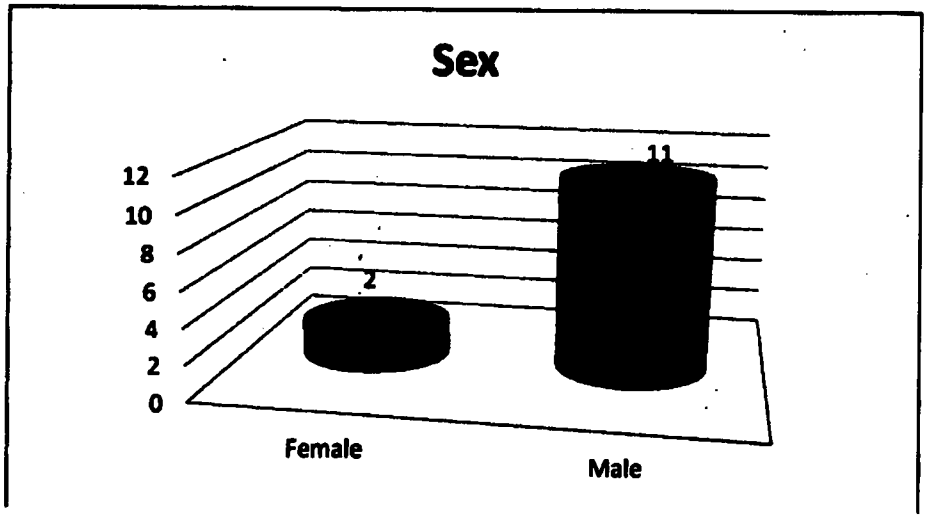
1. Focusing on functional communication early in the program.
   Functional communication included use of vocal communication (i.e. manding), augmentative communication (e.g. PECS) and sign language. Non-vocal communication included teaching students to initiate through gazing, reaching, or pointing; and teaching them to respond to more complex non-vocal communication such as non-vocal approval or following another's eye gaze.
2. Immersing the student in a language-rich environment.
   Teachers modeled functional and developmentally appropriate language to the students in natural environments by focusing on the students' motivation. Additionally, if language targets were challenging for the student, the teacher would present them in more structured table-based settings utilizing specialized teaching techniques such as discrimination training.
3. Using errorless teaching techniques (i.e. prompting for correct responses and fading prompts systematically).
4. Using positive consequences for correct responses and desired behaviors.
   Reinforcers for each student were identified and utilized to ensure student learning.
5. Including children with ASDs with neuro-typical peers, when appropriate.
   All children in the program had access to an on-site inclusive preschool class for up to four hours per day.
   a. Some students received small group instruction in an on-site inclusive preschool classroom for three hours daily in addition to one hour of 1:1 instruction each day.
   b. Other students received four hours per day of 1:1 instruction and were able to utilize the preschool inclusion class as much as needed based on recommendations made by their educational consultants.
6. Incidentally teaching in the child's natural environments.
   Classrooms were set up like typical preschool classrooms where children had access to a variety of developmentally appropriate toys and materials. Children were also exposed to a variety of group activities, including music, art, and drama classes each week as well as snack and lunch each day.
7. Using video modeling to show students appropriate behaviors from a variety of skill domains including, but not limited to, social, communication, play, self-help, and adaptive skills.
8. Using visual schedules, including pictures, symbols, or written words, to aid students in completing multi-step sequences such as self-help tasks or to communicate the daily schedule to students in order to target difficulties with transitions from one activity to the next.
9. Using story-based interventions individualized for each student or class, such as a social story describing the consequences for engaging in a particular desired or undesired behavior.

Student Demographics

1. ABC of NC served 13 students in the state-funded intensive early intervention program.
2. Age
   Because the program is designed to be an early intervention program, admission and "age-out criteria" have been developed to ensure that the program serves young children.
   a. New students could be no younger than 12 months and no older than 60 months (i.e. 5 years) at the time of admission into the program.
   b. Returning students (for the new fiscal year) could be no older than 66 months (i.e. 5.5 years) at the start of the fiscal year.

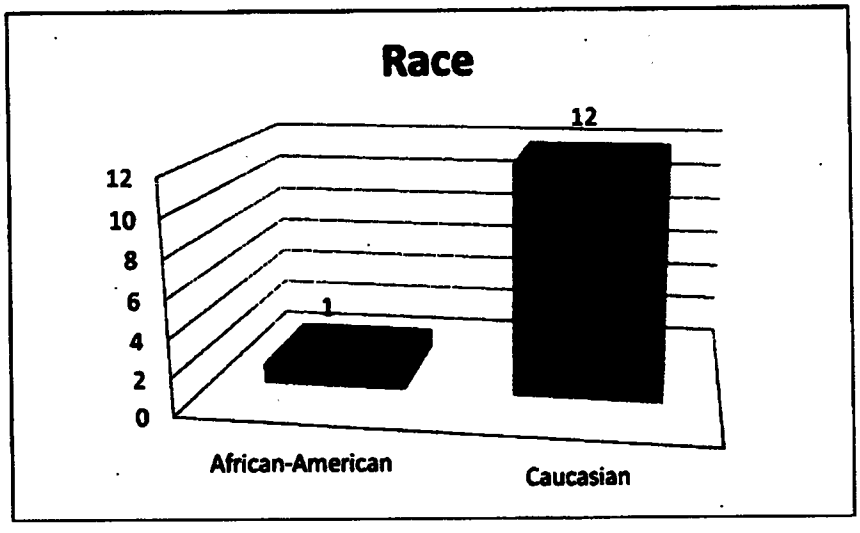


3. Sex
   Autism Spectrum Disorders are almost five times more common among boys (1 in 54) than among girls (Centers for Disease Control, 2012), reflected in the ABC of NC student population.



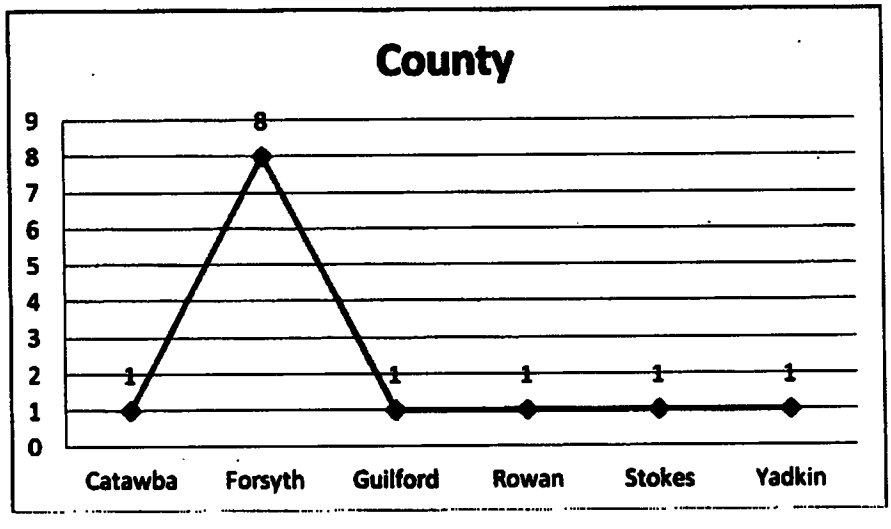
4. Race

Studies have shown that children of African American, Hispanic and Asian descent are less likely to receive an early diagnosis of autism than Caucasian children (Kennedy Krieger, 2012), and the ABC of NC early intervention student population reflects this. Only one non-Caucasian student applied for the early intervention program during this fiscal year. ABC of NC is in the process of opening a diagnostic clinic that will provide outreach to minority populations for assessment and evaluation.



5. Geographical Area

The early intervention program served students from six North Carolina counties.



Outcome Measures

ABC of NC conducts pre- and post-assessments annually on all students enrolled in center-based services. Outcome measures are based on results from these assessments, progress on IEP goals, and a final parent survey.

1. Pictorial Infant Communication Scale (PICS)
    a. Expectation: 80% of students will demonstrate improvement on at least 2 measures of the Pictorial Infant Communication Scales (PICS) or another modified joint attention assessment tool developed by a group of providers from across the state of North Carolina and based on the Early Social Communication Scales (ESCS).
    b. Results: 85% of students demonstrated improvement on at least 2 measures of the PICS. **MET**
2. Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
    a. Expectation: 80% of students will demonstrate improvement on at least 5 measures of the VB-MAPP.
    b. Results: 100% of students demonstrated improvement on at least 5 measures of the VB-MAPP. **MET**
3. Structured Play Assessment
    a. Expectation: 80% of students will increase at least 2 levels on the Structured Play Assessment.
    b. Results: 92% of students increased at least 2 levels on the Structured Play Assessment by demonstrating emergent skills of skills that were previously absent or mastery of skills that were previously only emerging. **MET**
4. Individualized Education Plan (IEP)
    a. Expectation: 80% of students will master at least 60% of all initial IEP goals.
    b. Results: 85% of students mastered 60% or more of their initial IEP goals. **MET**
5. Service Quality Measure
    a. Expectation: 90% of parents will report satisfaction with the program (based on surveys and/or other information-gathering methods).
    b. Results: 100% of respondents reported that they were "extremely satisfied" with the early intervention program when given choices of "extremely satisfied," "satisfied," "dissatisfied," or "extremely dissatisfied." **MET**

Budget Information

1. Detailed program budget/expenditures

Description	Budget	Expenditures
[redacted]	308,035.00	[redacted]
Office Supplies and Materials	2,950.00	[redacted]
Service Related supplies	1,500.00	[redacted]
[redacted]	4,450.00	[redacted]
Communications and Postage	4,875.00	[redacted]
Utilities	4,915.00	[redacted]
Repair and Maintenance	7,625.00	[redacted]
Advertising	500.00	[redacted]
[redacted]	17,915.00	[redacted]
Rent	32,390.00	[redacted]
Insurance and Bond	3,913.00	[redacted]
[redacted]	36,303.00	[redacted]
[redacted]	366,703.00	[redacted]

2. Detailed Personnel Chart

On average, nine teachers per month worked in the state-funded early intervention program. The personnel chart reflects those staff who worked in the program during the summer program (July-August) as well as the regular school year (August-June). Some staff who worked minimal hours in the program served as temporary summer staff or substitute teachers during staffing absences and changes.

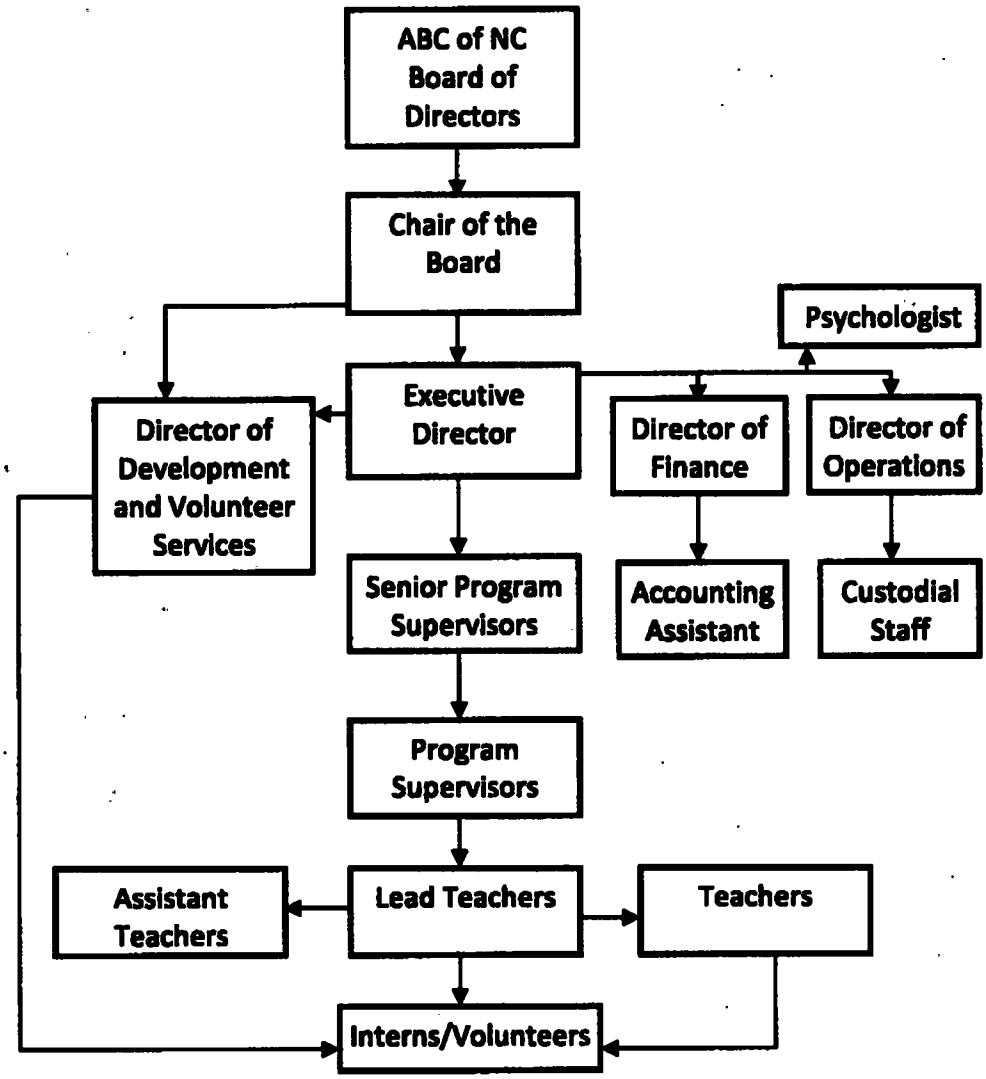
Program supervisors were responsible for writing each student's individualized education plan (IEP), teaching parent classes, conducting home-based trainings, and supervising teaching staff.

Employee Name	Position Title	[redacted]
Cindy Andree Bowen	Program Supervisor	
Elizabeth Donovan	Program Supervisor	
Stephanie Holladay	Program Supervisor	
Selene Johnson	Executive Director	
Angela Pesenti	Director of Finance	
Barbara Stockfish	Director of Operations	
Amy Vestal	Program Supervisor	
Andree-Bowen, Scott	Teacher	
Barclay, Alice	Teacher	
Bell, Lindsay	Teacher	
Carter-Jackson, Kristin	Lead Teacher	
Charles, Courtney	Teacher	
Charles, Daniel	Teacher	
Michael Errickson	Teacher	
Frank, Katie	Teacher	
Anne Gayle	Teacher	
Courtney Hall	Teacher	
Randilee Lucas	Assistant Teacher	

McClearen, Villa	Teacher	[redacted]
Shundra McLaurin	Teacher	
Jesse Nobles	Assistant Teacher	
Otwell, Meredith	Teacher	
Payton, Becky	Lead teacher	
Russell, Alex	Assistant Teacher	
Caira Smith	Teacher	
Smith-Murray, Ethan	Teacher	
Leigh Ellen Spencer	Lead Teacher	
Jennifer Whaley	Teacher	
Sara Beth White	Teacher	
Karen White	Teacher	
TOTAL		

3. Matching Funds
   Each family enrolled in the intensive early intervention program was required to pay a monthly tuition of $615.00. The total amount received in student tuition fees was $76, 961.00.

Organizational Chart



ABC of NC Child Development Center

Autism Early Intervention Model Program

Joint House and Senate HHS
Appropriations Subcommittee
February 20, 2013

Selene Johnson, M.Ed., BCBA
Executive Director

About ABC of NC

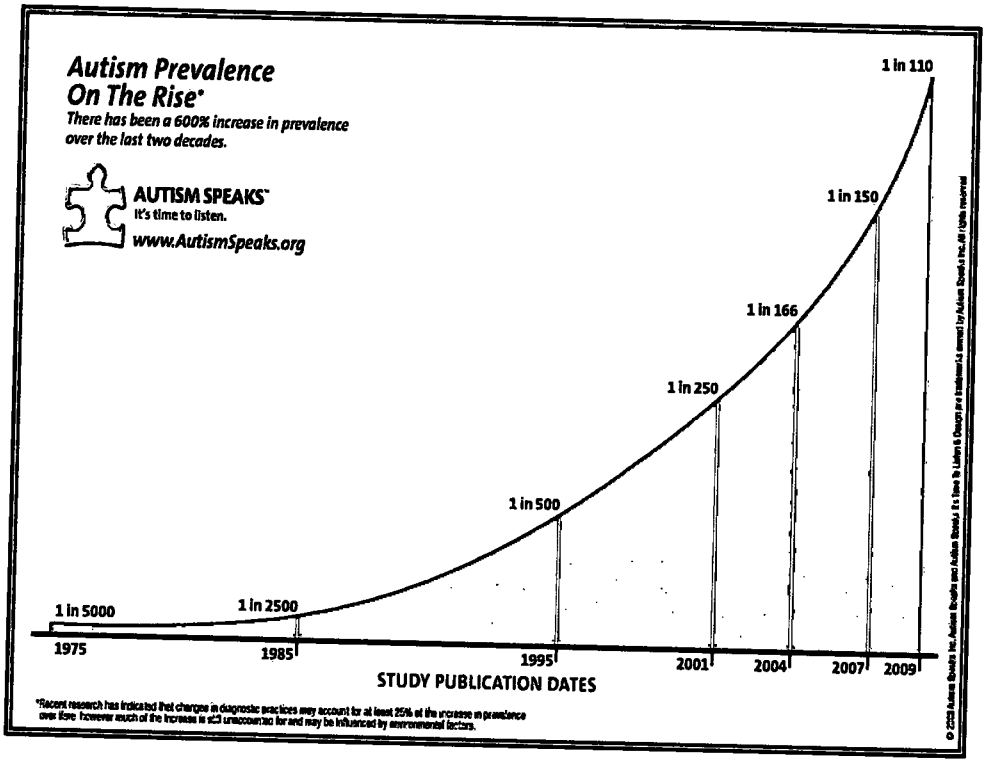
- Licensed non-public school in Winston Salem, NC
- Specialization in **autism spectrum disorders**
- Services for children preschool through age 21
- **Accredited** through AdvancEd and the Southern Association of Colleges and Schools (SACS-CASI)
- State-funded program provides **intensive early intervention** for 11-15 young children with autism per year

Mission

ABC of NC is committed to providing quality individualized educational services based on **evidence-based practices** in the field of autism treatment to children with autism spectrum disorders and their families. We are committed to seeking funding from a variety of sources so that we can **provide services to families from any economic background**. We support each student in developing the skills and motivation necessary to be able to learn and thrive in the **least restrictive setting** possible.

Autism Spectrum Disorder (ASD)

- A group of developmental disabilities that can cause significant social, communication and behavioral challenges
- Symptoms can range from mild to severe
- Autism affects **1 in 88** children
- ASDs are almost **5 times more common among boys** (1 in 54) than among girls (Centers for Disease Control, 2008)



Long-Term Savings

- The estimated lifetime societal cost of supports, services, and lost productivity for an adult with autism is **$3.2M** (Ganz, 2007).
- With early intensive behavioral intervention, the estimated **lifetime cost savings** can be $600,000 to $1M (Jacobsen, Mulick, & Green, 1998).

abc

Evidence-Based Interventions for Autism

- Studies have demonstrated that early intensive behavioral intervention (EIBI) can produce **substantial benefits** for many children with autism spectrum disorders
  (Dawson, et al., 2009; Jacobsen, Mulick, & Green, 1998; Lovaas, 1987; McEachin, Smith, & Lovaas, 1993; National Standards Report, 2009; U.S. Department of Health and Human Services, 1999)
- ABC of NC provides services based on evidence-based practices in the field of autism treatment and education, including EIBI

abc

State Program Student Outcomes

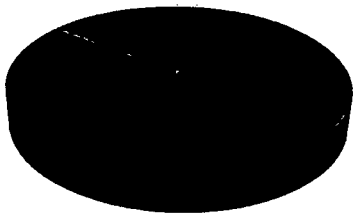
- Student outcome data are based on pre- and post-assessments on measures that address core autism deficits.
- ABC of NC has met all state program outcomes since the program's inception in 2007.

abc

2011/12 State Program Student Outcomes

85%

mastered 60% or more of their initial Individualized Education Plan goals



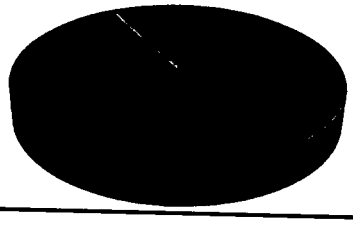
100%

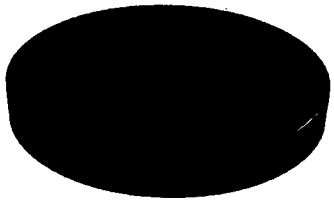
demonstrated improvement on the Verbal Behavior Milestones Assessment and Placement Program

2011/12 State Program Student Outcomes

92%

demonstrated improvement on the Structured Play Assessment





85%

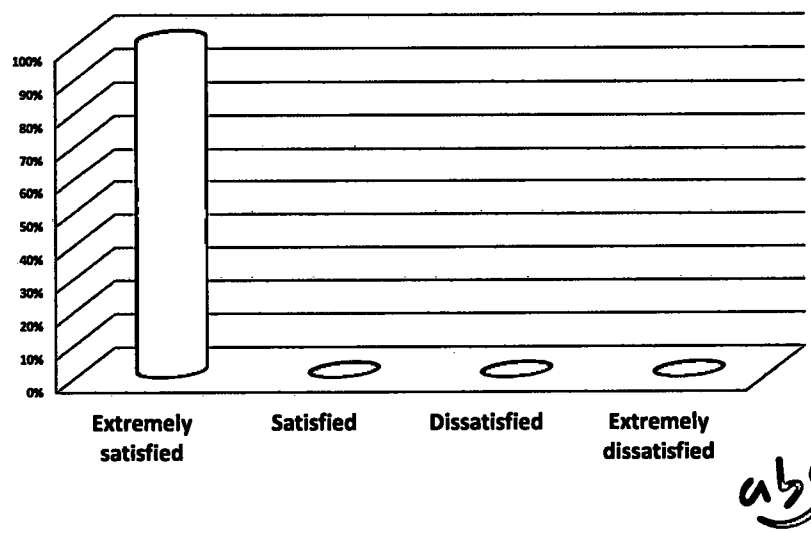
demonstrated improvement on the Pictorial Infant Communication Scales

Family Participation

- Research shows that best outcomes are achieved when families provide a consistent and supportive environment (National Research Council, 2001).
- ABC of NC parent activities include:
  - Weekly parent education classes
  - Team meetings and home visits
  - 100% open door policy for parent observations
- All families are required to pay a portion of their child(ren)'s tuition.

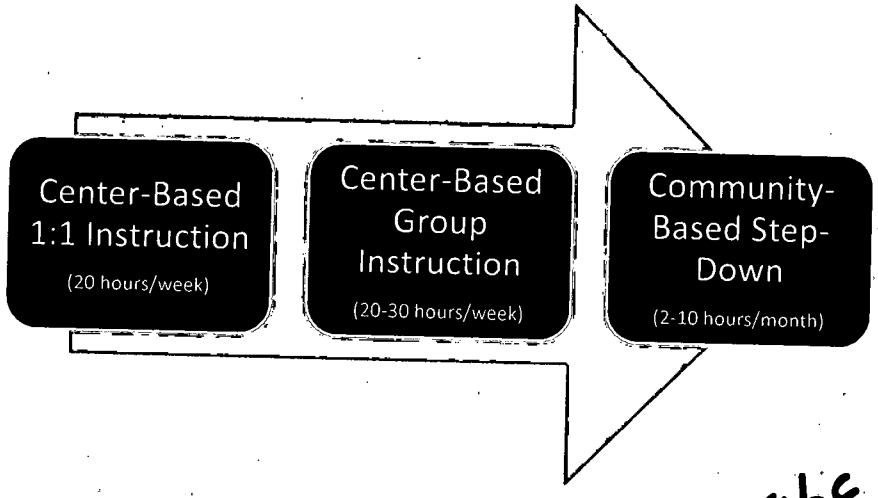
abc

Service Quality Measure: 2011/12 Parent Satisfaction Reports



abc

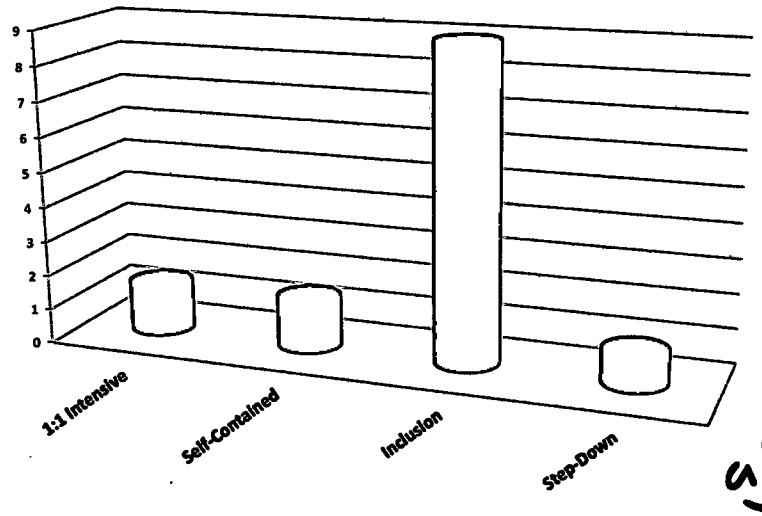
Program Progression



Inclusion Programs

ABC of NC provides peer-mediated instruction, an evidence-based practice that encourages interaction between children with autism and neuro-typical peers (Handleman & Harris, 2000; National Professional Development Center on ASD, 2010; National Standards Report, 2009; Odom, et al., 2003).

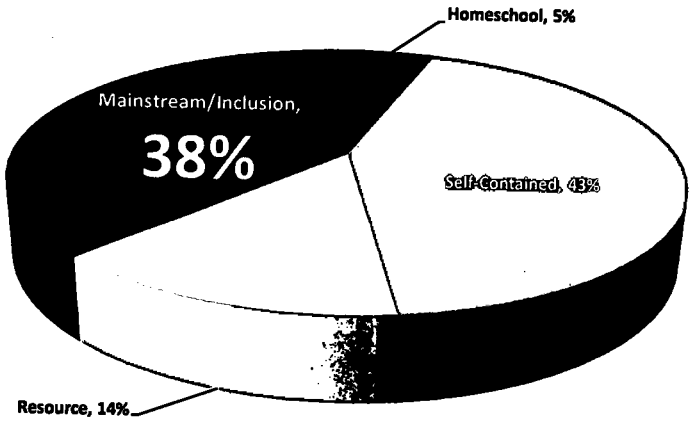
2011/12 State Program Student Program Placements



Reducing the Need for Intensive Support

Research indicates that with early intensive behavioral intervention, substantial numbers of children can attain intellectual, academic, communication, social, and daily living skills within the normal range, thus reducing the need for intensive school supports (Jacobsen, Mulick, & Green, 1998).

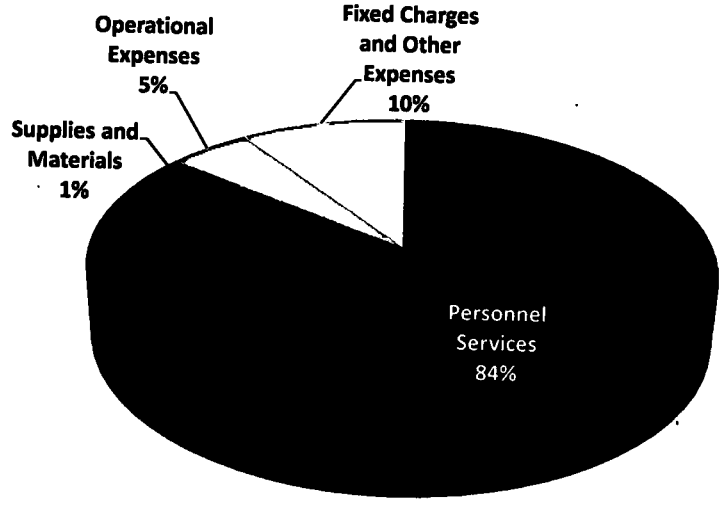
Student Placements within One Year of State Program Exit*



*Includes student data since program inception in 2007.

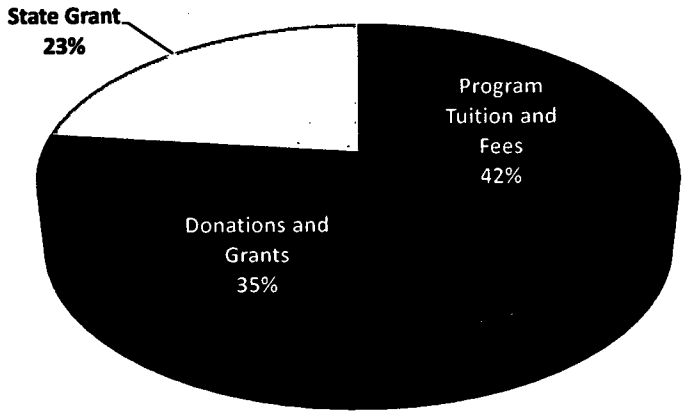
abc

State Program Expenditure Report

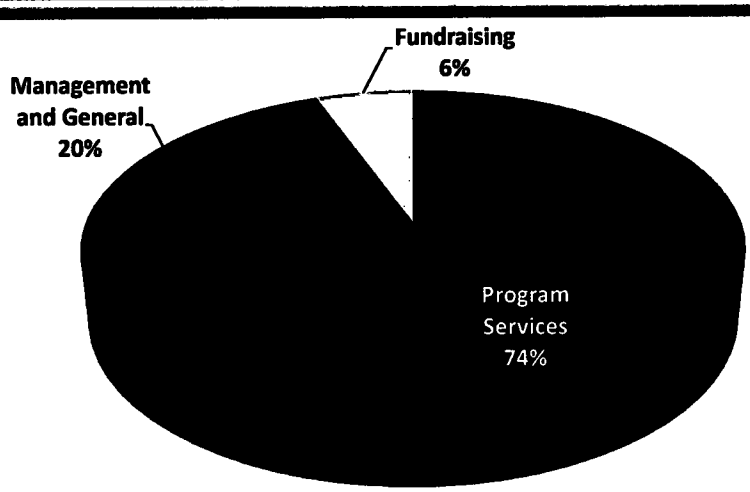


abc

ABC of NC Total Revenue



ABC of NC Functional Expense Allocation

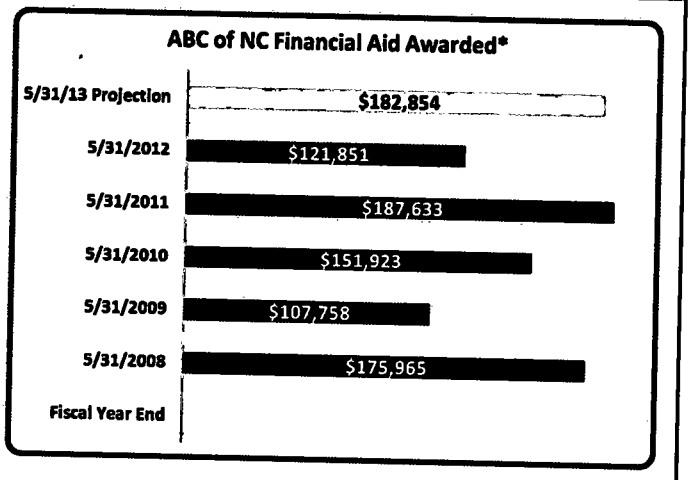


Financial Aid Program

ABC of NC
has awarded nearly

$1.2M*

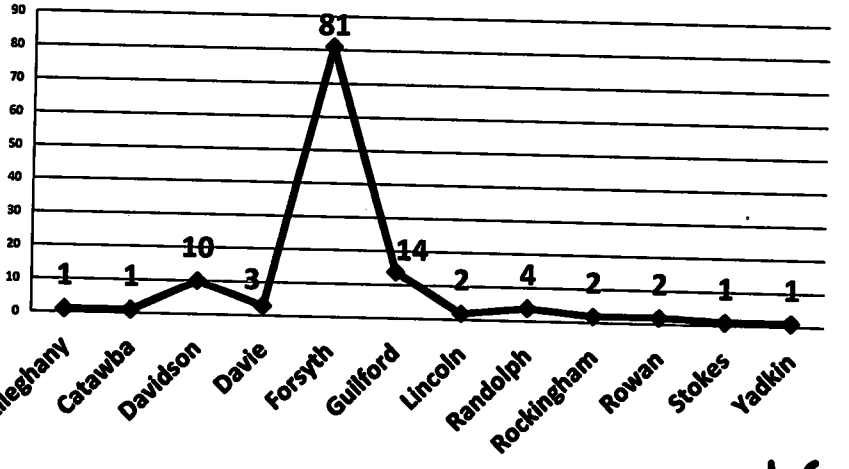
in privately-raised financial aid since 2005.



*These funds do not include any state program dollars.

abc

Services to Students in 12 Counties



abc

School District Trainings

- ABC of NC has provided teacher/professional education workshops and/or hands-on training and classroom consultation to **11** North Carolina school districts and numerous charter and private schools.

abc

In 2011/12, ABC of NC...

- Provided **50,416** hours of direct services to **122** students.
- Partnered with **8** college/university internship programs.
- Volunteers provided **2,769** hours of program support.
- Offered more than **30** free autism parent/professional classes to the community.
- Provided financial aid to **34%** of students.

abc

Long-Term Savings

- The estimated lifetime societal cost of supports, services, and lost productivity for an adult with autism is **$3.2M** (Ganz, 2007).
- With early intensive behavioral intervention, the estimated **lifetime cost savings** can be $600,000 to $1M (Jacobsen, Mulick, & Green, 1998).

Serving a Critical Need

With interventions like those provided through the state-funded program, individuals with autism can have a **fulfilling and productive** lifetime of learning.

References

- Autism Speaks (2010). *Autism prevalence on the rise.* Retrieved from http://blog.autismspeaks.org/2010/10/22/got-questions-answers-to-your-questions-from-the-autism-speaks%E2%80%99-science-staff-2/
- Centers for Disease Control. (2008). Prevalence of autism spectrum disorders — Autism and developmental disabilities monitoring network, 14 sites, United States. *MMWR Surveillance Summary.* Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6103a1.htm?s_cid=ss6103a1_w
- Dawson, G., Rogers, S., Munson, J., Smith, M., Winter, J., Greenson, J., Donaldson, A., & Varley, J. (2009). Randomized, controlled trial of an intervention for toddlers with autism: The early start Denver model. *Pediatrics.* Advance online publication. doi:10.1542/peds.2009-0958
- Ganz, M.L., (2007). The lifetime distribution of the incremental societal costs of autism. *Archives of Pediatrics and Adolescent Medicine, 161,* 343-349.
- Handleman, J.S., & Harris, S.L., eds. (2000). *Preschool education programs for children with autism* (2nd ed). Austin, TX: Pro-Ed.
- Jacobsen, J.W., Mulick, J.A., & Green, G. (1998). Cost-benefit estimates for early intensive behavioral intervention for young children with autism-General model and single state case. *Behavioral Interventions, 13,* 201-226.
- Lovaas, O.I. (1987). Behavioral treatment and normal intellectual and educational functioning in autistic children. *Journal of Consulting and Clinical Psychology, 55,* 3-9.

abc

References

- McEachin, J.J., Smith, T., & Lovaas, O.I. (1993). Long-term outcome for children with autism who received early intensive behavioral treatment. *American Journal on Mental Retardation, 97,* 359-372.
- National Autism Center. (2009). *National standards report.* Retrieved from http://www.nationalautismcenter.org/pdf/NAC%20Standards%20Report.pdf
- National Professional Development Center on Autism Spectrum Disorders. (2010). *Evidence base for peer-mediated instruction and intervention.* Retrieved from http://autismpdc.fpg.unc.edu/sites/autismpdc.fpg.unc.edu/files/PMII_EvidenceBase.pdf
- National Research Council. (2001). *Educating children with autism.* Washington, DC: National Academy Press.
- Odom, S.L., Brown, W.H., Frey, T., Karasu, N., Smith-Canter, L.L., & Strain, P.S. (2003). Evidence-based practices for young children with autism: Contributions for single-subject design research. *Focus on Autism and Other Developmental Disabilities, 18(*3), 166-175.
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

abc

ABC of NC Child Development Center

3904 Old Vineyard Road
Winston Salem, NC 27103

www.abcofnc.org

336.251.1180

Selene.Johnson@abcofnc.org

dear friends

Potential. All families want their children to reach their full potential—to achieve at the highest feasible level and to live happy, productive lives.

At ABC of NC Child Development Center, our vision is a world where children with autism spectrum disorder get that opportunity too. We are committed to effective teaching, evidence-based practices and affordable services so that the children with autism in our community have the best potential for success. We support each student in developing the skills and motivation necessary to be able to learn and thrive in the least restrictive setting possible.

As we invite our donors and volunteers to celebrate our 10th anniversary with us this year, we reflect on the impact our school has made on our community and the hundreds of families our center has served. Since 2002, ABC of NC has:

- Served over 300 children and their families
- Raised $1.1 million in financial aid for Piedmont Triad families for autism services from our organization
- Added educational programs including self-contained and inclusive classrooms
- Established collaborations with school systems, universities and other community service providers
- Extended our services to include parent classes, professional training and research projects
- Founded a diagnostic autism clinic set to open in the next year
- Received accreditation from Advanc-Ed and the Southern Association of Colleges and Schools (SACS)
- Traveled overseas to provide autism training and supplies to under-served families in Nepal and the Maldives
- Participated in long-reaching legislative activities including involvement in the state bill supporting autism insurance reform

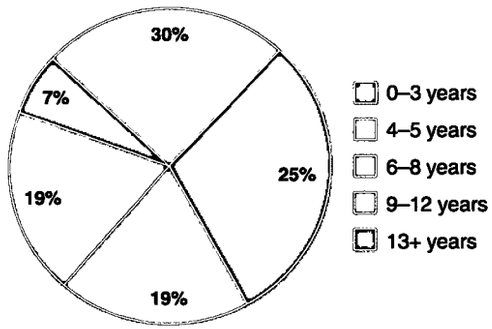
Thanks to our donors, our families, our employees and our community advocates, we have accomplished the seemingly impossible and have exceeded our dreams of potential. ABC of NC is here as a permanent addition to our generous community—improving, expanding and establishing programs for autism and meeting the demands of an ever-increasing community of families.

Happy Birthday ABC of NC!

Felice Brenner
Chair, Board of Directors

demographics

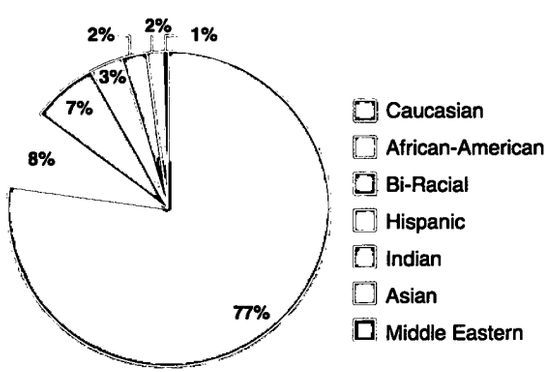
Age of Students Served



In North Carolina, autism affects an alarming one in 70 children and one in 43 boys.
– Centers for Disease Control, 2012

More children will be diagnosed with autism this year than with AIDS, diabetes and cancer combined.
– Autism Speaks, 2012

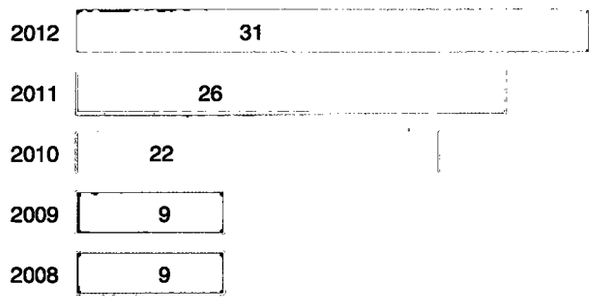
Student Ethnicity



financial aid

Since its founding, ABC of NC has provided over **1 million dollars** in financial aid to Piedmont Triad families.

Students Receiving Financial Aid
5 Year Comparison



quotes

"ABC really helped me learn to make good decisions like treating others the way you want to be treated. Now I am able to go to another school where I can learn and have fun."
– John Wittenberg, ABC of NC student

"When my child entered the program, he did not speak or interact with almost anyone. Now he speaks over 100 words and loves to engage with other people, especially other children. He shows empathy toward others and engages willingly with his brother, sister, father, and me at home. He is a new child!"

"The staff blows me away with their genuine care and attention to detail. I don't know where you find so many big-hearted, smart people who truly treat each student as an individual, but I'm glad that you do. I know that my child's individual needs are being identified and targeted and that makes it worth every penny."

vision

The vision of ABC of NC is that all children with autism spectrum disorder reach their full potential through effective teaching.

mission

ABC of NC is committed to providing quality individualized educational services based on evidence-based practices in the field of autism treatment to children with autism spectrum disorders and their families. We are committed to seeking funding from a variety of sources so that we can provide services to families from any economic background. We support each student in developing the skills and motivation necessary to be able to learn and thrive in the least restrictive setting possible.

ABC of NC Child Development Center
3904 Old Vineyard Road
Winston-Salem, NC 27104
www.abcofnc.org • (336) 251-1180

Find us on Facebook Follow us on Twitter

AdvancED™ ABC of NC is accredited by Advanc-Ed and the Southern Association of Colleges and Schools (SACS). United Way of Forsyth County code: #2652

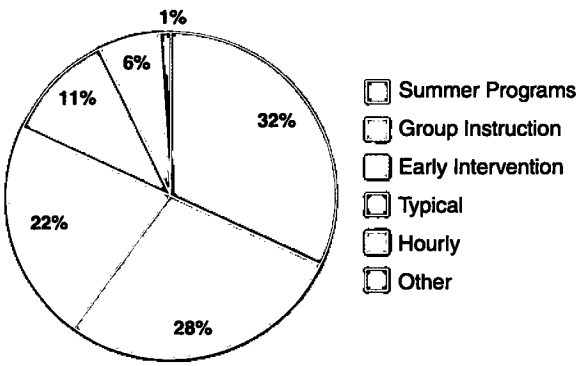
ABC of NC Child Development Center

annual *report*

2011–2012

students

Hours of Service Provided
by Service Type

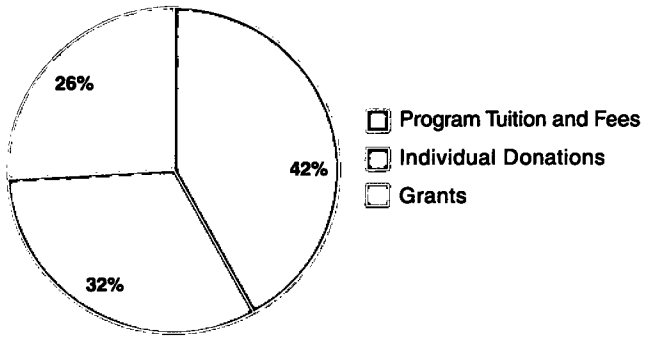


ABC of NC provided **50,416** hours of service to children in the 2011–2012 fiscal year.

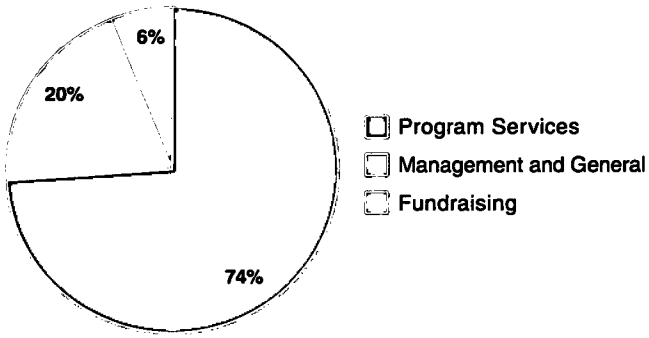
financials

34% of ABC of NC students with autism received financial assistance in fiscal year 2011–2012.

Total Revenue
by Type of Income



Functional Expense Allocation



josef's story

Our son Josef began attending ABC of NC only two days per week on a trial basis, while he attended his regular preschool for two days as well. Within six weeks, his teachers at his regular preschool told me they saw a difference in him. He had begun sitting through circle time and following directions and participating in activities with the rest of the class. I was in disbelief. This, along with the fact that he loved coming to ABC of NC, convinced me he should be at ABC of NC full-time.

Sixteen months later, I am still in disbelief—happy disbelief, at the progress he has made. I don't want to say he is a different child, because I now realize he had the potential to be so much more, and ABC of NC helped him realize this potential. Our experience has given me full faith in the staff and the philosophy of the school. The teachers and consultants work incredibly hard, focusing on the needs of each individual child. I am overwhelmed by their patience, warmth and commitment.

When we signed up for ABC of NC's diet expansion program, I knew that something good would come of it, as I had experienced so many times before with ABC of NC services. And, now that I have actually seen a diet expansion program in action, I am even more impressed and in awe of what the staff is able to accomplish. The fact that Josef will try new foods now is just so amazing and wonderful.

I can't thank the staff at ABC of NC enough. We have seen Josef blossom into a happy, talkative 4-year old, who loves being with his friends. He recently began attending a typical school full-time. We are very excited for him, and very grateful to ABC of NC.

Josef's mom
ne changed for confidentiality

Our Supporters

Thank you to the following donors who have made significant contributions to ABC of NC over the life of the organization:

Ann Brenner
John and Mary Louise Burress
WFU Health Sciences
Amarr Garage Doors
Richard and Felice Brenner
The Pratt Family Foundation
Abe and Miriam Brenner
Hatteras Financial Corporation
The Winston-Salem Foundation
Lawrence M. and Sally Brenner Wolfish
The Morris and Gertrude Brenner Foundation
The Fant Foundation
The Duchossois Family Foundation
Randall and Claire Tuttle
Mike and Wendy Brenner
Alfred Williams
Andrew and Ellen Schindler Foundation
Tommy Schmidt
Glenna Patton
Wake Forest Baptist Medical Center

Donors

For the year ending May 31, 2012

Thank you for making our work possible.

ACH Foam Technologies
Kent and Donna Adams
Melanie Adams
Sandra Adams
Thomas and Jean Adams
Bradley and Melissa Ader
Samuel and Vanessa Ajizian
Jennifer E. Aldous
Cabell Allen
Chuck and Susie Alt
Terrance and Barbara Andree
Andrew and Ellen Schindler Foundation
Cindy Andrew
Roxie Andrews
Richard and Susie Andrus
Ann Renna
Thomas and Tracy Arne
Keith and Becky Arnott
Arrow Tru-Line, Inc.
Michael and Deanna Avent
Bud and Stella Avret
David, Douglas and Jan Badger
Leslie and Suzanne Baker
Diann Barbacci
Scott and Debbie Barkow
Cynthia Barrett
David and Kathleen Barry
Wyatt P. and Bartlett Spencer Bassett
Eddy and Neil Beck
Michael and Lori Beck
Richard and Sandra Belmont
Bret and Beth Ann Berger
Mike and Barbara Berry
Biltmore Estate Reproductions, Inc.
Emmie Birkas
Bixby Presbyterian Church
Robert and Brooke Blasberg
Steven and Linda Block
Guy M. Blynn
Cecelia S. Bolar
Bowen, Hanes & Co., Inc.
Jack and Dianne Bowen
Thomas and Meredith Boylan
Glenn and Jennifer Brammer
Ann Brenner
Mike and Wendy Brenner
Richard and Felice Brenner
Van Brenner
Rivia Brown
Charles and Shannon Bruton
Robert and Sharon Bryan
The Budd Group
Richard and Brooke Burr
John and Mary Louise Burress
James and Elaine Byers
Casey Cadiente
K & W Cafeteria
Calvary Baptist Church
Camel Pawn Shop
Paul and Margaret Campbell
Canimex
Gene and Pat Capps
Carrubba's Italian Grill
James and Ashley Carras
Greg and Lisa Carter
Frances Cartner
Lawrence and Jacquelyn Chance
Charles and Otelia Chandler
Gordon Chapman
Pauline Chapman
Thomas Chapman
Nilla Childs
Hudnall and Claire Christopher
Gail Citron
Leonard Clein
Greenbrook Garden Club
Cameron and Natasha Cobb
Karen Coffey
Tommy and Betty Cole
The Dow Chemical Company
W. Mark and Susan Conger
George and Mary Cosentino
Elizabeth Sade Conwell
Danny and Jane Cooper
Deborah Cornatzer
Robert and Lisa Cornatzer
Daniel and Julie Coulter
Sharon B. Covitz, Ph.D.
Susann Craig
J. Scott Cramer
Jessica Craven
Donna Bembnister and Matthew Crisci
Meaghan Croom
Betty and John Crowder
Peggy Crutchfield
Chip and Shea Crutchfield
Abigail Cullinan
Jeff and Wanda Curley
Cynthia and David Daggett
John and Carol Danforth
Bill and Linda Davis
Donald and JoAnne Davis
Donna Davis
Kathryn Williams and Alan Davis
Kay S. Davis
Albert and Tricia DeForest
Dell Direct Giving Campaign
Christian and Mike Dew
John and Mary Jane Dewees
Charles and Courtney Douglas
Graham P. Dozier, III
Greg and Becky Ebert
Kathryn and Bobby Edwards
Mike and Elyse Edwards
Rod and Marcia Enns
Bessie Epes
Mike and Kristen Esposito
Gerald and Lee Evans
David and Sherrie Fain
Daniel and Sidney Falken
Larry and Mindy Feinstein
Michael and Paula Fischer
Carol Markey Fishburne
Howard and Joanne Floch
Ann Austin Flynt
McDara and Ragan Folan
Forsyth Country Day School
Fourshare, LLC dba Battery Watering Technologies
Pamela Fowler
Richard and Nancy Fowler
West and Jeni Fowler
Robert Freed and Robin Broyhill
Harvey Freeman, Jr.
Allen and Lynn Fritts
Carolyn O. Fulton
Paul Fulton
Athena P. Gallins
John and Jeannie Gallins
Jeffrey and Alison Gardner
Harold and Patricia Garner
John and Linda Garrou
Drew and Shea Gerringer
Arthur and Kathy Gibel
Glenn Family Foundation
Globe International Corporation
Kathleen Glover
James and Susan Gooding
Anzella Goodwin
Kristi Gordon
Louis Gottlieb
William and Cynthia Graham
Grieser Logistics
GSC Packaging, Inc.
Michael and Natalie Guld
Ira Robert Guttenberg
Christophe J. Gyves
Frank and Helen Hahn
Scott and Anita Hall
Drew and Kelley Hancock
Harris Teeter
Amalie Harris
Hatteras Financial Corporation
Sam and Kathryn Hauser
Dawn Haynes
Andrew and Traci Heffner
Hayes and Elizabeth Henderson
Wanda Hennis
Wendell and Nancy Herndon
Robert and Jan Hiersteiner
Peter and Mary Elizabeth Hollett
Amanda Hollis
George and Pam Hollodick
ine and William Hooke
nin and Ann Hough
Michael and Amy Hough
Gina J. Howard
Gregor and Cynthia Howard
Jeffrey and Lynn Howland
John and Gretchen Hoyle
D. Kramer Hughes
Keith and Patricia Hunt
Ed and Edy Hurdle
Hutchison Allgood Printing
Laura Hylton
Steven and Ana Iltis
Steven and Barbara Jacobs
Frank and Dell James
Rashid and Leigh An Janjua
Jeannie Jernigan
Jersey Shore Steel Company
Alleta Johnson
Claudia Johnson
Selene Johnson
Terry Johnson
Beverly and Janet Jones
F. Whitney and Suzanne Jones
Ellen and H. Richard Joyce, Jr
Bert and Dorothy Kalet
Patricia Keegan
John and Mary Keiger
Edward and Linda Kelly
Jeffrey and Jean Kelly
Murphy's Kids, Inc.
Barry and Jeanette King
David and Tammy Kinney
Elsie H. Kinney
Linda Kirby
Kurt and Mary-Ellen Klinepeter
Mark and Jenni Knudson
Mary Krochs
Rose Kroustalis
Gail Lake
Gilmour and Nancy Lake
Bryan and Suzanne Lakey
Donald and Teresa Lakey
Kimberly Lambert
Robert and Whitney Lang
Amy Lanning
Jack Lauer and Carol Kirby
George and Susan Lautemann
Thomas and Megan Lawson
Jack and Janice Levin
Bruce and Karen Lewis
Nathan Link
Little Creek Ventures
Janice Moore Little
Grins Enterprises, LLC.
V.B. and Dorothy Lougee
William and Tora Lowe
Lowes Food Store
Elizabeth Lynn
Paul Maggio and Debra Lee-Maggio
Richard and Carrie Malloy
Stan and Patti Mandel
David and Heidi Mann
Darryl R. Marsch and Laura Luykx
Lynn Marsh
Fred and Marilyn Martin
George and Cecilia Martin
Shawn Martin
Douglas and Mary Anne Maynard
John McConnell
Anita M. McDaniel
Walter and Shippey McDowell
McGladrey & Pullen, LLP.
Thomas and Jane McKim
Philip and Mary Martha McKinley
John and Grace McKinnon
Mac and Sheri McQuilkin
John and Polly Medlin
Joan Merry
Joseph and Cece Middleton
Don and Sandra Mikush
Gabriel and Gabrielle Miles
Joyce D. Miller
Milner's American Southern Cuisine
Jessie Mitchell
Dave Moffatt
Alan and Beverly Moore
Johnny and Adair Moorefield
Brian and Laura Moretz
Maureen and Rob Morrell
Mount Tabor UMC, Circle 9
Marcella Murphy
Neal and Jill Tuckabery
Emily Neese
Richard and Amy Nelson
Robert and Melanie Niblock
Marty Norman
Tadhg and Kathleen O'Gara
John and Cyndy O'Hara
Gary and Marian O'Neal
. Oona O'Neill
nd Roanne Ornelles
1 Otterbourg
David and Debra Owens
Mihaela Pacurar
Steve and Jeannie Paparoupas
Dale and Terra Parrish
Rudy and Lauren Pascual
John and Dominique Patrick
Shirley Hanes Perkins
Jonathan and Angela Pesenti
Jim and Roberta Pettit
Stephen and Carolyn Phelps
Herman Pickett
Ballard and Nancy Pinkard
Ruth F. Pitts
Edward and Nancy Pleasants
David Plyler
Stephen Knight Pond
Norm and Patricia Potter
Thomas and Karen Pranikoff
The Pratt Family Foundation
Jeanne Pratt
V.R. and Grace Price
Rachel Priddy
Primo Water
Alan Proctor
Hugh and Margaret Quinn
Thomas and Scottie Rader
Art and Carolyn Ramey
Cal and Mary Ratcliff
Richard and Katie Rauck
Kevin Reece
Susan Reid
Burton and Frances Reifler
Charles and Stephanie Reitz
James and Nancy Revercomb
Reynolds American Foundation
Reynolds American Inc. dba RAI Services Company
Mark and Lisa Rhoades
Rick and Penny Rice
Timothy and Ann Rigsby
RMIC Corporation
Robert H. Wager Company, Inc.
Preston and Kathleen Roberts
Stephen and Jean Robertson
Joan Roggenkamp
Greg and Tracy Rosen
Allan J. and Marcia Rosenberg
David and Lucia Rosenblatt
Sammy and Penny Rothrock
John and Susan Royster
Salem Investment Counselors
George and Eleanor Salley
John and Kathy Sapp
Robert and Alice Sarlls
Bill and Barbara Scantland
Marcus Schaefer and Claudia Zorn Schaefer
Mike Schaper
Andy and Nancy Schneider
Delayne L. Schoolfield
Marti Fessenden and Suzanne Schultz
Steve Scoggin
Timothy and Carolyn Scogin
Sedge Garden United Methodist Church
Selma Scott
John and Lora Sessions
Kimberly Sewell
ShapiroWalker Design
James and JoAnn Sharp
Theresa Sheeler
Sheffield Financial
Phyllis C. Sheffield
Tracey and Catherine Sheriff
Sherwood Flower Shop
Dale Shields
Benjamin Shirley
Rebecca Shneiderman
David Shoenfeld
Kim Shufran
Cynthia Silber
Paul and Sara Sinal
Michael and Anna Singer
Gregory and Ntina Skoteiniadis
Rick and Joanna Smothers
Sonbert Security Systems, Inc.
Source 4
Southern Atlantic Spring Manufacturing and Sales, LLC.
Ann Lewallen Spencer
Derek and Leigh Ellen Spencer
Nancy Neill Spencer
Mitchell L. Spindel and Kimberly Hobin
Richard Payne and Desiree Stanley-Payne
State Employee Combined Campaign
Steam Source
Bill and Sandy Steele
Kenneth A. Steele
Scott and Jennifer Steele
William Steele
Ann Stephenson
Amy Pope Stinnett
Barbara Stockfish
Wendi and Kevin Stogner
Brian and Kimberly Stone
Stephen and Lucy Strawsburg
Denzil and Carolyn Strickland
Daniel and Linda Sullivan
John and Stella Surratt
Ben and Sally Sutton
Target Take Charge of Education
The Grand Movie Theater
The Mary Duke Biddle Foundation
Virginia Thomas
John and Sherri Thomasson
Francie Thompson
Three Princes, Inc.
Camille H. Townsend
Julia Clinard Townsend
Tracker Industries
Triad Coordinated Services, Inc.
Steve and Gayle Tuch
Chris and Nancy Tuohy
Jodi L. Turner
Sandy Turner
Randall and Claire Tuttle
United Way of Davidson County
The United Way of Forsyth County
Norman and Suzanne Veasey
Wake Forest Baptist Medical Center
Wake Forest University Health Sciences
Denny and Cheryl Walker
Tory and Toni Walker
Susan B. Wall
Gwen Walter
Ben and Katie Warner
William and Judy Watson
Parks and Anissa Welch
Wells Fargo Bank
Tim Whitener
Brad and Jocelyn Whitley
Scott and Lauren Wierman
Roger and Jane Wiles
Aaron and Cynthia Williams
Charles and Ann Williams
Ben and Tillie Willis
Peter and Mary Louise Wilson
Winston-Salem Rotary Benevolent Fund
Winston-Salem State University
Vernon and Frankie Winters
John and Julie Wise
Debbie Wittenberg
John Wittenberg
John and Barbara Wolfe
Lawrence M. and Sally Brenner Wolfish
Karen Wood
Andy and Jane Worley
Meghan Yoho
Karen Young

Volunteers

Ana Acosta
Erica Alexander
Maya Alexander
Teige Arnott
Brooke Bond
Leslie Brown
Sandy Brown
Pauline Chapman
Laurie Cleary
Carole Croft
Hannah Dunlap
Elyse Edwards
Jasmine Erialle
Rose Fall
Cori Hurm
Myra Key
Alden Claire Knight
Jasmine Lloyd
Jon Merchant
McKenzie Millican
Jessie Mitchell
Louisa Monslave
Alexis Montgomery
Bev Moore
Marcy Murphy
Haley Pegram
Paige Priddy
Ann Renna
Daniel Rice
Jessica Stark
Will Stockfish
Amber Webb
Wanda Webster
Annie Wittenberg
Debbie Wittenberg

Interns and Practicum Students

Appalachian State University
Alyssa Edney
Jessica Hayworth
Whitley Shumaker

High Point University
Nicole Chryssos

Salem College
Hope Kerr-Read

UNC Greensboro
Elisa Bate
Kelly Buchanan
Jackie LeMere
James Sacks

UNCG Recreational Therapy Practicum Students
Denise Blanchfield
Brianna Edwards
Katie Ellenwood
Jade Farlow
Auriel Holman
Larry Jordan
Wylette Patterson
Jakita Phillips
Andrea Redden
Shaniqua Reeves
Shannon Rogers
Chelsea Tysinger

Wake Forest University
Ashley Dougherty
Ashley Kazouh
Ruby Mannankara
Sarah Myers

Winston Salem State University
Markella Betts
Jasmine Perry
Kendra Hammack

WSSU Occupational Therapy Practicum Students
Shari Harvey
Samantha Freer
Myra Lambert
Jessica Smith
Trina Taft
Richard Watkins

Administrative Staff

Selene Johnson, M.Ed., BCBA
Executive Director
Angela Pesenti
Director of Finance
Barbara Stockfish
Director of Operations
Kirstin Downie
Director of Development & Volunteer Services
Drew Coulter
Accounting Assistant

Program Supervisors

Cindy Andree Bowen
Lizzy Donovan
Stephanie Holladay

Instructional/ Support Staff

Cindy Barrett
Grady Blackburn
Mary Blackburn
Kristen Carter-Jackson
Courtney Charles
Daniel Charles
Mike Errickson
Katie Frank
Ted Giordano
Shanee Howell
Randi Lucas
Vilia McClearen
Shundra McLaurin
Becky Payton
Alex Russell
Leigh Ellen Spencer
Amy Vestal

Board of Directors

Melanie Adams, M.D.
Thomas R. Adams
Felice Brenner, Chair
Richard Brenner, President
John Burress
Kurt Klinepeter, M.D.
Beverly Moore, Secretary
Emily Neese, Treasurer
David Shapiro
Ken Steele
Debbie Wittenberg

ABC of NC makes every attempt to publish a complete list of donors and volunteers. Please contact us with additions, deletions or other

SUMMER FUN AND LEARNING

ABC of NC Child Development Center's Summer Education Program combines the fun of a summer day camp with evidence-based educational programs.

Why is the Summer Program effective?

- Children with autism spectrum disorder (ASD) learn through peer and play interaction in a fun and inclusive group environment;
- Students are grouped based on a variety of factors including age and developmental levels; and
- Specific goals are based on each student's Individualized Education Plan (IEP), developed by an experienced and highly qualified educational team.

The ABC of NC facility includes access to a wide variety of toys and activities, including art, drama, music, movies, computer games, water activities, and a playground.

DATES & TIMES

Monday – Friday
8:45 a.m. - 2:45 p.m.
Mid-June to Mid-August

Check the insert or visit www.abcofnc.org for specific dates and pricing.

ADMISSIONS

For an admissions application or to learn more about the Summer Education Program, please visit www.abcofnc.org or call (336) 251-1180. ABC of NC accepts:

- Current ABC of NC students;
- New students ranging from age three to 12 who are at risk or have been diagnosed with autism spectrum disorder, including Asperger's Syndrome; and
- Students who are typically developing from ages three to 12.

The Summer Education Program is designed for children with autism who may have:

- Limited language skills;
- Limited play interests; and
- Difficulty with peer interaction.

Children attending the Summer Education Program must have no aggressive, self-injurious, or destructive behaviors. Students with these challenges may benefit from ABC of NC's intensive year-round programs.

FAMILY INVOLVEMENT

As part of ABC of NC's philosophy to make families part of the educational process, the eight-week summer program includes:

- A pre-admission student assessment;
- A mid-session family conference; and
- A final progress review and recommendation meeting.

ABC OF NC MISSION

ABC of NC is committed to providing quality individualized educational services based on evidence-based practices in the field of autism treatment to children with autism spectrum disorders and their families.

We are committed to seeking funding from a variety of sources so that we can provide services to families from any economic background.

Our programs support each student in developing the skills and motivation necessary to be able to learn and thrive in the least restrictive setting possible.

HIGHLY TRAINED STAFF

ABC of NC's highly trained staff includes professionals from a variety of fields including special education, communication disorders, music therapy, elementary education, and psychology.

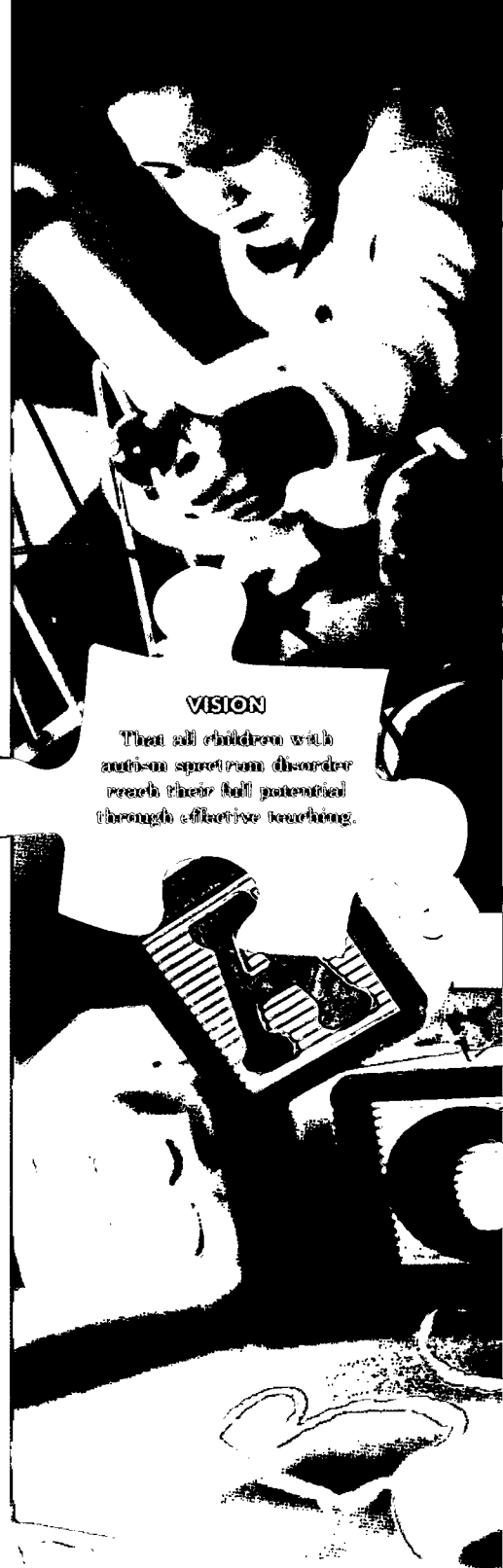
ABC of NC also works with local high schools, colleges and universities to provide internship and volunteer opportunities for students interested in autism.

PROGRAMS AND SERVICES

ABC of NC is the largest school in North Carolina exclusively serving children with autism. During the academic year, ABC of NC offers a variety of programs including group instruction, one-on-one intensive services, home-based and school-based services, social skills groups, and parent education opportunities.

For more information about ABC of NC's programs and services, please call (336) 251-1180.

ABC of NC reserves the right to facilitate the transition to a different program if the staff determines that a student is not placed in an appropriate setting.



VISION

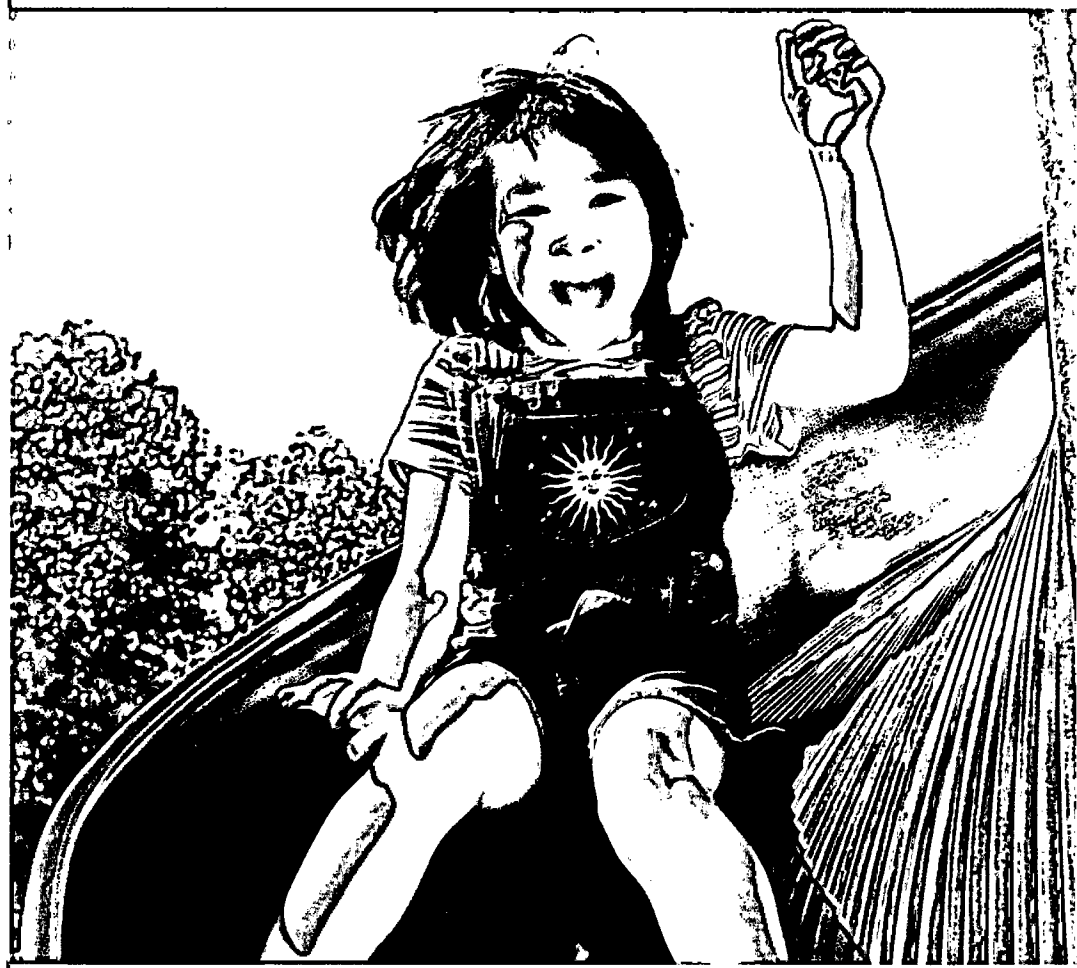
That all children with autism spectrum disorder reach their full potential through effective teaching.

ABC of NC Child Development Center

3904 Old Vineyard Road
Winston-Salem, NC 27104
(336) 251-1180 fax (336) 251-1181
www.abcofnc.org

Effective educational programs for children
with autism spectrum disorders.

summer fun and learning for children with autism



ABC of NC Child Development Center

Hope For An Understanding Of Autism

ABC of NC is the largest school in North Carolina focused exclusively on autism programming and the only center to feature transitional classrooms that include typically developing peers. Research indicates children with autism learn best in these integrated, inclusive environments using our proven methods based on the principles of applied behavior analysis (ABA) and other researched techniques.

ABC of NC is committed to providing quality individualized educational services based on evidence-based practices to children with autism spectrum disorders and their families. That's how we developed our vision – **that all children with autism reach their full potential through effective teaching.**

Hope For Independent Learning

Our philosophy is to teach children basic skills by creating an environment that motivates them to communicate and play with their teachers and transfer these skills as soon as possible to peers, siblings and other adults in less restrictive settings.

ABC of NC is uniquely positioned to provide a range of services for children beginning at diagnosis all the way through transitional programs to ensure our students' success in their regular community-based schools. Our rolling admission allows ABC of NC to accept students throughout the year, so clients can begin receiving services as soon as possible.

At ABC of NC, each student's individualized education plan (IEP) goals are created based on a variety of curricula and assessments. Our school is committed to building individualized programs for students using a variety of evidence-based educational techniques specific for children with autism. A current list of the assessments and educational techniques used by ABC of NC can be viewed at our website, www.abcofnc.org.

Our staff includes professionals from a variety of fields: special education, elementary education, early childhood education, communication disorders, music therapy, and psychology. The staff is highly trained in autism-specific techniques and receives ongoing training on new research throughout the year.

Hope For Appropriate And Effective Programming

ABC of NC offers a variety of programs and services proven effective for children with autism. These programs cover a broad range of intensity levels so that we can teach children at their appropriate development levels.

These include:

- **Group Instruction**
  Targets children's individual needs, while they learn alongside peers in a classroom environment. Goals include communication, play and social skills, adaptive living skills and classroom routines.
- **One-on-One Services**
  Designed for students who need intensive individualized intervention and may not yet be ready for the demands of a classroom environment. Goals include communication, play, social skills, and adaptive living skills.
- **Social Skills Groups**
  Meet once per week to develop language and social skills of students. Goals include, but are not limited to: sharing, negotiating, forgiving, problem solving, and taking others' perspectives.
- **Family Sessions and Parent Education Courses**
  Conducted by a staff member with a primary caregiver present, to demonstrate teaching techniques that can be replicated in the home by caregivers. ABC of NC also

ABC of NC Child Development Center

Vision

The vision of ABC of NC is that all children with autism spectrum disorder reach their full potential through effective teaching.

Mission

ABC of NC is committed to providing quality individualized educational services based on evidence-based practices in the field of autism treatment to children with autism spectrum disorders and their families. We are committed to seeking funding from a variety of sources so that we can provide services to families from any economic background. We support each student in developing the skills and motivation necessary to be able to learn and thrive in the least restrictive setting possible.

Contact Us

3904 Old Vineyard Road
Winston-Salem, NC 27104
(336) 251–1180 fax (336) 251–1181
www.abcofnc.org

Find us on Facebook

Follow us on Twitter

AdvancED ABC of NC is accredited by Advanc-Ed and the Southern Association of Colleges and Schools (SACS).

Hope For A Lifetime of Learning

At ABC of NC Child Development Center, we provide hope.

Hope for children with autism who deserve access to the best possible educational services. Hope for a safe place for children to become independent learners who are prepared for school, social settings and self-reliance. And, hope for a community that provides for families of children with autism through our effective programming.

Located in Winston-Salem, NC and serving a 10-county area, ABC of NC provides educational services for children diagnosed with autism spectrum disorder; pervasive developmental disorder, not otherwise specified; or Asperger's Syndrome; and students who are at risk for developing such disorders.

Residential Services, Inc.
111 Providence Road
Chapel Hill, North Carolina 27514
Phone: (919) 942-7391
Fax: (919) 933-4490
www.rsi-nc.org
Dennis Bradshaw, Executive Director

November 28, 2012

Mark Trogdon, Director
Fiscal Research Division
Suite 619, Legislative Office Building
Raleigh, NC 27603

Re: Residential Services, Inc.
Contract # 00025190
Response to William J. Scott, Jr. and Jalaine Moore
Request for Information
Pursuant to House Bill 950, Session Law 2012-142

Dear Mr. Trogdon:

We are writing in response to the request from William J. Scott, Jr., Section Chief to provide information about our State contract to members of the Legislative Subcommittees. Residential Services Inc. has received state support for our specialized intensive treatment program for children and adolescents with autism for a number of years. Developed in response to a significant need for non-institutional intensive alternatives the goal is to provide quality services and prevent hospitalization and institutionalization. Quality of life markers and cost of services dictates that keeping even very challenging individuals in the community is both the right thing and the most cost effective thing to do. Please find attached the following information:

1) Our mission, vision, and governance structure.
2) A description of the types of programs, services, and activities funded by State appropriations.
3) Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.
4) Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.
5) A detailed program budget and list of expenditures, including all positions funded and funding sources.
6) The source and amount of any matching funds received.

Attached please find the requested information. If you need additional information or clarification, please feel free to contact me.

Sincerely,

Dennis Bradshaw
Executive Director

1) Residential Services, Inc.'s Mission, Vision, and Governance Structure

Residential Services, Inc. is a private, nonprofit 501(c)3 corporation originally incorporated in 1974. RSI's mission is to provide living options and related supports to people with intellectual and developmental disabilities of all ages. RSI promotes quality of life by maximizing self-determination, development of independent living skills, community involvement, meaningful social roles, and socially responsible behavior. RSI's vision is that individuals with intellectual and developmental disabilities have the services and supports they choose in order to live lives characterized by happiness, dignity, health, and the highest possible degree of social responsibility and productivity.

RSI is governed by a 15-person volunteer Board of Directors. The Board directly supervises the Executive Director. The Executive Director is responsible for the day to day operations of the corporation.

2) A description of the types of programs, services, and activities funded by State appropriations

Residential Services, Inc. developed the Aberdeen home to meet the needs of the most challenging population subset of individuals with autism spectrum disorder: four adolescent/young adults with autism with the treatments and supports necessary to remain in their home county and attend public school. Without the intensive services provided by the RSI Aberdeen home, risk of hospitalization an/or institutionalization is high.

RSI's Aberdeen home is located in Carrboro, Orange County, North Carolina. The home provides services to four adolescents with a diagnosis of autism and very challenging behavioral issues. RSI provides a comprehensive approach to meeting the complex needs of the residents living at the Aberdeen home. Psychiatric needs are addressed through a contract with UNC Hospitals. A contract with Division TEACCH allows access to one of the leading programs for people with autism in the country. TEACCH provides both consultation and training to staff. The RSI psychologist team leaders, and staff members work together to maximize outcomes. An individual support plan is developed using person-centered principles. ISP development includes input from the family, the school system, and the support professional to develop a plan designed to provide growth and independence. Because of the special needs of this population, awake overnight staff are available to help manage behavioral and other issues. Without the services provided by RSI-Aberdeen, the four men and their families would be in crisis.

3) Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.

Four adolescents with severe autism and intellectual disabilities are served by the home. Three of the current residents are from Orange County. One resident is from Durham County. Services are provided in Orange County. When a vacancy occurs, applications from counties throughout North Carolina are considered.

4) Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.

The support provided by this contract allows the participants to remain in the community, thus avoiding more costly hospitalization or institutionalization. All participants have individual support plans and progress is monitored closely.

5) A detailed program budget and list of expenditures, including all positions funded and funding sources.

Budget attached.

6) The source and amount of any matching funds received.

There is no matching fund requirement.

RSI - INTENSIVE AUTISM SERVICES

Revenue	
CAP-MR	$205,000.00
MISC	$5,000.00
STATE CONTRACT	$246,424.00
SS BENEFITS	$52,032.00
Total Revenue	$508,456.00
Expenditures	
SALARIES	$303,000.00
FRINGE	$23,179.50
MED INSURANCE	$16,000.00
RETIREMENT	$7,800.00
TRAINING	$4,500.00
EMPLOYEE TESTING & IMMUNIZATION	$2,600.00
ADVERTISING (Help Wanted)	$1,200.00
TEACCH CONTRACT	$20,000.00
WC FEES AND REM	$1,800.00
RECREATION SUPPLIES	$3,500.00
FOOD	$18,000.00
NON LEG DRUGS	$500.00
MEDICAL SUPPLIES	$2,500.00
SUPPLIES	$2,000.00
UTILITIES	$5,800.00
MORTGAGE	$5,000.00
REPAIRS BUILDING & EQUIPMENT	$7,500.00
NON- CAPITALIZED EQUIPMENT	$2,800.00
GAS AUTO	$3,600.00
MILEAGE REIMBURSEMENT	$2,500.00
VEHICLE REP	$2,500.00
DEP VEH	$4,000.00
OFFICE SUPPLIES	$1,200.00
INSURANCE GEN	$5,073.18
LEGAL AND ACCOUNT	$4,200.00
COMPUTER RELATED	$3,500.00
TELEPHONE	$1,400.00
MISCELLANEOUS	$4,500.00
OVERHEAD	$48,303.32
TOTAL	$508,456.00

SALARY BREAKDOWN

PROGRAM DIRECTOR	$38,000.00
SHIFT LEADER (2)	$70,000.00
DIRECT SERVICES STAFF	$75,500.00
THIRD SHIFT	$58,000.00
NURSING, PSCHOLOGY SW	$8,000.00
SUBSTITUTE STAFFING	$30,000.00
SUMMER /HOLIDAY STAFFING	$18,000.00
M&R STAFF	$5,500.00
TOTAL STAFFING	$303,000.00

RSI

Residential Services, Inc.

A Tradition of New Possibilities

Founded in 1974, Chapel Hill, North Carolina

MISSION

R_ ₁ ovides living options and related supports to people of all ages who have been diagnosed with a developmental disability. We promote quality of life by maximizing self-determination, development of independent living skills, community involvement, meaningful social roles and socially responsible behavior.

VISION

Our vision is for individuals with disabilities to have the services and supports they choose in order to live lives characterized by happiness, dignity, health and the highest degree of social responsibility and productivity possible.

Community living is enhanced through team sports at RSI.

111 Providence Rd.
Chapel Hill, NC 27514.
Tel: (919) 942-7391
Fax: (919) 933-4490
Website: www.rsi-nc.org

Residential Services, Inc.

MISSION

RESIDENTIAL SERVICES INCORPORATED

THE BEGINNING

Until the early 1970s, large institutions provided most of the services available to people with developmental disabilities. Families began to question that service model and to advocate for additional options for their family members with developmental disabilities. Group homes and other service models were developed as families and advocates began to brainstorm new ideas. In Chapel Hill, North Carolina, a group of dedicated parents, community leaders, and UNC professionals joined forces with one mission – to create quality services for people with developmental disabilities. Founded in 1974, Residential Services, Inc. was the result of this effort. RSI was one of the first organizations in North Carolina to provide community-based residential services and today carries on the tradition of providing a wide array of service.

TODAY

Residential Services provides an array of service options. Persons with developmental disabilities and their families or advocates can work with the RSI clinical staff to determine which existing service best meets the needs of the individual or to develop specific supports. RSI has many years of experience working with people with developmental disabilities and helping them to lead full and meaningful lives. The process begins with an application conference to review the person's specific requests for services and the resources available. The RSI staff will work with the person and the family or advocate to identify the option that best meets the person's individual situation. For some people, the best option may be a small 3-6 bed community home, while others may prefer their own apartment or single-family home. Older persons may prefer the tranquility of a country setting at the new Spring Glen retirement center. RSI staff members will work to explore all of the options. Currently, RSI provides services to over 100 individuals with developmental disabilities.

LEADERSHIP

Successful organization must have strong visionary leadership. The Residential Services, Inc. Board of Directors provides that leadership. Board members come from a variety of backgrounds, but all members have a common belief in the organization and its mission. Many Board members have advanced degrees and are acknowledged leaders in their respective fields.

Strong Board leadership has been a hallmark of RSI for all of its 30-year existence. Developing new service models to meet new challenges has been a key to RSI's success over the years. Board committees work with key staff members in the vital areas of finance, advocacy, and program development.

In addition to Board leadership, senior staff leadership is another key element of RSI's success. Senior staff members have decades of experience in the management of a non-profit corporation and in providing services to persons with developmental disabilities.

Over two-thirds of current RSI employees are college graduates or are students at the University of North Carolina. RSI provides a challenging, intellectually stimulating environment for all staff members.

LEADERSHIP STAFF

Sam Weir, MD, President – 3 years with Board
Chris Hollister, President Elect – 4 years with Board
Jerry Levit, Past President – 14 years with Board
Robert Stifler, MD, Treasurer – 9 years with Board
Echo Meyer, PhD, Secretary – 1 year with Board
Karl Bauman, PhD – 1 year with Board
Steve Chall – 1 year with Board
Betty Ann Rogers – 19 years with Board
Norbert Schneider, DDS – 12 years with Board
Victoria Shea, PhD – 25 years with Board
John Stewart, JD – 29 years with Board
Mary E. Van Bourgondien, PhD – 21 years with Board

IMPACT

I[illegible] dedicated to meeting the needs of people with developmental disabilities and their families. For over 30 years, RSI has expanded options for people with developmental disabilities. From a single six-bed home, RSI has grown to provide services for over 100 children and adults. From facilitating living independently in one's own apartment or home to caring for elderly citizens with developmental disabilities, RSI has continuously expanded available options in our community.

RSI has also created programs and alternatives in the areas of employment, day services, retirement services, and leisure. A key element of RSI's success is collaborating with community agencies whenever possible. This emphasis on collaboration helps ensure that individuals with developmental disabilities have as many options as possible.

Self-sufficiency adds self-esteem; independence to the extent of every individual's capacity is an important goal at RSI.

I nediate Care Facilities for Persons with Mental Retardation

(ICF-MR) Homes are designed to assist individuals with comprehensive needs to live active, fulfilling, and productive lives. Residents of ICF-MR homes work toward personal goals and learn a variety of skills to live and work more independently. Staff are on site 24 hours per day, and services include psychological support, social work, speech/language therapy, occupational therapy, physical therapy, recreation, nursing, dietary consultation, and pharmacy consultation.

Supported Living, Independent Living, and Apartment Programs

Independent and Supported Living arrangements are available for individuals who demonstrate the ability to structure their own time and who possess basic safety and self-care skills. Many residents are competitively employed and advocate for themselves in order to be active members of the community.

Autism Services

RSI provides several homes highly specialized to serve the unique needs of persons with autism. RSI coordinates closely with the University of North Carolina TEACCH (Treatment and Education of Autistic and related Communication handicapped Children) Program. Children in the autism program attend public schools while adults work with TEACCH supported employment, Life Options, and other vocational programs.

The Continuing Care Retirement Center, Spring Glen

S] Glen opened in October 2003. It is the first retirement facility in North Carolina to accommodate the specific needs and desires of seniors with developmental disabilities. A combination of ICF-MR, Supported Living and Independent Living options are available for the fifteen people living at Spring Glen. On-site amenities include a fitness room, walking trails, and patio garden.

Life Options

Life Options is a vocational and learning program designed for adults who require specialized vocational accommodations or who find more meaning through continued learning, recreation, and fitness. Life Options operates an online bookstore in addition to making a variety of products. Life Options' yard maintenance crew maintains home and office grounds. A greenhouse provides another option for people with developmental disabilities.

Learning new skills supports a healthy mind and healthy body.

SUPPORT

ntial Services, Inc. is a private, non-profit corporation, and all donations are tax-deductible. Private contributions, gifts from charitable foundations, and grants play an important role in helping RSI grow and provide quality services.

By utilizing public, private, federal, and personal financial support, RSI is able to develop new services and maintain financial stability. Government funds including Social Security and Medicaid pay for many, but not all of, RSI's financial obligations. Private support is critical to maintaining the quality of services provided by RSI.

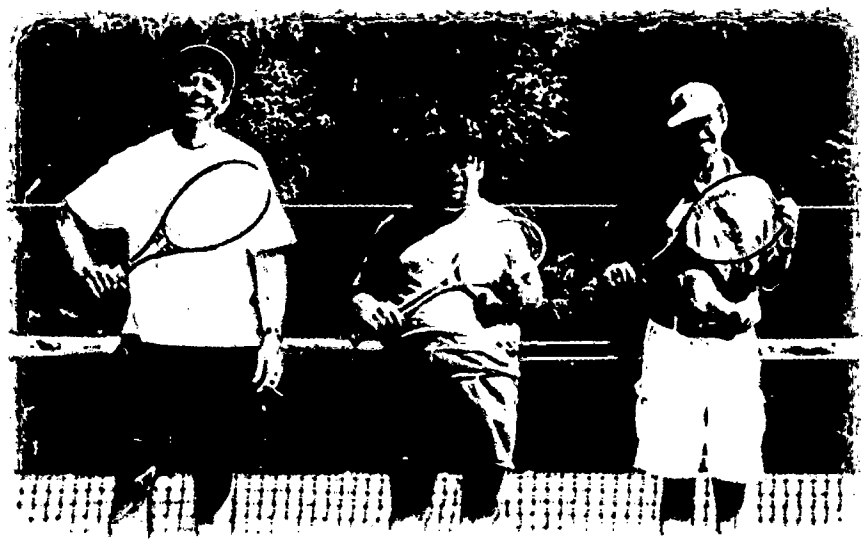
Donations to the RSI Security Fund help to provide for the long-term financial health of the organization. Donations of cash, stocks, bonds, real estate, and other types of support help to meet this critical need within the organization. The RSI Board Finance Committee reviews the Fund on a regular basis to ensure that each donation provides the maximum value to the organization.

Donations of all sizes are gratefully received.

ENDOWMENT

The RSI Endowment Fund is the most effective and immediate means of maintaining programs offered by RSI. Created in 1995, i ides a firm financial base for the operation of the organization and assures uninterrupted, quality services for residents. Uncertain times challenge funding for RSI; alternate funding sources are imperative.

For information on planned giving, please contact:
Dennis Bradshaw
(919) 942-7391



Outdoor activities are part of a healthy living focus for residents at RSI.

111 Providence Rd.
Chapel Hill, NC 27514
Tel: (919) 942-7391
Fax: (919) 933-4490
Website: www.rsi-nc.org

Congressman David Price congratulates Secretary of Health & Human Services Carmen Hooker Odom following her endorsement of the civil rights of individuals with developmental disabilities at the opening of Spring Glen.

A Tradition of New Possibilities

Dennis Bradshaw, Executive Director
dbradshaw@rsi-nc.org
(919) 942-7391, ext.111
Website: www.rsi-nc.org

Oxford House

A Successful Government – Private Partnership in North Carolina since 1991

Overview

- Oxford House, Inc. (OHI) is the umbrella organization for the more than 1,600 individual Oxford Houses. Oxford Houses are self-run, self-supported recovery houses for individuals recovering from alcoholism and/or drug addiction. Many also have co-occurring mental illness.
- All Oxford Houses are rented residential houses. Oxford House owns no real property.
- OHI, the umbrella organization, focuses its efforts on the expansion of the network of Oxford Houses and on supporting existing houses.
- With no time limits on residency, and reliance on House residents to manage their own Oxford Houses, the program has proven to be highly successful – as proven by academic research and the program's listing on the Federal Registry of Evidence-based Programs and Practices.

Overview Continued

- Oxford House has successfully operated in North Carolina for over 20 years and there are currently 155 Oxford Houses in the state.
- The recently-released 2012 Oxford House Annual Report provides considerable information about OHI, its policies and practices, and its finances. Copies are available on the Oxford House website at: www.oxfordhouse.org and hard copies are available for members of this committee.

Background

- The Oxford House concept took root in North Carolina in 1990 when Former-Senator James Broyhill introduced the concept to Governor Jim Martin and key legislative leaders. The legislature then earmarked $200,000 to bring trained Oxford House outreach workers into the state to begin development of a state network of Oxford Houses. The first two North Carolina Oxford Houses – in Asheville and in Durham – are still in existence today.

Current Status

- Currently there are 155 Oxford Houses in North Carolina, with a total of 1,162 recovery beds. There are 114 houses for men; 39 houses for women; and 2 houses for women and children. As in all Oxford Houses, House residents – once voted in by current residents – can stay as long as they feel they need to stay as long as they totally refrain from using drugs or alcohol.
- OHI currently receives funding from North Carolina in the amount of $550,000. This amount supports both managing a revolving loan fund and providing technical assistance through the use of trained outreach workers. Broken down by the number of recovery beds, the total $550,000 support to OHI results in a cost of $473 per recovery bed annually – less than $10 a week per bed.

Why Oxford Houses Work

- All Oxford Houses are rented, not owned. OHI owns no real property. Renting ordinary houses in good neighborhoods permits expansion to meet demand and permits property to remain part of the local property tax base. Furthermore, renting precludes the need for time limits on residency.
- All Oxford Houses are self-run and self-supported by the residents themselves. Residents take on leadership responsibilities, develop peer support, build self-esteem, and strengthen long-term recovery. They get jobs and develop a habit of paying bills and supporting themselves. Many residents had been homeless or incarcerated prior to entering an Oxford House and relied on government support – either through direct payments or through being housed in government-supported jails and other facilities.
- Independent academic research has demonstrated that the self-governance elements of Oxford House living – along with the lack of residency time limits – foster long-term sobriety. The Oxford House website (www.oxfordhouse.org) contains much of the peer-reviewed research. The evidence also led to the program's inclusion on the Federal Registry of Evidence-based Programs and Practices.

How the Money is Spent

- OHI-trained and supervised outreach workers establish new Oxford Houses and teach new residents how they operate; network with local communities, agencies and organizations; work with state agencies (e.g. prisons and courts); and connect residents to support networks.
- Outreach workers also provide technical assistance for starting new Oxford Houses (e.g., loan fund application assistance, lease negotiation) and serve as resource persons for residents in new and existing Oxford Houses. Outreach workers also help organization local and statewide workshops.

Oversight Of The Revolving Loan Fund

- OHI administers a loan fund that provides start-up loans to new Oxford Houses. Since 1991, 200+ loans (averaging $4,000 each) have been made; a total of $800,000 has been loaned. The current loan capacity is about $140,000, or which $121,000 is outstanding. Each dollar of the initially-allocated $100,000 fund has been used 4-5 times over to establish new Oxford Houses.

Profile of NC Oxford House Residents

Addicted to alcohol and other drugs	63 %; Alcohol only, 37%
Race	White – 54%; Black – 42%; other 4%
Gender	Men – 74%; Women 26%
Previous Incarceration	76% with average jail time of 13 months
Previous homelessness	53% with average length of time 6 months
Average age	42 years [range 19-72]
Veterans	11%
Marital status	45% Never Married; 18% Separated; 33% Divorced and 4% still Married
Average length of stay in House	10.1 Months
Applicants per vacancy	+4
Average sobriety of NC residents	16 months

What Next

- OHI will continue its current program of developing new Oxford Houses and supporting existing Oxford Houses.
- OHI will continue development of new initiatives that are showing success:
  - **Use of OHI web-based house/vacancy tools**
  - **Criminal Justice Initiative**
  - **Peer Advocate Initiative**
- OHI will continue to focus on developing the network of Oxford Houses in North Carolina while maintaining both quality control and cost-effectiveness.

Oxford House, Inc.
Contract Number 2079 FY'12

Mandatory Reporting Per House Bill 950, Session Law 2012-1042

11/29/2012

Submitted By: Kathleen Gibson, COO
Kathleen.gibson@oxfordhouse.org
919-395-8206

Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 – FY'12

Table of Contents

Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 - FY'12

SECTION I

The Entity's Mission, Purpose And Governance Structure

Program Overview

Founded in 1975, Oxford House, Inc. is a Delaware nonprofit, 501(C)(3) corporation that serves as the umbrella organization of a worldwide network of more than 1,500 individual Oxford Houses. Its central office is at 1010 Wayne Avenue, Suite 300, Silver Spring, Maryland 20910. The mission of Oxford House is to foster the development of Oxford Houses in order to provide recovering alcoholics and drug addicts the opportunity to live in an environment designed to support recovery without relapse.

The Oxford House philosophy posits that all addict and alcoholics, irrespective of the type, severity or length of their addiction, are capable of achieving long-term sobriety and becoming healthy, responsible and productive citizens in the community. Oxford Houses provide that opportunity. Total abstinence - long-term recovery without relapse - remains the basic philosophy of the Oxford House program. Throughout its 37-year history, Oxford House has encouraged independent academic researchers to evaluate the Oxford House program. The result is that there are many research reports on Oxford House that show that the program works - and that it works for many difficult-to-reach populations.

The organization's overarching goals are: (1) to maintain and expand the successful and cost-effective network of Oxford Houses to give more recovering alcoholics and addicts the time and peer support needed to achieve recovery without relapse and (2) to educate the broader community about the need to focus on the long-term recovery and dispel the notion that relapse is part of the disease.

Oxford Houses provide the living environment that helps residents become comfortable enough in sobriety to stay clean and sober without relapse. The philosophy behind Oxford House™ is three-fold: (1) self-help is the bedrock of recovery, (2) disciplined democracy is key to living together successfully, and (3) self-support builds sobriety comfortable enough to avoid relapse.

The Oxford House Manual© is the basic blueprint that provides the organization and structure that permits groups of recovering individuals to live together successfully in a supportive environment. All Oxford Houses are rented ordinary single-family houses in good neighborhoods. There are Oxford Houses for men and Oxford Houses for women but there are no co-ed houses. The average number of residents per house is about eight.

Oxford Houses work because they: (1) have no time limit on how long a resident can live in an Oxford House, (2) follow a democratic system of self-run operations, (3) utilize self-support to pay all of the household expenses, and (4) adhere to the absolute requirement that any resident who returns to using alcohol or drugs must be immediately expelled. Oxford Houses provides the time, peer support and living environment necessary to support long-term recovery without relapse. Some individuals live in an Oxford Houses a few months; others for many years. Together, these individuals develop each Oxford House into a place where residents can learn to live a responsible life without the use of alcohol and drugs.

In part because alcoholism, drug addiction and co-occurring mental illness are egalitarian diseases, Oxford Houses serve a highly diverse population. As noted in the Oxford House 2011 Annual Report, National Oxford House Resident Profile on page 1*(Attachment 1)*. Three-quarters of Oxford House residents have been addicted to drugs and alcohol, and a quarter of the residents have been

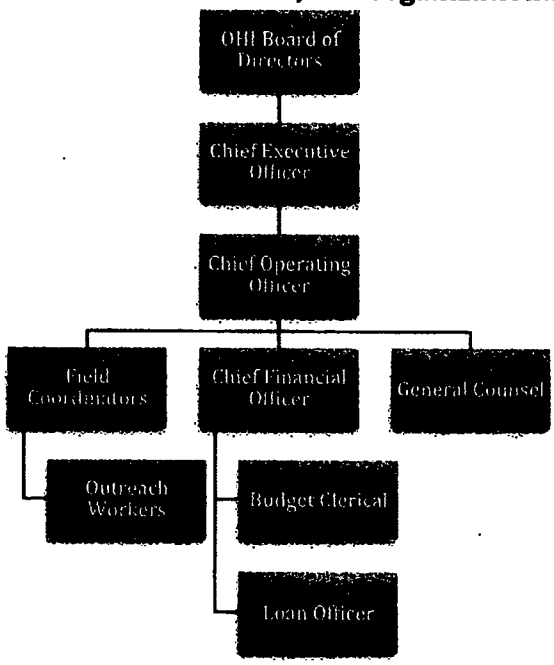
addicted to alcohol only. A significant portion of the Oxford House population (63%) has been homeless and many residents (79%) have been in jail. There is wide variation in age, educational attainment, and job and income history among Oxford House residents. In addition, Oxford House serves very diverse ethnic and racial populations. Some Oxford Houses serve particular special interest groups (e.g., gays and lesbians, women with children, and hearing-impaired individuals). As of June 30, 2012 there were 383 Oxford Houses for women, and 1,138 Houses for men. The total network of total houses is 1,521. As of June 30, 2012, forty-five states had Oxford Houses. The total number of residents across all states is 12,028. The number of women residents is 2,959, and the number of men residents is 9,069. The average age of residents is 36.2 years. The average cost per person per week is $100 (range $85-$155). Two areas where Oxford House is especially active are in providing housing for: Veterans (18 % of Oxford House residents) and Women and Children (102 of the 383 women's house are dedicated for this purpose).

Oxford House focuses on recovery without relapse. It tracks its results through its own surveys and through the work of independent academic researchers. Much of the independent academic work is available on the Oxford House website (www.oxfordhouse.org) under "Publications/Evaluations/DePaul."

Oxford Houses in North Carolina began in 1991 under a contract between Oxford House, Inc. (OHI) and the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disability and Substance Abuse Services [DHHS DMH/DD/SAS]. Today there are 150 Oxford House in the state - 109 for recovering men; 38 for recovering women; and 3 for recovering women and children, as a result of the DHHS DMH/DD/SAS and OHI agreements between 1991 and 2012. At any particular time, there are more than 1,120 recovering individuals living in the North Carolina Oxford Houses. This proposal is designed to maintain and expand the existing network of Oxford Recovery Homes in North Carolina and to administer the North Carolina PL 10-690 Revolving Loan Fund.

Figure 1 below shows the Organizational Structure of Oxford House.

Figure 1 – Oxford House Organization Chart
Overall Oxford House, Inc. Organizational Chart



Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 - FY'12

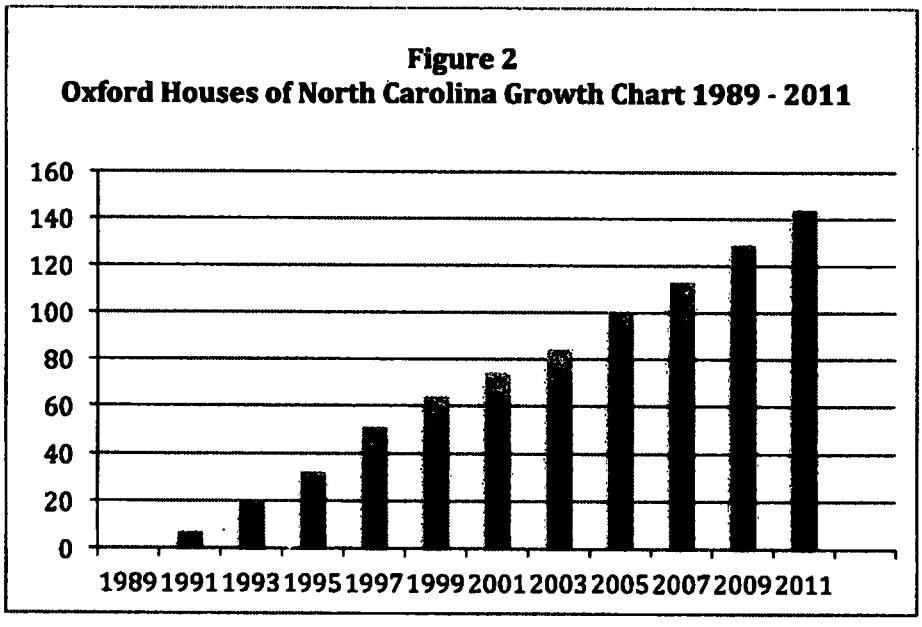
Note: Oxford House, Inc. is a nonprofit corporation incorporated in the State of Delaware with its place of business at 1010 Wayne Ave. Suite 300, Silver Spring, Maryland 20910. Its website is www.oxfordhouse.org. The telephone number for Oxford House, Inc. is 301-587-2916 and the facsimile number is 301-589-0302.

Oxford House, Inc. is the umbrella organization for all individual Oxford Houses. Each Oxford House has a charter from Oxford House, Inc. and has the sole authority to issue such charters as the copyright and trademark holder of the Oxford House system of operation and related materials. Started in 1975, in Silver Spring, Maryland, the network of Oxford Houses as of June 2012 consists of 1,521 individual Oxford Houses [1,138 for men and 383 for women] with a total of 12,028 recovery beds.

During 2011, more than 25,000 individuals lived in one of the nation's Oxford Houses with 4,432 [17%] expelled because of relapse into using alcohol or illicit drugs. Each Oxford House is self-run and self-supported following charter conditions and procedures in the Oxford House Manual©. The three charter conditions are: [1] the group must be democratically self-run following the discipline Oxford House system of operation, [2] the group must be financially self-supporting, and [3] the group must immediately expel any resident who returns to using alcohol or illicit drugs. There is no time limit for how long a resident can reside in an Oxford House provided the resident pays the requisite equal share of household expenses [the average share was $103 per week in 2012] and stays clean and sober. On average, a person lives in Oxford House a little less than one year. More than 80% stay clean and sober.

Below is a chart of the Development of Oxford Houses In North Carolina between 1989 and 2011

Figure 2
Oxford Houses of North Carolina Growth Chart 1989 - 2011



Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 - FY'12

SECTION II

A Description Of The Types Of Programs, Services, And Activities Funded By State Appropriations

1. Problem Statement

The purpose of the contract is to meet the requirements of § 2036 of the Anti-Drug Abuse Act of 1988 (PL 100-690, approved November 18, 1988), which amended Subpart I of Part B of Title XIX of the Public Health Services Act (42 USC 300x) by adding a program entitled "Group Homes for Recovering Substance Abusers."

Oxford House, Inc. is the 501(c) (3) umbrella organization of a national network of democratically run, financially self-supported homes for recovering substance abusers. The first Oxford House opened in 1975 in Maryland, with the enactment of the Anti-Drug Abuse Act of 1988 (P.L. 100-690), Oxford Houses began to expand nationwide out of the Maryland area. The Act's provision for revolving loan funds in the states, which facilitated the creation of recovery homes based on the Oxford House model, helped Oxford Houses expand to the current level of more than 1,580 nationally.

Addiction is a terrible disease that affects individuals, families and communities. The North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) notes in Appendices for Community Systems Progress Report from Medicaid and State Service Claims Data based on claims paid through October 31, 2010, that nearly 609,513 adults need substance abuse services for the one year period July 1, 2009 to June 30, 2010, but the state's public system only will serve an estimated 11 percent 65,799 of those in need. Although addiction is a prevalent disease it can be treated. Affordable recovery housing is an essential part of effective treatment, especially for persons in the early stages of recovery. For twenty years, Oxford House, Inc. has helped fill this need for affordable housing in treating addiction in North Carolina. In June of 2012, with 150 houses in 29 cities, Oxford House has the capacity to assist more than 1,076 North Carolinians recovering from substance abuse. However, the demand for additional Oxford House units remains.

Recent data from the Division of Prisons, North Carolina Department of Corrections (DOC) suggests this demand for Oxford House units is likely to increase in the future. NC DOC released 28,860 inmates from prison in FY08-09, and approximately 86 percent or (24,820) of NC inmates need substance abuse services. The US Department of Justice estimates that about 67 percent of people on probation "can be characterized as alcohol-or-drug-involved offenders." Based on FY 08-09 data, there were approximately 110,000 people under probation supervised by the Division of Community Corrections, NC DOC, on any given day in NC, which suggests that as many as 73,700 probationers may need substance abuse services. Drug offenders comprise one third of all persons convicted of a felony in state courts, and one half of all homicides are alcohol related. The National Clearinghouse for Alcohol and Drug Information (NCADI) reports, "Inmates with substance use disorders are the most likely to be re-incarcerated -- again and again -- and the length of their sentences continually increases. The more prior convictions an individual has, the more likely he has a substance use disorder. In State prisons, 41 percent of first offenders have used drugs, compared to 63 percent of inmates with two prior convictions and 81 percent of inmates with six or more prior convictions. Half of State parole and probation violators were under the influence of drugs, alcohol, or both when they committed their new offense. State prison inmates with six or more prior convictions are three times more likely than first-time offenders to be regular crack cocaine users. Former SAMHSA Administrator Nelba Chavez summarizes the need for community programs that will help break the cycle of relapse and recidivism by stating, "Substance abuse

treatment gains in prison may be lost if treatment is not continued after the offender is released. Many prisoners after release have no place to live, no job, and no family or social support, all factors that increase the risk of relapse. Providing support services are a critical part of ensuring the continuity of care as offenders with substance abuse problems move from incarceration to the community." These individuals face severe limitations on financial, familial and personal resources, finding treatment and comprehensive services offer the most effective resources for improved outcomes for this population. By providing a place to live and support services, Oxford Houses reduce the risk of relapse among ex-offenders and other Oxford House residents. According to Oxford House North Carolina Resident Survey conducted fall 2008, 81.3 percent of the residents in Oxford Houses had served time in jail or some correctional facility an average of 17.9 months. During this survey period, 73 percent of all the Oxford House residents had experienced homelessness averaging about 6 months. For many recovering substance abusers who are re-entering society Oxford Houses will serve as tools of transition. Most houses had accepted parolees and probationers as residents within the prior year.

At the 2005 Annual Meeting of the American Psychological Association researchers from DePaul University released results of two longitudinal studies that verify Oxford House as a best practices model for effectively promoting long-term abstinence. One study assessed 150 participants in Illinois who were randomly assigned to either an Oxford House or "usual care conditions" after undergoing treatment for addictions to alcohol or drugs. At the end of the two-year period, 65 percent of participants in Oxford Houses had refrained from substance use as compared to only 31 percent of participants living elsewhere. Oxford House residents also experienced higher positive outcomes in general including a higher level of monthly net income ($989.40 vs. $440.00) and lower incarceration rates (three percent vs. nine percent). The leader of the research team, Dr. Leonard A. Jason, stated, "Even we were amazed at the results. These findings suggest tremendous public policy benefits for these types of low-cost, residential, non-medical care options for individuals with substance abuse problems." The second study collected data from residents living in some 213 Oxford Houses in 16 states around the country. Nearly 900 participants were interviewed every four months for a year. At the end of the 12-month period, 87 percent of the residents were still drug free. On average, about 65 percent of residents "cycle out" of Oxford House after a year, yet, according to the study—even among those who no longer resided at the recovery homes—the rate of relapse was extremely low. "We found that six months in Oxford House is what made a really big difference in recovery," explained Dr. Jason. This conviction was recaptured in Dr. Jason's recently 2008 published book, Rescued Lives: The Oxford House Approach to Substance Abuse, in which he noted "the best interventions might involve working with naturally occurring healing processes, such as what occurs in Oxford Houses". The American Correctional Association and the Hazelden Foundation 1996 Handbook for probation, parole and community corrections states, "Oxford House, Inc. is fast becoming one of the most important and cost-free community-based resources available for community corrections". (Partners in Change by Edward M. Read, Hazelden and the American Correctional Association, 1996, page 144.)

Although Oxford House, Inc. as of June 30, 2012 provided more than 1,076 recovery beds for persons recovering from substance abuse an unmet need remains throughout North Carolina. These fiscal year applications for Oxford House units per month exceed admissions per month by an average of 58 units.

Demand Measure

From January 2010 through December 2010, Oxford House received an average of 186 applications for residence per month but only had an average of 128 admissions per month resulting in an average unmet demand of 58 units or beds per month or 696 per year.

2. Project Objectives

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) notes in Appendices for Community Systems Progress Report from Medicaid and State Service Claims Data based on claims paid through October 31, 2010 that nearly 609,513 adults need substance abuse services for the one year period July 1, 2009 to June 30, 2010, but the state's public system only will serve an estimated 11 percent, 65,799 of those in need. To provide peer operated recovery homes as safe, affordable, and drug free living situations with the support of peers in recovery, support from Oxford House, Inc., and access to other supports in the community in which individuals are taught how to become self-sufficient by learning life skills in a peer supportive environment.

3. Project Methods or Designs

- **To open new houses**, Oxford House, Inc. will provide technical services and support for the establishment of six new self-run, self-supported recovery homes throughout the State of North Carolina by the end of the contract period. Oxford House will provide technical assistance to new group of recovering individuals, helping them to rent suitable houses and recruit suitable residents. In addition, Oxford House outreach workers will teach new groups how to operate a self-run, self-supported recovery house effectively. Specific outputs for opening these houses include locating the six houses, signing multiple-year leases for the houses, coordinating tenant substance abuse recovery support, and assisting tenants in finding and maintaining employment.

The contractor will assure that special populations such as Latinos, persons with hearing disabilities, and physically handicapped individuals will have culturally competent access to the existing Oxford Houses and the six new houses opened during this contract period. In addition, Oxford House staff will notify the Local Management Entity (LME) as they plan to locate Oxford Houses in the counties served by the LME. In addition to the above, Oxford House, Inc. agrees to maintain active communication with and notification to the Division contract administrator of any sensitive community concerns or issues related to the establishment of an Oxford House.

- **To maintain the state revolving loan fund** by administering the application, administration, and repayment of start-up loans made to eligible applicants of six or more recovering individuals from the North Carolina Recovery House Revolving Loan Fund.

- **To establish and maintain programs at correctional institutions** to educate individuals on the Oxford House model. The goal of the Criminal Justice Initiative for the next SFY will be to serve at least 20 re-entering substance users and mentor them in their transition. From July 1, 2005 to March 30, 2011, Oxford House Criminal Justice outreach staff placed over 900 men and women in Oxford Houses exceeding its expectations.

Inputs:

- Staff and other resources described in the Budget Narrative.

Outputs:

- Open 6 new houses.
- Administer loans to groups of 6 or more recovering individuals Starting new Oxford Houses.
- Serve at least 20 re-entering substance users and mentor them in their transition from incarceration

Figure 3 below represents a sample of Oxford House Outreach Worker Duties.

Figure 3 - Outreach Worker Duties

The following chart describes the activities and duties of the outreach workers.

Task	Action of Outreach Worker
1. Finding a suitable house	➢ The outreach worker has been trained to recognize the characteristics of suitable house to rent. ➢ The outreach workers know how to execute a legal lease between the landlord and the group or entity that is made up of ever changing residents. ➢ The outreach worker is able to answer zoning questions –In a general way – and is backed up by the expertise of the central service office in Silver Spring.
2. Obtaining a charter from Oxford House Inc.	➢ Outreach worker helps newly recovering individuals to fill out the charter application form and submits it to Oxford House, Inc. to get a "conditional" charter that is valid for up to six months. ➢ Outreach worker helps the new group to fulfill the requirements of the "conditional" charter so that the group can be granted a "permanent" charter.
3. Obtaining an FEIN [federal tax identification number] from IRS to enable the group to establish a checking account in the name of the group.	➢ Since the mid-eighties every bank account needs either a social security number [in the case of an individual] or a FEIN [in the case of a group, association, partnership or corporation]. The outreach worker processes the paperwork to obtain a FEIN and helps the group to establish a checking account in the name of the individual Oxford House™.
4. Recruiting initial residents for the new house.	➢ Working with treatment providers and the recovery community to explain the value of Oxford House living to get referrals. ➢ Convincing a newly recovering individual that living in an Oxford House™ provides the time, peer support and living environment to gain comfortable sobriety without relapse.
5. Teaching residents in a newly established Oxford House the standard system of operations needed to effectively operate the house.	➢ Teaching new residents the need for a weekly business meeting and the procedures to follow. ➢ Helping the residents elect the five essential officers needed to operate each house and teaching each person the duties of each office holder. ➢ Helping the residents get the household furnishing needed for the house [from beds to brooms]. ➢ Story telling while living in the house to infuse the group with the belief and culture of Oxford House™ and its role in promoting recovery without relapse.
6. Instilling a dedication to reach out to other recovering individuals to share the benefits of Oxford House living.	➢ Teaching residents how to make presentations to providers to get new recruits. ➢ Promotion of expansion within an area to meet the need of newly recovering individuals and to organize a mutually supportive chapter. ➢ Building a habit of attending 12-step meetings and the encouragement of frequent contact between residents and Oxford House World Services to resolve house issues, promote expansion.
7. Ongoing training and education of existing residents of Oxford House to ensure quality control of the Oxford House.	➢ Assist Chapters in conducting Officer Training Workshops every six months. ➢ Help develop and conduct Annual Oxford House state conference.

Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 - FY'12

SECTION III

Statistical And Demographical Information On The Number Of Persons Served By The Programs, Services, And Activities, Including The Counties In Which Services Are Provided

The successful Oxford House experience is quantified by both internal and external measurement. The North Carolina field staff submits to the Division a Monthly Housing Activity Report that includes data from each house regarding the number of applications, number of beds available, number of admissions, number of residents leaving the houses and the reasons for leaving: relapse, voluntary or other causes such as disruptive behavior. These data gives the State valuable information on the provision of care and the functioning of each individual home.

Another report that provides valuable information on Oxford House is the Annual Resident Profile Survey. This is a yearly survey completed by all residents residing in North Carolina Oxford Houses. This data are compiled by the State Coordinator and used to generate a profile of NC residents that shows resident race and ethnicity, disability status, prior homelessness, prior incarceration (individuals just released as a past of the Criminal Justice Initiative as well as individuals incarcerated in the past), average lengths of sobriety and average monthly earnings.

To evaluate the Criminal Justice Initiative component of the Oxford House project, the State Coordinator maintains a database to track individuals entering Oxford House from the correctional system. The information is gathered using a modified version of the Treatment Alternatives to Safe Communities Criminal Justice Management (TASC CJM) Intake, Six-Month Update and Discharge forms provided by NC DMH/DD/SAS and is provided to the Division on a quarterly basis.

The primary outcome measure for this contract is for Oxford House to establish and implement operations for six new Oxford Houses by June 30, 2011. In addition to this outcome measure, Figure 4 (below) summarizes additional outcome and the service quality measures that will be gleaned from the Monthly Housing Activity Report and Annual Resident Profile Survey:

Figure 4- Outcome and Service Quality Measures

Project Report	Outcome Measure
Monthly Housing Activity Report	Average annual occupancy rate from the sum of monthly housing reports will be at least 80%.
	Average annual relapse rate (total # residents that relapse/total # residents) from the sum of monthly housing reports will be no higher than 10%
Annual Resident Profile Survey	Average Length of sobriety for residents will be greater than 12 months.
	Employment rate for residents will be at least 75%.
	Average number of 12-step meetings that each resident attends per week will be at least 5.0
	At least 80% of residents surveyed will say that Oxford House is "very important to sobriety."
	At least 80% of residents surveyed will say they would recommend Oxford House to other persons with substance abuse issues.

Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 – FY'12

The national Oxford House staff will manage this loan fund and provide the state with the following reports:

- Monthly Financial Status Report due by the 10th day following the end of the month
- Monthly Housing Activity Report due by the 15th day following the end of the month
- Quarterly Activities and Accomplishments Report due by the 15th day following the end of the quarter
- Quarterly Oxford House Criminal Justice Housing Report due by the 15th day following the end of the quarter
- Annual Financial Audit due six months following the end of their audit fiscal year.
- Annual Resident Profile Survey completed annually by June 30.

The following Figure 5 is a list of counties served in North Carolina and numbers of Oxford Homes in each county:

Figure 5 – North Carolina Oxford Houses By County

County In North Carolina	# Of Oxford Houses
Alamance	1
Buncombe	7
Catawba	3
Cumberland	6
Dare	3
Durham	13
Forsyth	9
Gaston	1
Guilford	21
Harnett	1
Iredell	1
Johnston	1
Mecklenburg	20
New Hanover	3
Orange	13
Person	1
Pitt	9
Randolph	2
Rowan	2
Swain	1
Vance	2
Wake	28
Wayne	2

Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 - FY'12

SECTION IV

Outcome Measures That Demonstrate The Impact And Effectiveness Of The Programs, Services, And Activities. A Detailed Program Budget And List Of Expenditures, Including All Positions Funded And Funding Sources

The following Figure 6, "2012, 2011 and 2010 Profile Of North Carolina Oxford Houses" and "Resident Activity Report" (Attached) dated June 30, 2012 demonstrate the effectiveness of the program.

Figure 6 - The 2010, 2011 and 2012 Profile Of North Carolina Oxford Houses And Residents

The World Services Office of Oxford House collects data monthly from each Oxford House with respect to applications, admissions, expulsions for cause and voluntary departures. Resident profiles are obtained using the confidential survey questionnaire designed by the late William Spillane, Ph. D. In his 1988 Evaluation of Oxford Houses The house figures below are current as of June 30, 2012. Resident profiles are derived from state surveys conducted in late 2010, early 2011. 2012 data noted in bold. Net Gain of new Oxford Houses was 13. Net gain in recovery beds was 98.

	2012	2011	2010			2012	2011	2010
Number of Women's Houses:	41	38	37		# Of Women's Recovery beds:	298	278	269
Number of Houses For Men:	109	106	100		# Of Men's Recovery beds:	817	798	748
State Network of Houses:	150	144	137		Total Number of Recovery beds:	1,115	1,076	1,017
Average Age:	42 Years	39 Years	41 Years		Residents Participating in this survey:	726	703	623
Age Range:	19-72 Years	18-69 Years	18-74 Years		Rent Per Group Per Month [Ave]:[range $1,200 to $3,500]	$1,355	$1,375	$1,380
Cost Per Person Per Week: [average]: [range $85 - $135]	$102	$105	$105		Average Years of Education:	13 Yrs	12.45	13 Yrs
Percent Military Veterans:	11%	13%	16%		Average Monthly Earnings:	$1,346	$1,199	$1,228
Percent Addicted to Only Alcohol:	37%	36%	37%		Residents Working on date of survey:[1]	81%	72%	67%
Percent Addicted To Drugs or Drugs and Alcohol:	43%	52%	63%		Residents Receiving SSI/Disability Benefits/Unemployment:	10%		
Race –					Marital Status –			
White;	59%	55%	57%		Never Married	44%	47.9%	49 %
Black;	37%	42%	41%		Separated	14%	11.4%	13 %
Hispanic;	3%	3.6%	2%		Divorced	36%	32.4%	30 %
Other [Native American]	.06%				Married	4%	5.4%	5 %
					Widowed	2%	2.9%	3 %
Prior Homelessness:	62%	71%	58%		Average Number of Previous Attempts for Sobriety:	5	6	5
Average Time Homeless:	5 Mos.	9Mos.	8 Mos.		Percent Expelled for Relapse:[2]	>10%	>10%	>10%
Prior Jail:	78%	83%	80%		Percent Going To weekly Counseling *plus* AA or NA:	35%	33%	50%
Average Jail Time:	21 Mos.	19 Mos.	18 Mos.		Average AA or NA Meetings Attended Per Week:	4.4	5.2	5.4
Average Length of Sobriety of House Residents:	16 Mos.	15 Mos.	20 Mos.		Average Number of Applicants For Each Vacant Bed:	+4.0	+3.4	+4.0
Average Length of Stay In An Oxford House:	11 Mos.	10 Mos.	9 Mos.		Percent of Residents finding Oxford House *Very* Important to Them:	95%	96%	97%
Annual Number of individuals served: [Based on a 2.1 bed turnover rate]	2342	2257	2136		Percent of Residents that would Recommend Oxford House to Others:	97%	94%	96%

[1] Dates vary slightly because surveys were completed over a six-week period but basically for 2010 date was 11/30/2010; for 2011 the date was 6/30/2011 and for 2012 the date was 6/30/12. Note that house data [number and number of recovery beds is current as of 9/30/11.
[2] For "the percent expelled for relapse" calculations are based on averaging actual number of relapses per month divided into the number of residents served for that month for that fiscal year.[information derived from monthly activity data report]

Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 – FY'12

SECTION V

A Detailed Program Budget And List Of Expenditures, Including All Positions Funded And Funding Sources.

Below Figure 7, is the Oxford House; Inc. approved Budget for fiscal year FY'11-12:

Contractor: Oxford House Inc.	SFY 11-12
Contract #	Total
Description: Residential Housing Services	Program Costs
Personnel	
1) Salary/Wages/Benefits	$233,888
2) Professional Services	$11,499
3) Total Personnel Services	$245,387
Supplies and Materials	
4) Office Supplies and Materials	$4,750
5) Computer Supplies & Software	
6) Janitorial Supplies	
7) Educational/Medical Supplies	
8) Total Supplies and Materials	$4,750
Operational Expenses	
10) Travel	$77,234
11) Board Member Expense (Travel, Per Diem)	
12) Communications (Telephone, Postage, etc.)	$18,527
13) Utilities	
14) Printing and Binding	$3,102
15) Repair and Maintenance	
16) Computer Services (Accting, Payroll, etc.)	
17) Employee Training	
18) Advertising	
19) Total Operational Expenses	$98,863
Fixed Charges and Expenses	
20) Office Rent (Land, Buildings, etc.)	
21) Furniture Rental	
22) Equipment Rental (Phone, Computer, etc.)	
23) Dues and Subscriptions	
24) Insurance and Bond	$1,000
25) Total Fixed Charges & Other Expenses	$1,000
Capital Outlay	
26) Office Furniture	
27) Computer Equipment	
28) Total Capital Outlay	
29) Subcontract	
30) Total Subcontracts	
31) Total Purchases of Services Costs	
32) Total of Direct Costs	$350,000
33) Indirect Costs	
34) Total Budgeted Expenditures	$350,000

Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 – FY'12

Budget Narrative: July 1, 2011 – June 30, 2012

Personnel Services Total $233,888

1) Salary/Wages/Benefits

$10,650 This is figured at $1,775 each per 6 new houses and covers wages and benefits paid to the staff of the Corporate Office in Silver Spring, MD who provide technical assistance to individual house residents who want clarification on specific house issues, clarification on their rights as house members, helping field Coordinators plan workshops, provide training for field coordinators, process information for permanent charters to houses and chapters, coordinate with state officials, field coordinators, treatment providers as to location of houses and the need for expansion and long-term maintenance of existing houses.

$12,000 - Covers a portion of salaries and wages for Corporate Office staff in Silver Spring, MD to manage the State Revolving Long Fund-PL100-690 that includes processing the applications, reviewing leases, collection of loan payments and filing monthly financial and statistical reports. (This is not based upon individual FTEs, but is an estimated cost for the above tasks).

$211,238 - Includes wages and benefits for state staff as described in the table below. Benefits of $37,238 include FICA (7.65%) at $11,017, health insurance at $24,000, unemployment insurance (.30%) at $432, Workers Comprehensive Insurance (.27%) at $389, and Futa as $1,400.

Figure 8 below is the Personnel Salary and Benefits Chart:

Name	Salary	Full-Time Salary	Benefits	Totals	FICA @ 7.65%	Health Insurance	Unemployment Insurance @ .30%	Workers Comp. Insurance @ .27%	Futa
State Coordinator	$45,000	$45,000	$10,050	$55,050	$3,443	$6,000	$135	$122	$350
Outreach Person #1	$36,000	$42,000	$9,309	$45,309	$2,754	$6,000	$108	$97	$350
Outreach Person #2	$30,000	$30,000	$8,816	$38,816	$2,295	$6,000	$90	$81	$350
Outreach Person #3	$33,000	$34,500	$9,063	$42,063	$2,525	$6,000	$99	$89	$350
Criminal Justice Outreach	$15,000	$15,000		$15,000					
Outreach Contract	$15,000	$15,000		$15,000					

treatment providers, correctional facilities and other agencies that may have a need for Oxford Houses. The State Coordinator also serves as liaison between the houses and communities where Oxford Houses exist to insure a good neighborly relationship. The State Coordinator, in conjunction with the Oxford Corporate Office staff, works with local officials to make sure Oxford Houses are located within the guidelines of the communities. One full-time outreach worker is employed as the Criminal Justice Outreach Worker, whose responsibilities include: presenting Oxford House orientation seminars at various Department of Corrections Facilities to educate individuals on the Oxford House model and the value of Oxford House living; mentoring re-entry individuals (a minimum of ten) by arranging for house interviews, assisting them in getting established in an Oxford House, providing assistance with obtaining necessary services to ensure their success; and keeping detailed records of each individual entering Oxford House from the Corrections system. They report to the State Coordinator.

Professional Services Total $11,499

2) Professional Services

$4,650 ($775 per house) to cover as-needed activities such as lawsuits, public relations, research and evaluation, negotiating grant proposals, etc.

$3,600 ($600 per house) to cover bookkeeping activities such as processing time and expense reports for field coordinators and other outreach personnel to insure proper reimbursement and also to insure proper data entry for billing and accurate audit and accounting.

$3,249 - Covers most of the cost of preparing financial data for annual financial report to the state agency.

Supplies and Materials Total $4,750

4) Office Supplies and Materials $4,750
This covers manuals for houses and chapters, supplies for charters, house business forms etc., coupon books and materials for start up kits for new houses and miscellaneous materials necessary to operate the state office.

Operational Expenses Total $98,863

10) Travel $77,234
This includes cost for staff to attend house/chapter/state workshops, meetings with community leaders, state agency officials concerning contracts and expansion etc. Mileage is $75,848 and is derive by computing the actual number of miles driven by the state staff (101,923 miles), plus the anticipated travel of one additional full-time staff with additional travel of increased salary of part-time staff (49,773 miles) made full-time this fiscal year and multiplying that figure by $.50/mile. Overage in mileage/travel expense is covered by Oxford House Corporate Office's "unrestricted donation fund".

Travel covers costs for State Coordinator, the three Field Technicians, and the full-time Criminal Justice Outreach Workers and non-paid technical assistants in locating new houses, assisting existing houses in finding new locations, when needed and travel around the state for conferences, workshops and presentations to treatment providers and other interested agencies. Also includes cost of travel to and from individual Oxford Houses to provide technical assistance. Meals and lodging costs for travel to Annual staff training held for two days in Silver Spring, MD in March 2012. (Out-of-state reimbursement for the five state staff estimated for two days $1,155.50).

Reimbursement for travel for subsistence and lodging will comply with State travel policy established rates.

12) Communications (Telephone, postage, etc.) $18,527

This includes cost for a toll free telephone line for houses to call for information, materials, etc.; postage for current house lists and phone numbers for houses, treatment providers; the telephone/fax and postage cost of the Revolving Loan Fund Managers to communicate with the houses and/or individuals applying for new loans including: a toll-free telephone service; a toll-free facsimile service [particularly needed because each self-run house has only local telephone service to avoid problems of individuals running up big bills]; mailings of coupon books to loan recipients, mailing of information to groups inquiring about the revolving loan fund and mailing of monthly financial statements. Each house has local phone service only but the central office with its toll-free numbers services as a way to connect field personnel and residents of houses within the state. The State Coordinator has a phone and fax line set up in order for the houses to have 24 hour access.

14) Printing and Binding $3,102

Covers the cost of copying and printing monthly financial statements and statistical reports, reminder notices to groups with outstanding loans, manuals and pamphlets, forms, etc.

Fixed Charges and Other Expenses Total $1,000

24) INSURANCE AND BOND - $1,000 - Covers the cost of liability and dishonest insurance for Oxford House employees working in and with the state.

32) Total of Direct Costs - $350,000

34) Total Budgeted Expenditures - $350,000

Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 – FY'12

SECTION VI

The Source And Amount Of Any Matching Funds Received By The Entity

This section does not applicable to the Oxford House, Inc. contract.

Oxford House, Inc. Mandatory Reporting
Per House Bill 950, Session Law 2012-1042
For Year FY'11 – FY'12

Attachments:

- Oxford House Annual Report
- North Carolina Oxford House Activity Report dated June 30, 2012
- An introduction to the North Carolina Oxford House Program
- FSR Final June 30, 2012 Expenditures

An Introduction To The North Carolina Oxford House Program

Oxford House Ilford
Charlotte, NC
Est. July 2007

An Introduction to the North Carolina Oxford House Program

Mission Statement

Oxford House, Inc. exists to educate individuals and private and public entities in the benefits of the Oxford House concept of group homes for recovering substance abusers. It allocates all resources, including grant funds, property donations, and available personnel, to replicate democratically self-run and self-supported Oxford Houses to assist in the recovery of substance abusers.

Size of the Oxford House Program in North Carolina

As of June 2012 there are 150 Oxford Houses in the State of North Carolina.

Total Number Of Houses	150
Total Number Of Beds	1115
Houses For Men	109
Houses For Women	38
Houses For Women And Children	2

- Houses Are Located In 24 Counties
- Capacity Is Expanding At An Average Of Eight Houses Per Year.
- The First Two Oxford Houses Opened 1991, in Durham & Asheville, NC.
- The Most Recent Oxford House Open Greenville, NC March Of 2012.

Capacity is expanding at an average of eight houses per year.
First two Oxford Houses opened 1991, Durham, NC & Asheville, NC
Most recent Oxford House open Charlotte, NC June of 2012

Oxford House is an important housing resource for individuals in recovery in the State of North Carolina. Houses are peer run, independent, and organized to support recovery. The success of the model is based on adherence to the three basic principles of immediate expulsion of relapsers, being run democratically by the residents and financial self-support. The Oxford House Model is listed in the National Registry of Evidence-Based Programs and Practices- More information is available http://nrepp.samhsa.gov/ViewIntervention.aspx?id=223 . We have enjoyed great success since 1991, with the support of the North Carolina Department of Health and Human Services MH/DD/SAS Section.

Basics of Oxford House

The first Oxford House started in 1975 in the Washington D.C. area. That one Oxford House has grown to over 1550 Oxford Houses in 44 states, and internationally in Australia, Ghana and Canada today. Growth of the model accelerated in 1989 when Congress passed PL 100-690. The statute incorporated the basics of the peer run housing into legislation that provided funding for recovering individuals to borrow money to rent a house. Under the legislation, each state received a one-time amount of $100,000 to establish a revolving loan fund for startup of peer run housing.

The revolving fund loan is an important tool for housing start ups because most recovering individuals do not have financial resources when they are coming out of treatment. The loan (up

An Introduction to the North Carolina Oxford House Program

to $4,000) is used to cover costs such first month rent, rental deposits, and utility hookups. Houses repay the loans over a 24-month period.

As soon as the houses began to expand nationwide, cities began trying to enforce local zoning laws relating to numbers of unrelated people living together in one house. In its defense, Oxford House began using the 1988 Fair Housing Amendments administered by HUD to fight these suits. Under the Federal Fair Housing Act, recovering addicts are considered handicapped and zoning laws may not treat unrelated individuals differently from families.

North Carolina Oxford House Staff:			
Chief Operating Officer	Kathleen Gibson	919.395.8206	kathleen.gibson@oxfordhouse.org
Regional Outreach Manager	John Fox	919.395.8192	john.fox@oxfordhouse.org
Outreach Services Rep.	Greg Folino	704.207.6137	greg.folino@oxfordhouse.org
Outreach Services Rep. – Re-entry Specialist	Kurtis Taylor	919.247.7831	kurtis.taylor@oxfordhouse.org
Outreach Services Rep.	Misty Wilkins	919.520.5793	misty.wilkins@oxfordhouse.org
Outreach Services Rep.	Keith Gibson	919.673.1042	keith.gibson@oxfordhouse.org
Outreach Services Rep.	Matt Diedrich	803.984.5347	matt.diedrich@oxfordhouse.org
Special Projects	Paula Harrington	919.616.3020	paula.harrington@oxfordhouse.org
Women's Resource Coordinator (Wake County)	Karen McKinnon-Sutton	919.812.8282	karen.sutton@oxfordhouse.org

Oxford Houses Are Based On Three Basic Principles:

- Houses are peer run.

The engine that runs the house is the weekly house meeting where each member gets a vote on issues affecting the house. The meetings cover all aspects of house business such as: the payment of bills, approval of purchases, chore assignments, and response to disruptive behavior. Members elect officers who serve for six-month terms. The weekly meetings provide each resident with a feeling of empowerment as they participate in the running of the house and a sense of community with other residents.

- Houses are self-supporting.

The residents share the total expenses for the house. Rents vary from $360 to $450 per month depending on the community and the underlying rental cost of the house. An individual's share of the cost includes rent, utilities, cable, food staples, cleaning supplies, revolving fund loan repayment, dues, and other expenses. The only items not covered in the weekly rent are each individual's groceries.

- There is a zero a tolerance policy toward relapse.

People are asked to leave if they use alcohol or drugs. This is an important policy as experience has shown that relapse spreads quickly in a house if it is tolerated, and it begins to affect the norms for the house. However, individuals who have relapsed are encouraged to seek

treatment and re-apply after a return to sobriety.

Other Facts About Oxford Houses

- Houses interview prospective residents and then house members vote on admission. An 80% yes vote is required to accept a new resident. A house vote is the only method of admission once a house is established.

- Seven to ten people live in a house. Seven is the minimum number for a viable house due to economics. A house with seven or more members has a financial cushion while smaller houses begin to run into financial difficulties with every vacant bed. Often new members come directly from treatment and have no resources.

- House residents are expected to participate in a recovery programs in the community.

- In North Carolina Oxford Houses are chartered with Oxford House Inc., the national non-profit organization. When houses are opened they receive a manual that provides all the information needed to operate a house. Included are job descriptions for house officers, how to maintain a bookkeeping systems, how to run meetings, the philosophy of the model, and other topics. Experienced members of other houses and outreach staff also mentor the new house.

- Oxford Houses are good neighbors. There is an emphasis on maintenance of properties to the neighborhood norm. Houses are located in good neighborhoods in the belief that addicts do better if they don't return to a using environment. Living in good neighborhood sets a different standard.

- Because everyone is different in the amount of time they need to become comfortable with sobriety, residents can live in an Oxford House as long as they feel a need. In North Carolina, the average length of stay for residents is 13 to 15 months. There are currently individuals who have resided in houses for ten or more years.

- Oxford Houses are rented on the open market. Oxford Houses are good deal for owners as the rental agreement can be indefinite without breaks in occupancy. Some houses have been rented in North Carolina for fourteen years and a number of owners have purchased houses specifically for use as Oxford House rentals.

- Some Oxford Houses have closed. The typical reasons for closure are owner re-occupancy, sale of the property, excessive rent levels, lack of maintenance by an owner, and a poor location that contributes to high vacancy levels. It is rare, but occasionally a house is closed because it hasn't functioned well over a period of time.

- When three or more houses are in an area, they begin organizing locally into Oxford House Chapters. Each house elects a representative to the chapter. The chapter is the most important source of peer support to individual houses. There are currently 19 Chapters North Carolina. Chapter functions include; monthly meetings, assistance to individual houses, occasional financial support to a house, opening new houses, audits of houses when needed, promotion with treatment agencies, and social events.

- The North Carolina Oxford House State Association (NCOHSA) is another level of peer support to chapters and houses. The NCOHSA is made up of a representative of each chapter and alumni. The functions are similar to chapter functions. The NCOHSA can respond to a chapter or a house experiencing difficulty, can make

loans or grant to a chapter, and helps to plan and support training events.

- Referrals to Oxford Houses originate from a variety of sources Including treatment agencies, 12 step support groups, Drug Courts, VA Hospitals, Correctional Facilities other agendas, and word of mouth.

- Potential Residents should call houses directly to set up interviews.

Counselor Pre-Screening:

Substance abuse counselors are the primary source of referrals to Oxford Houses. Getting a workable match between the individual and tine Oxford House is important, as residents who are disruptive and not serious about recovery can cause serious problems for a house. Counselors can be a big help if they take the time to pre-screen potential referrals. The following criteria are afforded for use.

- Is the individual willing and able to live in a shared housing arrangement? Has the individual shown reasonable behavior in an in-patient setting?
- Has the individual thought about his/her own recovery and is he/she determined for recovery?
- Does the individual have a recovery plan when he/she finishes treatment?

For more information visit the North Carolina State Oxford House website at www.oxfordhousenc.org or the national website at www.oxfordhouse.org .

For more information on the International Oxford House movement call 1-800-689-6411.

ANGELA HARPER
PROGRAM MANAGER
NC DEPT. OF MH/DD/SAS

North Carolina Oxford Houses
House Activity Report
Jun-12

Total Houses	150
Men's Houses	109
Women's Houses	38
Women and Children	3

Total Beds	1115
Men's Beds	817
Women's Beds	292
Children Beds	6

ANGELA HARPER
PROGRAM MANAGER
NC DEPT. OF MH/DD/SAS

HOUSE NAME	PHONE	CITY	M/F	NO# BED	NO# RES	VAC	NO# APP	NO # ADM	LEAVING HOUSE VOL	RELAPSE	OTHER	TOTAL
ASHEBORO	336/625-3752	ASHEBORO	M	7	4	3	2	1	0	1	1	2
COX	336/633-3993	ASHEBORO	M	6	2	4	3	1	1	0	0	1
MAIN STREET	336/625-5059	ASHEBORO	M	6	2	4	3	2	1	1	1	3
ASHEVILLE	828/254-2768	ASHEVILLE	M	7	6	1	3	1	0	0	1	1
AURORA II	828/424-7471	ASHEVILLE	M	7	6	1	4	2	1	1	0	2
CHURCH STREET	828/258-1560	ASHEVILLE	W	9	8	1	1	1	1	0	0	1
EUCLID	828/350-0720	ASHEVILLE	M	6	5	1	2	2	0	0	1	1
ROUND TOP	828/274-1375	ASHEVILLE	M	6	6	0	2	2	0	0	1	1
STATE STREET	828/252-1481	ASHEVILLE	M	8	5	3	1	1	1	0	0	1
WYOMING	828/254-1001	ASHEVILLE	W	8	6	2	4	2	0	0	1	1
CARRBORO	919/370-4327	CARRBORO	M	8	8	0	1	1	0	0	0	0
WEATHERHILL	919/537-8049	CARRBORO	W	6	4	2	0	0	0	0	0	0
CARY	919/651-9603	CARY	M	8	8	0	0	0	0	0	0	0
OAKRIDGE	919/468-9306	CARY	M	9	8	1	2	1	0	1	0	1
POND	919/651-9456	CARY	W	8	7	1	2	2	2	0	0	2
CAROLINA AVENUE	919/370-4380	CHAPEL HILL	W	7	5	2	1	1	0	2	0	2
CEDAR HILL	919/370-3350	CHAPEL HILL	W	8	4	4	1	1	1	0	0	1
CHRISTOPHER	919/537-8785	CHAPEL HILL	M	8	7	1	1	0	0	0	0	0
COVINGTON	919/251-9078	CHAPEL HILL	W	6	4	2	0	0	0	0	1	1
DALEY	919/370-3193	CHAPEL HILL	M	9	5	4	5	4	1	1	0	2
FRANKLIN STREET	919/370-3518	CHAPEL HILL	W	7	6	1	2	2	0	1	0	1
HOMESTEAD	919/370-4263	CHAPEL HILL	M	7	7	0	4	4	0	0	0	0
KINGS MILL ROAD	919/370-3021	CHAPEL HILL	M	8	7	1	2	2	0	0	0	0
ORGAN CREEK	919/240-4313	CHAPEL HILL	M	10	10	0	0	0	0	0	0	0
ATESIDE	919/240-5147	CHAPEL HILL	W	8	5	3	2	2	0	2	0	2
SWANN	919/537-8384	CHAPEL HILL	W	6	5	1	2	2	0	1	1	2
WILLOW	919/370-7548	CHAPEL HILL	M	8	8	0	2	2	0	0	1	1
BLUFF WOOD COVE	704/972-8497	CHARLOTTE	M	6	3	3	1	1	1	0	0	1
CARRIAGE	704/532-9022	CHARLOTTE	M	6	5	1	1	1	0	0	0	0
CEDARWILD	704/719-4518	CHARLOTTE	M	7	6	1	0	0	0	0	0	0
DINGLEWOOD	704/332-8311	CHARLOTTE	M	6	6	0	5	3	1	0	0	1
FIELDBROOK	704/405-7907	CHARLOTTE	M	6	6	0	0	0	0	1	3	4
FOLKSTON DRIVE	704/568-2007	CHARLOTTE	M	6	5	1	0	0	0	0	0	0
HAVENWOOD	704/719-1936	CHARLOTTE	M	7	6	1	1	1	0	0	0	0
HYDE PARK	704/900-8179	CHARLOTTE	M	7	6	1	1	1	0	0	1	1
IDLEBROOK	704/719-1144	CHARLOTTE	M	7	3	4	1	1	0	2	0	2
ILFORD	704/531-1458	CHARLOTTE	W	8	4	4	0	0	0	0	0	0
MAYRIDGE	704/537-8700	CHARLOTTE	W	6	5	1	3	1	0	1	0	1
PIEDMONT	980/233-8863	CHARLOTTE	M	6	4	2	3	2	1	1	1	3
SHAMROCK	704/344-1525	CHARLOTTE	W	6	3	3	3	1	0	1	0	1
SHARMECK	704/207-6137	CHARLOTTE	M	6	2	4	2	2	0	0	0	0
SHARON-AMITY	704/900-7024	CHARLOTTE	W	8	5	3	1	1	0	0	1	1
SPRAY	704/719-4290	CHARLOTTE	M	7	5	2	2	2	0	1	0	1
STILLWELL OAKS	704/537-2668	CHARLOTTE	M	7	4	3	1	1	0	0	0	0
SUDBERRY	704/910-0898	CHARLOTTE	W	8	5	3	2	2	0	0	1	1
WYANOKE	980/406-3559	CHARLOTTE	M	6	5	1	1	2	0	0	0	0
DUNN	910/292-3059	DUNN	M	7	7	0	3	3	0	0	0	0
AMHURST ROAD	919/237-3401	DURHAM	W	9	8	1	3	2	1	0	0	1
IVER	919/767-4919	DURHAM	M	9	7	2	2	2	1	0	0	1
RHAM	919/425-1929	DURHAM	M	9	8	1	3	3	1	0	0	1

ANGELA HARPER
PROGRAM MANAGER
NC DEPT. OF MH/DD/SAS

HOUSE NAME	PHONE	CITY	M/F	NO# BED	NO# RES	VAC	NO# APP	NO # ADM	LEAVING HOUSE VOL	RELAPSE	OTHER	TOTA
FERRIS	919/237-2667	DURHAM	W	7	4	3	0	0	0	0	1	1
GARDENVIEW	919/251-9831	DURHAM	W	7	4	3	0	0	0	1	0	1
GUESS ROAD	919/765-5481	DURHAM	M	8	6	2	2	1	0	1	0	1
MAYNARD	919/294-6598	DURHAM	M	6	5	1	1	1	0	0	0	0
MORREENE ROAD	919/767-0099	DURHAM	M	10	6	4	3	3	0	1	0	1
PEACE STREET	919/381-6647	DURHAM	M	9	6	3	0	0	0	0	0	0
SHIRLEY STREET	919/768-0308	DURHAM	M	11	6	5	1	1	0	0	0	0
SPAULDING	919/381-4931	DURHAM	M	7	3	4	2	2	1	1	0	2
STADIUM	919/767-0081	DURHAM	W	7	4	3	3	1	1	1	0	2
TRIANGLE	919/767-5956	DURHAM	W	7	6	1	2	2	0	0	0	0
CYPRESS ROAD	910/433-9123	FAYETTEVILLE	W	6	2	4	2	0	1	0	1	2
ELDER	910/425-8221	FAYETTEVILLE	M	6	4	2	3	1	2	3	0	5
HAYMOUNT	910/778-8109	FAYETTEVILLE	M	6	6	0	3	2	1	0	0	1
RAEFORD ROAD	910/568/5199	FAYETTEVILLE	M	6	4	2	2	1	0	0	1	1
SPRUCE	910/483-2745	FAYETTEVILLE	M	6	4	2	4	3	0	1	0	1
STEDMAN	910/323/1273	FAYETTEVILLE	M	6	4	2	2	1	0	0	0	0
GARNER	919/329-0325	GARNER	M	8	4	4	2	1	0	1	1	2
FAITH	704/671-4376	GASTONIA	M	8	5	3	0	0	0	0	0	0
GOLDSBORO	919/583-8441	GOLDSBORO	M	10	5	5	3	3	0	0	0	0
MULBERRY	919/735-1241	GOLDSBORO	W	6	3	3	1	1	0	3	0	3
ALAMANCE	336/437-8212	GRAHAM	M	8	4	4	2	1	0	2	1	3
AYCOCK	336/370-0070	GREENSBORO	M	8	6	2	2	2	1	0	1	2
AZALEA	336/617/6032	GREENSBORO	M	6	5	1	0	0	1	0	0	1
FAWN	336/285/9083	GREENSBORO	M	7	4	3	4	3	0	2	0	2
FLEMING	336/285/9012	GREENSBORO	M	7	6	1	1	1	0	0	0	0
FONTAINE	336/547-9407	GREENSBORO	W	7	7	0	2	2	0	0	0	0
GLEN HAVEN	336/676-5516	GREENSBORO	M	6	2	4	3	2	1	2	0	3
HARVARD	336/285-9073	GREENSBORO	M	8	7	1	1	1	0	1	0	1
IRVING PARK	336/676-4096	GREENSBORO	M	8	7	1	3	3	0	2	0	2
MADRE	336/275-7216	GREENSBORO	M	7	6	1	3	2	1	0	1	2
MENDEN HALL	336/272-6674	GREENSBORO	M	7	4	3	2	1	0	0	0	0
MOREHEAD	336/370-0900	GREENSBORO	M	8	8	0	1	1	0	0	0	0
ONSLOW	336/632-0901	GREENSBORO	M	7	5	2	1	1	1	0	0	1
REPON	336/547-6008	GREENSBORO	M	7	5	2	2	2	1	2	0	3
SPICEWOOD	336/617-4451	GREENSBORO	W	7	7	0	7	5	0	1	4	5
VANDALIA	336/855-7868	GREENSBORO	M	7	3	4	3	2	1	0	1	2
WALKER	336/230-2128	GREENSBORO	M	7	4	3	3	2	2	0	0	2
WESTHAVEN	336/547-0778	GREENSBORO	W	7	4	3	2	1	1	0	0	1
CHARLES STREET	252/364-8965	GREENVILLE	M	8	6	2	3	3	2	0	0	2
DELLWOOD	252/830-6700	GREENVILLE	M	8	7	1	2	2	2	0	0	2
EAST WESTWOOD	252/329/0200	GREENVILLE	W	7	3	4	3	3	1	0	0	1
EASTWOOD	252/413-0835	GREENVILLE	W	8	6	2	4	3	0	1	0	1
EVANS	252/752-3976	GREENVILLE	W	7	6	1	2	2	0	0	0	0
GLENWOOD II	252/321-2029	GREENVILLE	M	7	6	1	6	6	3	0	0	3
GREENVILLE	252/756-1616	GREENVILLE	M	8	7	1	1	1	0	0	0	0
MEMORIAL DRIVE	252/439-8528	GREENVILLE	M	6	3	3	2	1	0	1	1	2
RED BANKS	252/565-5245	GREENVILLE	M	8	6	2	4	3	0	0	0	0
HENDERSON	252/430-8679	HENDERSON	M	10	7	3	3	0	0	0	0	0
YOUNG	252/572-4530	HENDERSON	M	9	9	0	3	1	0	0	0	0
GRACE	828/855-1427	HICKORY	M	7	4	3	2	1	1	1	0	2

ANGELA HARPER
PROGRAM MANAGER
NC DEPT. OF MH/DD/SAS

HOUSE NAME	PHONE	CITY	M/F	NO# BED	NO# RES	VAC	NO# APP	NO # ADM	LEAVING HOUSE VOL	RELAPSE	OTHER	TOTAL
..EWMONT	828/855-1016	HICKORY	W	8	6	2	2	1	0	0	1	1
ZMAURA WAY	828/855-3964	HICKORY	M	9	6	3	0	0	0	0	0	0
HAYWORTH	336/307-3259	HIGH POINT	W	6	3	3	2	2	1	0	1	2
HIGH POINT	336/307-2123	HIGH POINT	M	7	6	1	1	0	0	0	0	0
LEXINGTON AVE.	336/307-3348	HIGH POINT	W	6	2	4	2	2	1	0	1	2
OLD WINSTON RD.	336/307-3811	HIGH POINT	M	8	7	1	4	4	0	0	1	1
PARKWAY	336/289-5132	HIGH POINT	M	8	8	0	1	1	0	0	0	0
OCEAN ACRES	252/207/0524	KILL DEVILS HILL	M	8	6	2	2	2	1	2	0	3
SEA BREEZE	252/715-1242	KILL DEVILS HILL	W	7	7	0	3	3	0	0	0	0
SOUNDSIDE	252/441-8874	KILL DEVILS HILL	M	7	6	1	2	1	0	1	0	1
MORGANTON	828/437-2795	MORGANTON	M	6	4	2	2	2	0	2	0	2
ARROWWOOD	919/838-9939	RALEIGH	M	9	7	2	0	0	0	0	1	1
BATTLE RIDGE	919/326-8824	RALEIGH	M	4	4	0	0	0	0	0	0	0
BRENTWOOD	919/876-9260	RALEIGH	W	9	8	1	1	1	0	0	1	1
BRINKLEY	919/981-6523	RALEIGH	M	9	9	0	3	3	0	0	0	0
CROSSLINK	919/755-0603	RALEIGH	M	9	7	2	1	0	1	0	0	1
FIRELIGHT	919/834-8139	RALEIGH	M	9	7	2	3	4	0	1	0	1
HEARTH	919/875-9656	RALEIGH	M	8	8	0	0	0	0	0	0	0
HOLLY DRIVE	919/844-3543	RALEIGH	W	7	7	0	2	2	0	0	0	0
JONES FRAKLIN	919/900-8538	RALEIGH	M	10	10	0	4	3	2	1	0	3
LORIMER	919/851-1756	RALEIGH	M	9	8	1	1	0	0	0	0	0
MORDECAI	919/325-9753	RALEIGH	M	9	9	0	2	1	1	0	0	1
NEW BERN	919/803-4939	RALEIGH	M	7	5	2	3	2	1	1	0	2
NEW HOPE	919/322-0011	RALEIGH	M	9	8	1	5	5	3	1	0	4
ORTH HILLS	919/844-8311	RALEIGH	W	9	9	0	3	3	2	0	0	2
ORTH RALEIGH	919/784-8611	RALEIGH	M	9	8	1	6	4	1	0	1	2
PINECREST	919/873-1655	RALEIGH	M	9	9	0	2	1	0	0	0	0
QUAIL HOLLOW	919/247-7831	RALEIGH	M	8	3	5	3	3	0	0	0	0
STEEDS RUNS	919/803-1046	RALEIGH	W	8	8	0	1	1	1	0	0	1
STOCKTON	919/322-0685	RALEIGH	W	8	8	0	6	3	2	0	1	3
VAN THOMAS	919/803-5547	RALEIGH	W	8	8	0	4	2	1	0	0	1
WIMBLETON	919/781-6505	RALEIGH	M	6	6	0	2	2	0	0	2	2
ROXBORO	336/599-1721	ROXBORO	M	8	4	4	2	2	1	0	0	1
JACKSON WAY	704/762-9800	SALISBURY	W	9	6	3	2	2	1	0	0	1
SALISBURY	704/212-2493	SALISBURY	M	11	6	5	4	3	0	1	1	2
SMITHFIELD	919/209-0042	SMITHFIELD	M	8	3	5	2	0	1	0	2	3
BOST	704/380-4143	STATESVILLE	M	8	5	3	2	2	1	0	0	1
CHEROKEE	828/497-5717	WHITTER	M	6	5	1	0	0	1	0	0	1
CAMDEN CIRCLE	910/763-4487	WILMINGTON	M	8	7	1	1	1	2	0	0	2
COVIL	910/452-5703	WILMINGTON	M	6	5	1	4	2	0	1	0	1
SMITH CREEK	910/792-6030	WILMINGTON	M	7	7	0	0	0	0	0	0	0
BISCAYNE	336/293-8350	WINSTON-SALEM	M	7	4	3	1	1	1	0	0	1
BREWER	336/293-7453	WINSTON-SALEM	M	7	5	2	3	3	0	1	1	2
HEMLOCK	336/245-3539	WINSTON-SALEM	M	6	3	3	1	1	0	0	1	1
KINGHILL	336/725-5338	WINSTON-SALEM	W	6	4	2	1	1	2	1	0	3
LYNDHURST	336/722-3366	WINSTON-SALEM	M	6	5	1	2	1	1	1	0	2
NEW FOUNDATION	336/306-3109	WINSTON-SALEM	M	7	6	1	3	1	0	1	0	1
RENOLDA	336/923-5460	WINSTON-SALEM	M	8	8	0	2	2	2	0	0	2
SHATTALON	336/765-2401	WINSTON-SALEM	W	7	6	1	5	5	2	1	0	3
ESTMORE	336/765-2401	WINSTON-SALEM	M	7	6	1	2	2	0	1	1	2
				1115	843	272	314	240	73	63	45	181
				NO# BED	NO# RES	VAC	NO# APP	NO # ADM	VOL	RELAPSE	OTHER	TOTAL

DMH/DD/SAS Form #1003-FA

FINANCIAL STATUS REPORT

N.C. Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Request for Reimbursement

1) Project: Residential Housing Services	5) Contract #: 2079
2) Organization Name: Oxford House, Inc.	6) Contract Period: July 1, 2011 - June 30, 2012
3) Mailing Address: 1010 Wayne Ave., Suite 300	7) Contact Person: Leann Watkins
Silver Spring, MD 20910	8) Telephone # 301-587-2916
	9) Total Amount Requested (Item 24):
4) Final Report: y Amended Report: y	10) Period covered by this request From:06/1/12 To:06/30/12

Expenditure Category	A. Approved Budget	B. Previously Reported Expenditures	C. Current Period Expenditures	D. Year to Date Expenditures (Column B plus C)	E. Unexpended Balance (Column A minus D)	F. Monthly Match Expenditures	G. Year to Date Match Expenditures
11) Total Personnel Costs	245,387.00	245,387.00		245,387.00			
12) Total Supplies and Materials	4,750.00	4,750.00		4,750.00			
13) Total Current Obligations	98,863.00	98,863.00		98,863.00			
14) Total Fixed Charges & Other Expenses	1,000.00	1,000.00		1,000.00			
15) Total Capital Outlay							
16) Total Grants and Contracts							
17) Total Purchase of Services Costs							
18) Indirect Costs							
19) TOTALS	$350,000.00	$350,000.00		$350,000.00			
20) PROGRAM INCOME							
21) NET TOTAL (Line 19 minus line 20)	$350,000.00	$350,000.00		$350,000.00			

COMPUTATION OF CASH REQUIREMENTS

22) Total Cash Received and Requested to Date		24) Total Cash Payment Requested (Line 22 minus Line 23)	
23) Total Year to Date Expenditures (Column D, line 21)	$350,000.00	25) MINIMUM REQUIRED MATCH FOR TOTAL EXPENDITURES	

CERTIFICATION:

As chief executive officer or designee of the recipient organization, under penalties of perjury I hereby certify that the cost or units billed for reimbursement on the above Request For Reimbursement were incurred or delivered according to the provisions of the assistance agreement. I further certify that any required matching expenditures have been incurred, and that to the best of my knowledge and belief we have complied with all laws, regulations and contractual provisions that are conditions of payment under this contract.

26) Authorized Contractor Signature & Title: _____ Date _____

27) DMH/DD/SAS Section Approval & Title: _____ Date _____

28) DMH/DD/SAS Contract Office Approval: _____ Date _____

FDR due by the 10th of each month whether or not requesting funds.

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center • Raleigh, North Carolina 27699-3001
Tel 919-733-7011 • Fax 919-508-0951

Beverly Eaves Perdue, Governor
Albert A. Delia, Acting Secretary

Jim Jarrard, Acting Director

October 29, 2012

MEMORANDUM

TO: **DMH/DD/SAS Non Profit Contractors**

FROM: **William J. Scott, Jr., Section Chief**
RRM/DMH/DD/SAS

RE: **Mandatory Reporting by House Bill 950, Session Law 2012-142**

Per **House Bill 950, Session Law 2012-142,** the North Carolina Department of Health and Human Services (DHHS) shall require non-state entities receiving direct state appropriations to submit under Section 10.19.(b) a report to include the following information about the fiscal year preceding the year in which the report is due:

1) The entity's mission, purpose, and governance structure.
2) A description of the types of programs, services, and activities funded by State appropriations.
3) Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.
4) Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.
5) A detailed program budget and list of expenditures, including all positions funded and funding sources.
6) The source and amount of any matching funds received by the entity.

All requested information above must be data from state fiscal year 2012 (July 1, 2011-June 30, 2012) and is due to DMH/DD/SAS Financial Operations (see contact information below) with a copy to your DMH/DD/SAS Contract Administrator on **Friday, November 16, 2012,** by close of business. The Division will compile and forward the requested documentation to the Joint Legislative Oversight Committee on Health and Human Services, 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.

Please direct all inquiries to your DMH/DD/SAS Contract Administrator. Thank you for your time and cooperation in this matter.

Requested information should be submitted to:

DMH/DD/SAS Financial Operations
Jalaine Moore, Contract Manager
3013 Mail Service Center
Raleigh, NC 27699-3013
or
325 N. Salisbury Street
Raleigh, NC 27603
jalaine.moore@dhhs.nc.gov

cc: Rachel Noell, Contract Administrator CPM
Mya Williams, Contract Administrator CPM
Renee Rader, Contract Administrator CPM
Sandy Ellsworth, Contract Administrator CPM
Angela Harper, Contract Administrator CPM
Janice White, Contract Administrator CPM
Walt Caison, Team Leader CPM
Janice Petersen, Team Leader CPM
Flo Stein, Chief CPM
Katrina Blount, Contract Manager Financial Operations
Jalaine Moore, Contract Manager Financial Operations

VISITOR REGISTRATION SHEET

Joint Appropriation on Health + Human Servic 2-20-2013

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Spencer Clark	DMHDDSAS
Jimmy Broughton	Womble Carlyle
John Burress	ABC of NC
Lorri Unumb	Autism Speaks
Kerri Erb	ASNC
Jennifer Mahan	ASNC
Tracey Sherrill	ASNC
Jenny Yates	Parent Advocate
Gary Cyrus	DHHS DAAS
Donny Streets	DHHS DAAS

VISITOR REGISTRATION SHEET

Jt Appropriations HHS sub — 2/20/13

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ken Melton	K.M.A.
Julia Adams	The Arc.
Melissa Clepper-Faith MD	Hillsborough Pediatrics
Sharon Foster M.D	Raleigh Pediatrics
Joel Maynard	GRM & Assoc
Joanne Stevens	NCNA
Jonathan Brubaker	Brubaker & Assoc.
LC [illegible]	CSS
[illegible]	I [illegible]

VISITOR REGISTRATION SHEET

JT HHS Appropriations Sub 2/20/13

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Julia Adams	The Arc of NC
Dan Mitchell	TCA
Chris McClain	Brooks Pierce
Charles Marshall	" "
JOE LANIER	NELSON MULLINS
Kelly Kemp	NAMI NC
Rachel Beaulieu	NCDPI
PAIGE WORSHAM	Center for Public Policy Research
TJ Bradbee	Nexsen Pruet
Selene Johnson	ABC of NC - Winston Salem NC
Angela Pesenti	ABC of NC - Winston-Salem, NC

VISITOR REGISTRATION SHEET

Jt HHS Appropriations Sub — 2/20/13

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Darry Cyrus	DHHS DAAS
JESSICA HERRMANN	GOVERNOR'S INSTITUTE
[illegible]	NCAHEC
George Smith	Nexsen Pruet
Matthew McConnell	Carolinas HealthCare Sys.
Peggy Smith	NC Assisted Living Assoc.
Sarah Wolfe	MWC LLC
Kay Paksoy	NASW-NC
ROSE HOBAN	NC TIth News
Chris Bryant	NCMS
G. Peyton Maynard	NCAFP

VISITOR REGISTRATION SHEET

H Appropriation on Health & Human Servic 2-20-2013
Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Angela Pesenti	ABC of NC - Winston-Salem, NC
Selene Johnson	ABC of NC - Winston-Salem, NC
Amy Vostal	ABC of NC - Winston Salem NC
Cindy Andree Bowen	ABC of NC - Winston-Salem NC
Stephenie Holladay	ABC of NC - Winston-Salem NC
Matt Gross	NCR
Stan Shore	NC Reds Society
Teresa Sue Bratton	NCPS
Theresa FLYNN	NCPS
Lori Tackman	NCPS
Jameelah Melton MD	NCPS

VISITOR REGISTRATION SHEET

2-20-13

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John W Smith	AOC
Suzanne Merrill	DHHS-DAAS
Curtis Bass	NC Providers Assn.
Ashley Parker	Parker Law Firm
Kay Paksay	NASW-NC
BRAD ALLEN	NC SENIOR GAMES
ROSE HOBAN	NC HEALTH NEWS
Bethany Hudson	Steinburg LA
Elise McDowell	Troutman Sanders
Andrew Bell	NCDOT
Jenny Yarbrough	Parent Blinder

/

VISITOR REGISTRATION SHEET

2-20-13

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lindsey Welch	DSOHF
LISA MOON	DSOHF
Sherry Bradsher	DHHS
Adam Sholar	DHHS
Dirk Carlton	
[illegible]	SEANC
TRACY COLLINS	AHEC
Dean Plunkett	Plunkett Stratt
Cory Dunn	DRNC
Jennifer Ngo	NCMS, UNC
Meredith Miller	NCMS, UNC

VISITOR REGISTRATION SHEET

2-20-13

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Emily VanderSchaaf	NC Pediatric Society
Will Barnett	N.C. Med. Soc.
Sarah Rothacker	Brooks & Assoc.
[illegible]	Salisbury Post
Andrea Reynolds	NCFOM
[illegible]	NCFOM

VISITOR REGISTRATION SHEET

2-20-13

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
CAROL ORNITZ	NC BRAIN INJURY ADVISORY COUNCIL
Pete O'Connell	Marching Orders
Betsy Verdin	American Heart Assn
Reggie Harvey	The Longmire Group
Charles Tetzlaff	Meridian Senior Living
Andy Chase	KMA
EDDY HOLCKIN	ALZHEIMER FOUNDATION

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

February 21, 2013
Legislative Office Building - Room 643
8:30 a.m.

Representative Mark Hollo, Presiding

Welcome and Introductions by Chairs

Brain Injury Association	Sandra Farmer, President
ARC of North Carolina	Dave Richard, Executive Director
Autism Society of N. Carolina	Tracey Sheriff, CEO
Mariposa School for Children with Autism	Mark Stafford, Executive Director
Easter Seals UCP of North Carolina and Virginia	Elizabeth DeBiasi, Board Chair
Prevent Blindness NC	Jennifer Talbot, CEO

Adjourn

Next Meeting: Tuesday, February26th, 8:30 a.m.

Joint Committee on Appropriations on Health and Human Services
Thursday, February 21, 2013 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations on Health and Human Services met at 8:30 AM on February 21, 2013, in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, Jean Farmer-Butterfield, Carl Ford, Jim Fulghum, Mark Hollo, Donny Lambeth, Susan Martin, and Tom Murry were present, along with 4 Senate members.

Representative Hollo presided.

Representative Hollo opened the meeting by welcoming everyone and recognizing the House Sergeants-at-Arms—Fred Hines and Charles Godwin—and the Senate Sergeants-at-Arms—Leslie Wright and Steve Wilson. He also recognized the Pages in attendance. For the House were Mackenzie Fiss of Mecklenburg County, Anna Freeman of Wake County, Kayla Hawkins of Vance County, and Jason Howe of Wilson County. For the Senate was Cole Williams of Guilford County.

The following presented their respective organizations to the committee and answered questions from committee members: President of Brain Injury Associaton, Sandra Farmer; Executive Director of ARC of North Carolina, Dave Richard; CEO of Autism Society of North Carolina, Tracey Sheriff; Executive Director of Mariposa School for Children with Autism, Mark Stafford; Board Chair of Easter Seals UCP of North Carolina and Virgina, Elizabeth DeBiasi.

After the introduction of Dave Richard, Executive Director of ARC of North Carolina, Representative Jean Farmer-Butterfield stated that for purposes of transparency she wanted to make clear that she is associated with ARC of North Carolina.

Due to time constraints, CEO Jennifer Talbot's presentation of Prevent Blindness North Carolina was rescheduled for the next meeting of this committee—February 26, 2013.

The meeting adjourned at 9:51 AM.

Representative Mark Hollo
Presiding

Susan Fanning, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 14, 2013 10:30 AM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Thursday, February 21, 2013 at 8:30 AM

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Thursday	February 21, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Brain Injury Association of North Carolina
2113 Cameron Street, Ste. 242 (PO Box 10912)
919-833-9634

House Bill 950, Session Law 2012-142 Report

1. The Brain Injury Association of NC (BIANC) is the single statewide organization whose goal is to create a better future for individuals with brain injury through prevention, research, education and advocacy. An official affiliate of the Brain Injury Association of America, BIANC's mission is to offer help, hope and a voice to people with brain injuries and their families. Brain injury is a leading cause of death and disability in North Carolina according to discharge data from hospitals and trauma centers, with traumatic brain injury (TBI) being the most prevalent. The direct cost of medical and rehabilitation treatment, long term care, and the indirect cost of loss of income for individuals and families is enormous. The CDC estimates that the annual national cost is over $76 billion dollars. North Carolina's acute medical and rehabilitation resources provide excellent care but the full impact of TBI is experienced by the families and survivors over time and in local communities. TBI has been termed the "silent epidemic" as well as and the signature wound of the war in Iraq and Afghanistan. Military service members with brain injuries who are returning to their home communities in NC are increasing the demands for information support, care and services.

   The Brain Injury Association of North Carolina is a 501 (c) 3 non-profit organization which was founded in 1982 by a group of families who recognized that they needed more support and information to better care for their loved ones with brain injuries. The Association has grown over the years to include four Brain Injury Resource Centers, one volunteer resource site and over 30 support groups with membership ranging from 10 to 50 people. BIANC provides educational opportunities, retreats and training programs for families and persons with brain injury, access to information and referral sources, community education, prevention activities and linkages with networks of medical centers, rehabilitation facilities and public agencies, non-profit organizations and long term care providers.

   BIANC is directed and managed by an Executive Director, CEO from the central office at the Raleigh Brain Injury Resource Center. The Executive Director reports to the Board of Directors which is composed of 17 to 20 volunteer members who are professionals, family members and persons with brain injuries from across the state. The BOD holds quarterly meetings, develops the strategic plan, and oversees the budget and financial development for the Association. Brain Injury Resource Centers are also located in Greenville, Asheville, Charlotte and a volunteer center is in Winston Salem. Regional Resource coordinators from each of the statewide Centers report to the Executive Director. BIANC collaborates with Project STAR for management of the Charlotte Resource Center at Carolinas Rehabilitation. Because of limited staff resources, there is significant dependence on volunteers and student interns to supplement outreach and support activities.

2. The regional Brain Injury Resource Centers are the cornerstone for a) early intervention by providing information and referral and support to families and persons with brain injuries, b) educating caregivers and providers, c) supporting primary and secondary prevention efforts, d) building linkages between hospital/rehabilitation providers and community services/resources, and e) helping families navigate a complex array of public and private agencies and programs with varying funding sources and eligibility requirements.

Analysis of calls and recommendations of focus groups of families, persons with brain injury and providers of services held within the last several years, as well as the State Plan on Brain injury Services, consistently identify needs for a) information about the causes and consequences of brain injury , b) improved awareness of and access to North Carolina's service delivery systems with emphasis on early intervention, d) strengthening regional centers and support groups across the state: f) greater public awareness of the scope of the problem g) prevention of brain injury to reduce the economic and societal costs.

The contract between the Brain Injury Association of NC and the NC Division of Mental Health/ Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) addresses each of these needs through a) providing a comprehensive program of information and referral as well as dissemination of information and education, b) collaboration with the Division and its Local Management Entities (LMEs) c) support groups recruitment, training and leadership development, d) public education initiatives and e) dissemination of morbidity and mortality data to support prevention initiatives.

The DMH/DD/SAS contract with the Brain Injury Association of North Carolina includes requirements that BIANC:

A) Maintain staff supervision and resources for four Brain injury Resource Centers to provide information and referrals to individuals with TBI, their families, and professionals via telephone, mail, email and social networking sites,
Contract deliverables include:

a) Provide information and referral upon request about traumatic brain injury (TBI), prevention, and awareness to at least 2,00 individuals with TBI, their families, and professionals via phone, mail, email and social networking sites.
b) Maintain a statewide 1-800 helpline for people seeking information about brain injury including resources and support services.
c) Provide specialized TBI information to 8 acute care and rehabilitation hospital case manager/ discharge planners, LME points of contact, and 3 Alcohol and Drug Abuse Treatment Centers (ADATCs) across the state including referral resources and support group information.
d) Maintain and report dissemination data of products/projects developed and implemented under the auspices of DMH/DD/SAS.
e) Maintain a statewide TBI resource book and TBI Education Resource manual on the BIANC website.
f) Coordinate a Professional Provider Council for education on relevant clinical issues; organize at least two regional meetings.
g) Write and disseminate an annual report.
h) Provide staff support for statewide Brain Injury Advisory Council.

B) Provide training and education about brain injury and promote prevention of TBI among the public as well as consumers, professionals and service providers statewide.
Contract deliverables include:

a) With DMH/DD/SAS, review and update all informational products developed/disseminated by BIANC under DMH/DD/SAS auspices.

b) Exhibit/present at 8 clinical conferences (such as the NC Council) at least one per quarter, to reach at least 500 people.
c) Collaborate with AHEC on one statewide conference on brain injury for professionals with minimum attendance of 100.
d) Publish *Starting Point* newsletter, quarterly in electronic and print format with special columns to address identified needs of families and persons with brain injuries. Disseminate to a minimum of 1,000 consumers, family members and professionals per quarter, including information on upcoming events, BIANC updates and information for caregivers and support group leaders.
e) Provide a minimum of 8 regional TBI trainings throughout the state for LME staff, service providers and/or professionals.
f) Provide at least 2 specialized TBI trainings to meet the needs of the LMEs and other service providers requesting individualized training.
g) Develop and implement education plan for schools/coaches around sports concussion across the state.
h) Coordinate health and wellness activities for individuals who have sustained brain injury.

C) Maintain, expand and strengthen the network of brain injury support groups for statewide availability and accessibility to meet the needs of people with brain injury and their families.
Contract deliverables include:

a) Provide three regional trainings to support group leaders in skills such as communication, leadership, group process and social skills to facilitate effective meetings and activities.
b) Maintain ongoing communication with acute care and rehabilitation providers regarding availability and benefits of support groups for early referral of families and persons with brain injuries.
c) Communicate with support group facilitators and members via email and other appropriate means regarding support group meetings, events and activities.
d) Assist support group leaders with developing networks of community based natural supports to help those with brain injuries to better integrate in their home communities.

3) The Brain Injury Association of North Carolina serves all people in our state who are living with the effects of brain injury. This includes people of all ages, ethnicities, and social/economic backgrounds. The Brain Injury Association of America notes that brain injury may affect anyone, anytime and anyplace and BIANC provides outreach and support to children, youth, young adults and older adults. However, young adult males are the demographic most likely to sustain a serve brain injury with lifelong needs for care and support. It is estimated that the cost of long term care for a young person with a brain injury will be over $4 million dollars.

The four regional BIANC offices cover all areas of the state and handled call inquiry calls from the state's 100 counties. More than 30 brain injury support groups across the state provide support to families in all regions. Also, BIANC coordinated regional information and training programs with Mountain Area AHEC, Southeastern Area AHEC and Wake AHEC

4) The Brain Injury Association of NC met and exceeded all of our DMH/DD/SAS contract goals for information and support, training, and support groups assistance for 2011-2012

A) Resource Center deliverables:

- BIANC provided information and resource support to 2,054 people who called the 1-800 Helpline or sent emails requesting information.
- BIANC also mailed 715 informational packets, disseminated 7,000 newsletters, sent monthly information updates via email to 1,811 contacts, and communicated with 2,484 Facebook friends and 889 Twitter followers.
- BIANC developed two specialized Skill Packets, one for family members and one for professionals at rehabilitation hospitals, to educate families about brain injury and provide guidelines for transitioning from the hospital to home or community placement. BIANC staff met regularly with case managers/discharge planners at each of the eight regional rehabilitation hospitals to verify that families were receiving the information and support that they needed to help with their discharge planning. BIANC also participated in trainings at the regional Alcohol and Drug Abuse Treatment Centers (ADATCs) to educate the treatment staff about the most effective treatment models for people with brain injuries who have substance use/abuse issues.
- BIANC received regular updates from the North Carolina Department of Public Health with new data on brain injury incidence, prevalence and impact which we included in our monthly email reports and newsletter editions. We also provided regular updates on the re-structuring of the MH/DD/SAS system to help families and professionals navigate the service delivery system
- BIANC developed a comprehensive directory of resources for people with brain injuries including information on treatment facilities, healthcare professionals, long term care options, state agencies and community resources. The resource directory is available on our website and copies are disseminated to rehabilitation hospitals, Local Management Entities and other professional groups.
- BIANC coordinated four Professional Provider Council meetings for residential and day program providers across the state. We provided education and information about clinical issues and changes in the state MH/DD/SAS system and encouraged service providers to share information about best practice procedures
- BIANC developed an annual report documenting our accomplishments and goals for 2011. The annual report was added to our website and disseminated to the public.
- BIANC staff provided administrative/technical support for quarterly meetings of the Brain Injury Advisory Council

Outcome measures for the Brain Injury Resource Centers included two caller satisfaction surveys, one at the time of the original call and a follow up questionnaire utilizing an on-line survey program. The first survey indicated that 92% of callers responded that the call met their needs and 97 % in the second survey indicated that they agreed or strongly agreed that the call was helpful.

B) Training and education deliverables:

- BIANC reviewed and updated all informational products developed/disseminated by BIANC under DMH/DD/SAS including Skill Packs for families and professionals and our statewide resource directory
- BIANC staff exhibited and or presented at 13 clinical conferences including presentations at the NC Conference on Aging, the Department of Public Instruction's Exceptional Children's Conference, the National Black Speech Association Conference and the NC TIDE Conference. BIANC provided information and education to over 1,700 participants at the 13 conferences.
- BIANC collaborated with WakeAHEC to provide an annual statewide professional symposium "Traumatic Brain Injury 2011: After the Big Bang, Managing Your New Universe" on Oct. 27 -28 in Raleigh. The conference had 130 attendees.

- BIANC published a quarterly newsletter, *Starting Point*, with specialized columns which addressed the needs of families and persons with brain injuries. Editions covered the themes of research, caregivers, sport injuries and military families. Each edition was disseminated to over 1,200 people including persons with brain injuries, family members, rehabilitation hospitals and professionals.
- BIANC provided Brain Injury 101 training programs to 19 groups including LME staff, service providers and professionals from OPC, Mecklenburg, ECBH, Wake and Western Highlands LMEs. BIANC training programs also included four certified brain injury specialist (CBIS) trainings which offered CBIS certification from the Brain Injury Association of America for direct care staff and professionals.
- BIANC provided 11 individualized training programs for LMEs and service providers who requested help to better serve specific individuals with traumatic brain injuries. These trainings included programs for a military support group in Fayetteville, adult care or assisted living facilities and the Analenisgi Mental Health Center in Cherokee, NC
- BIANC developed a training program to help prevent, evaluate and manage sport concussions for youth sport groups. The program was presented to local high schools and youth sport groups in the Raleigh, Greenville, Asheville and Charlotte areas.
- BIANC coordinated a statewide weekend wellness retreat for over 100 survivors and support group leaders which was funded by donations from corporate sponsors, members of the NC Pilot club and individuals. BIANC also coordinated three regional wellness day events which focused on good health management including exercise programs, eating and diet regimens and socialization. The goal of the wellness events was to improve the quality of the lives of people living with brain injury and to prevent secondary illness like obesity, hypertension, and depression.
- Outcome measure included completing 53 training programs across the state reaching over 2,763 individuals. The training sessions were well attended and evaluations of the programs demonstrated an average of 85% ratings as either satisfied or very satisfied.

C) Support Group deliverables:

- BIANC provided three regional training programs to support group leaders across the state. The training programs included information on leadership, communications, group process and developing skills to ensure that the support groups are effective and sustainable.
- BIANC staff had regular meetings with acute care and rehabilitation hospital staff and provided information on the availability and benefits of support groups for early referral of families and persons with brain injuries. Many of the regional support groups are affiliated with and meet at rehabilitation hospitals including WakeMed in Raleigh, UNC Hospital in Chapel Hill , Moses Cone in Greensboro and Coastal Rehab in Wilmington.
- BIANC communicated with the support groups leaders and members via monthly email updates, quarterly newsletters, and support group presentations to provide information on events, activities and important developments in brain injury service delivery and care.
- BIANC sponsored an annual family conference "Building Community from the Inside Out" which targeted people with brain injuries, their families ,caregivers, military/veterans, and service providers and provided information on ways that families can help a person with a disability become involved in community activities.

Outcome measures included providing four regional support group leader training programs and six support group in-services. BIANC surveyed the regional Support Group Leaders and determined that 80% found our programs and services to be either helpful or very helpful.

5) Below is BIANC's total budget for NC State fiscal year July 2011-June 2012. The budget included:

Expenses 2011-12

Personnel		Total	MH/DD/SAS	HRSA	Gen Fund
Salaries					
Executive director	1 FTE	$52,000.00	$34,320.00	$13,000.00	
Community support coordinator (Triangle)	.75 FTE	$33,000.00	$16,800.00		
Community support coordinator (Eastern)	.33 FTE	$13,200.00	$10,000.00		$3,200.00
Community support coordinator (Western)	1 FTE	$40,000.00	$16,800.00	$19,318.00	
Business manager	.75 FTE	$33,000.00	$16,800.00	$8,925.00	
Assistant support coordinator	1 FTE	$38,000.00	$10,400.00	$19,318.00	
Training Coordinator	1 FTE	$42,000.00	$0.00	$42,000.00	
Benefits		$42,704.00	$17,870.00	$17,417.00	
Total		$293,904.00	$122,990.00	$119,978.00	$3,200.00
Supplies and Materials					
Office supplies		$12,758.00	$8,540.00	$4,218.00	
Education/Community outreach materials		$10,000.00	$9,500.00	$500.00	
Total		$22,758.00	$18,040.00	$4,718.00	$0.00
Program Support					
Travel (auto mileage & overnight stay)		$15,000.00	$6,500.00	$8,500.00	
Telephone and Internet		$12,500.00	$6,279.00	$6,221.00	
Printing		$19,000.00	$10,900.00	$5,200.00	$2,900.00
Payroll and accounting services		$8,800.00			$9,341.00
Professional development		$2,000.00	$500.00		$1,500.00
Advertising/marketing		$1,000.00			
Board member expenses		$500.00			
Website support		$1,000.00			$1,000.00
Consultant fees/ honorariums		$6,000.00			$614.00
Event expenses (camp & training events)		$19,000.00		$10,274.00	$8,726.00
Total		$84,800.00	$24,179.00	$30,195.00	$24,081.00
Fixed Charges and Expenses					
Rent		$11,588.00	$11,400.00		$343.00
Dues (BIAA)		$13,994.00			$6,427.00
Insurance and bond		$5,000.00	$3,000.00		$2,000.00
Total		$30,582.00	$14,400.00		$8,770.00
Project STAR subcontract		$45,614.00	$45,614.00		
Total expenditures		$477,658.00	$225,223.00	$154,891.00	$36,051.00
Income 2011-12					
MH/DD/SAS Contract		$225,000.00			
HRSA Grant		$167,000.00			
Vidant Foundation Grant		$8,000.00			
Carolina Panthers Charities Grant		$10,000.00			
Total		$410,000.00			
Fundraising Income					
Membership/donations		$20,000.00			
Memorials		$4,000.00			
Walk and Roll-athon		$45,000.00			
Ride for the Rock (bike race)		$5,000.00			
Fall Fund Raising Events		$15,000.00			
Corporate Sponsors		$40,000.00			
Conference/trainings		$5,000.00			
Total		$134,000.00			
Total income		$544,000.00			

6) The BIANC budget includes revenue from contracts with the NC Division of Mental Health/Developmental Disabilities/Substance Abuse Services from state funds, a MH/DD/SAS contract funded through the federal Health Resources Service Administration (HRSA), a grant with the Vidant Hospital Foundation, a grant with the Carolina Panthers Charities, membership fees, donations and memorials, and fundraising events.

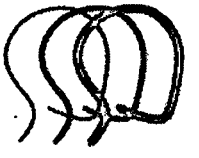
The HRSA contract provides $167,000.00 per year for five years from 2010 through 2014. BIANC provides $90,000 per year in-kind match from donated time from volunteers and rental space. BIANC has used the HRSA funds to provide technical assistance to develop two new clubhouse day programs for people with brain injuries, including military service members, developed an ombudsman program with volunteers who have a brain injury or are family members and offered a yearly statewide family conference.

The Vidant Hospital Foundation Grant is in its 9th year and provides $8,000 which helps support the BIANC office in Greenville, NC. The office is located at the National Guard's Family Readiness Centers and provides support to civilian and military families in eastern NC.

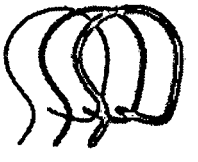
The Carolina Panthers Charities grant is for $10,000 and provides funds to disseminate smart phone applications donated by the Gfeller Sport Medicine Center which help athletic personnel evaluate and manage concussions on the sports field. BIANC's training coordinator educates the staff of youth sports organizations and middle schools about the concussions and the appropriate use of the phone application.

BIANC received $134,000 in funding from donations, memorials, membership fees and fundraising events that is used to support our work across the state. We also receive in-kind donation of office space from CarePartners in Asheville, Carolinas Rehabilitation in Charlotte, Wake Forest Baptist Medical Center in Winston-Salem and the National Guard Family Readiness Center in Greenville.

The Brain Injury Association of North Carolina (BIANC)



February 20, 2013



BIANC is the single statewide organization representing over 180,000 living with Traumatic Brain Injury (TBI) in North Carolina.

The Mission of BIANC:

To offer help, hope, and a voice for people with brain injuries and their families.

A brain injury survivor and his mother at a BIANC event

In recent years, there has been a dramatic increase of TBI awareness from returning military and sport concussion research.

Traumatic Brain Injury
is one of the signature combat wounds
of the Iraq and Afghanistan wars

BIANC maintained 4 regional offices and provided information and referrals to 2,054 people via our 1-800 Helpline and email correspondence.

BIANC mailed 715 informational packets, 7000 newsletters, monthly eBlasts to 1,811 contacts, and provided strong outreach via social media outlets.

Other accomplishments:

- Provided Skill Packs for 8 regional rehab hospitals for both Families and Professionals
- Maintained a website with a comprehensive resource directory listing professionals, agencies, and providing guidance in choosing service providers
- Coordinated Professional Provider Council meetings for residential and day program providers allowing groups to share successes and problem solve challenges

Training & Education

- BIANC presented or exhibited at 13 clinical conferences including the NC Conference on Aging and DPI's Exceptional Children's Conference
- Provided educational materials to over 1,700 participants
- Collaborated with Wake AHEC on a statewide professional TBI Symposium for 130 attendees
- Provided TBI 101 training programs to 19 groups including LMEs, service providers, and professionals across North Carolina
- Coordinated a statewide health and wellness retreat and regional day events

Training & Education cont'd:

- BIANC provided Certified Brain Injury Specialist (CBIS) from BIAA to 65 professionals to increase expertise in clinical settings
- Provided specialized staff training for 11 groups working with individuals with brain injury including adult care and assisted living programs and military support groups
- Developed and implemented a training program to educate school and youth sport groups to prevent, evaluate, and manage sport concussions (dispersal of Concussion Recognition and Response App to coaches and trainers)

Brain Injury Support Groups

- BIANC supported over 30 active brain injury support groups statewide
- Provided 3 regional training programs for support group leaders across the state

Brain Injury Family Conference

BIANC sponsored an annual Family Conference for 125 survivors, their families, caregivers, and military servicemen and women.

Other Projects:

- Brain Injury Clubhouse Day Programs (Raleigh and Asheville)
- Brain Injury Ombudsman Program with 12 volunteer members statewide providing one-on-one support to survivors, families, caregivers, and professionals

Association Income

State Contract	$225,000
HRSA Contract	$167,000
Vidant Hosp. Foundation	$8,000
Carolina Panthers Charities	$10,000
Conferences/Trainings	$5000
Donations & Fundraising	$154,000

Total: $544,000

Brain Injury Association of North Carolina

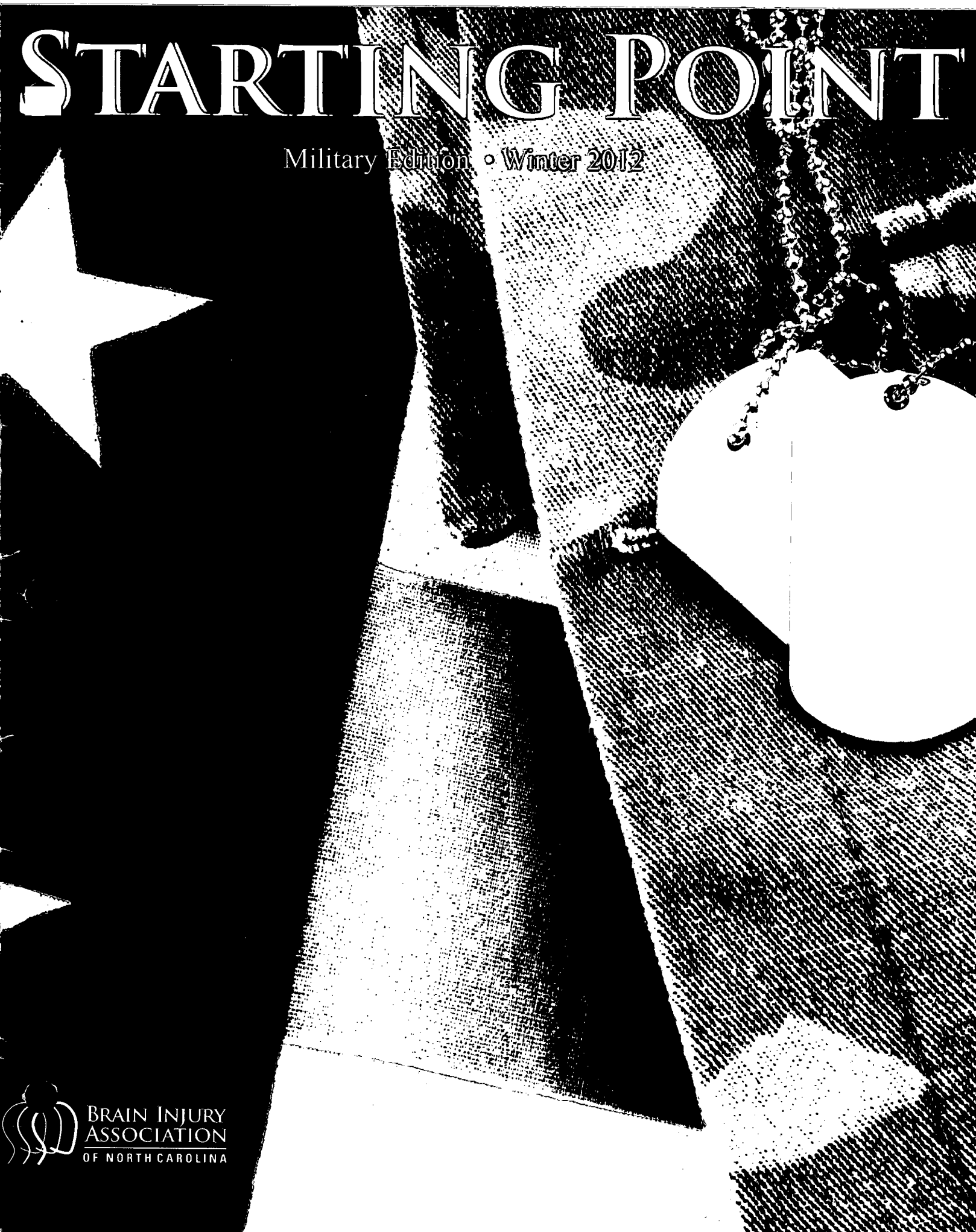
1-800-377-1464

www.bianc.net

Offering help, hope, and a voice for people with brain injury and their families

STARTING POINT

Military Edition • Winter 2012



BRAIN INJURY ASSOCIATION OF NORTH CAROLINA

Board of Directors

Karen McCulloch
Co-Chair

Katrina Miller
Co-Chair

Susan Baker

Cindy Boyd

Marie Britt

Kim Delisle

Steven J. Elizondo

Tami Guerrier

Pam Guthrie

Marian Hartman

Thomas Henson

Francesca Monachino

James O'Brien

Johna Register-Mihalik

Mike Sink

Pier Tarrant

Mark White

Corporate Sponsors

Charles G. Monnett, III and Associates - *Diamond*
www. carolinalaw.com
200 Queens Road, Suite 300, Charlotte, NC 28204
Tel: 800-977-3077

Carolinas Rehabilitation - *Gold*
www.carolinasrehabilitation.org
1100 Blythe Boulevard, Charlotte, NC 28203
Tel: 704-355-3558 or 877-734-2251

HensonFuerst, PA - *Gold*
www.lawmed.com
2501 Blue Ridge Road, Suite 390, Raleigh, NC 27607
Tel: 888-419-9955

Law Offices of Michael A. DeMayo LLP - *Gold*
www.demayolaw.com
1211 E. Morehead Street, Suite 100, Charlotte, NC 28204
Tel: 704-333-1000

Learning Services - *Gold*
www.learningservices.com
5301 Robbins Drive, Raleigh, NC 27610
Tel: 888-419-9955

CarePartners - *Silver*
www.carepartners.org
68 Sweeten Creek Road, Asheville, NC 28803
Tel: 828-274-6195

Wake Forest Baptist Health - *Silver*
www.wakehealth.com
Medical Center Boulevard, Winston-Salem, NC 27157
Tel: 336-716-2011

Hinds' Feet Farm - *Bronze*
www.hindsfeetfarm.org
14625 Black Farms Road, Huntersville, NC 28078
Tel: 704-992-1424

Seven Lakes Eye Care - *Bronze*
drbarry@sevenlakeseyecare.com
1110 Seven Lakes Drive, PO Box 839, West End, NC 27367
Tel: 910-673-3973

BIANC President's Report

I want to thank all of you who helped make 2012 a good year for the Brain Injury Association of North Carolina. We could not do our work without your support and guidance. Our corporate sponsors, board members, association members, fundraising participants and volunteers all allow us to fulfill our mission of offering help, hope and a voice for people with brain injuries and their families, and I offer our most heartfelt thanks for your support.

In 2012, several families chose to honor the Brain Injury Association of North Carolina with memorial donations for family members. We are especially grateful for the recognition that these families have given us as a way to remember their loved ones, and we will strive to do good work in their honor. The Brian Preston family, the David Herbert family, the Logan Stroud family, the Roger Bizzell family and others can be assured their generous support will help people with brain injuries have better lives.

We face many challenges in 2013 when there will be a record number of new legislators in the NC general assembly: a new governor, changes to the state Mental Health/Developmental Disabilities/ Substance Abuse system, and health care reform initiatives. We have many friends and supporters in state government, but we need to educate more of our elected officials about the needs of people with brain injuries. The Brain Injury Association of America states that "brain injury is not an event or a final outcome, it is the beginning of a lifelong disease process and it is a leading cause of death and disability. Brain injury is something most individuals don't think about until it happens to them or their family member. When it does, their lives quickly spin out of control, and they need compassionate, informed guidance to navigate the intricate system of care."

We need to let people know that a brain injury can happen to anyone, anytime, anywhere with devastating consequences for the injured person and their family. The Brain Injury Association of North Carolina stands ready to help those who need assistance and support, and we continue to need your help to accomplish our goals.

Happy New Year to everyone—2013 is going to be a great year!

Thank you for your support,

Sandra Farmer

Sandra Farmer

Brain Injury Association of North Carolina

Family Helpline
1-800-377-1464
www.bianc.net

Brain Injury Resource Centers

Asheville
CarePartners
68 Sweeten Creek Road
Asheville, NC 28803
828-277-4868

Charlotte
Carolinas Rehabilitation
1100 Blythe Boulevard
Charlotte, NC 28203
704-960-0561
Fax: 704-355-0589

Greenville
P.O. Box 30496
Greenville, NC 27833
252-717-3347

Raleigh
P.O. Box 10912
Raleigh, NC 27605
919-833-9634
Fax: 919-833-5415

Volunteer Resource Center

Triad
Wake Forest Baptist Health
Sticht Center-3rd Floor
Medical Center Drive
Winston Salem, NC 27517
336-713-8582
336-882-1911

Are You a Member of BIANC?

By joining BIANC, you will become part of a state and national organization creating a better future through brain injury prevention, support, education and advocacy.

What your Membership helps support:

* BIANC Resource Centers
* Family Helpline
* Support Group Grants
* Education, Prevention, Support, and Advocacy programs for survivors, family members, and professionals

Membership benefits include a subscription to our quarterly newsletter, *Starting Point*, a subscription to the national newsletter *TBI Challenge*, and discounted registration for events sponsored by the Brain Injury Association of North Carolina.

Basic Membership: $38 a year and includes all above benefits. Membership will not be denied to survivors and family members with limited resources.

Executive Membership: $100 a year. Includes all above benefits, plus recognition in publications by the Brain Injury Association of North Carolina.

Platinum Membership: $250 a year. Includes all of the above benefits, five complementary memberships to distribute to clients, a certificate suitable for framing, and recognition on our website.

Corporate Sponsorship: Corporate sponsorship programs are also available. These include advertising space in BIANC publications and at BIANC events. Call 919-833-9634 for more information.

To become a member, visit www.bianc.net and click on "Join BIANC"

Stay Connected!

Find us on Facebook:
http://www.facebook.com/BIANorthCarolina
And Twitter:
www.twitter.com/BrainInjuryNC

For help finding us on Facebook or Twitter, visit our website: www.bianc.net

Save the Date

Roger Bizzell Memorial Cornhole Tournament
March 2, 2013

Ride for the Rock
March 9, 2013

CBIS Class - Charlotte, NC
May 14-15, 2013

East Carolina Behavioral Health
2013 Spring Conference
May 23, 2013

Care Notes

"A Brain Injury Changed My Life"

Jackie McMichael

A brain injury changed my life. Not from any injury I have suffered, but from an injury my husband endured in November 2004. While on active duty with the North Carolina National Guard in Iraq, my husband was the target of a remote detonated Improvised Explosive Device (IED) just 3 weeks before returning home. He was one of the lucky ones. The "bad guys" as my then 3 year old son, called them, did not complete their mission. Mike was shaken up, but seemingly ok. I didn't even know about the incident until many months later. He came home and looked fine. Over the next several years, we became more and more aware of the lasting damage he suffered due to that blast. We spent years struggling to identify what was wrong, but in that time we faced financial challenges; emotional turmoil and a marriage that had at best become distant.

I knew after about 6 months that Mike was not "right". While he was high functioning and at a glance seemed fine, I knew he was anything but. Mike was unable to manage money, his short term memory was drastically different, he was easy to anger and he shook constantly to name just a few observations. I did not know what to do and I felt very alone and ashamed. My soul mate left me.

It took a long time but I realized some very key principles that helped me keep my family together and keep my sanity in the process.

Be an active participant in your family members care: With Mike's short term memory issues he often would forget the laundry list of concerns we would have for his doctor or the list of medication changes made. I finally started calling and just leaving messages and/or sending emails of what I was seeing.

Create a care team if one does not exist: Mike had varied needs and at first I had to insist his different providers talk to each other. The ones that worked with me continue to be his providers today. They are looking at the full picture, not just one piece of the puzzle. Brain injuries are not cookie cutter.

Set boundaries: I am Mike's wife, not his psychologist, pharmacist or social worker. I needed to team up with his caregivers and be a part of that collaborative care process, but not try to own it on my own. Mike had to ultimately own his improvement. My role was to support him, listen and love him, but not at the expense of my own well-being. Once I accepted that and lived that decision, it provided Mike the structure he needed to begin his true rehabilitation.

Respect the boundaries: I never contacted a doctor or therapist without Mike knowing. No matter what, they are *your loved one's* care team and you need that relationship to be strong and owned by your loved one so healing can begin.

Find a support system for you to lean on. For a very long time Mike was not capable of something as simple as me complaining about my day.

Mike is not the man I married, he never will be again. When I see that written here I am compelled to also write that I am no longer the girl he married. Brain injury changed our lives. I never dwell on what could have been, or what should have been because this is what it is. Our journey so far has been about acceptance and is long from over as I am a better person thanks to Mike's strength and determination to come back to me. ☼

Support Link

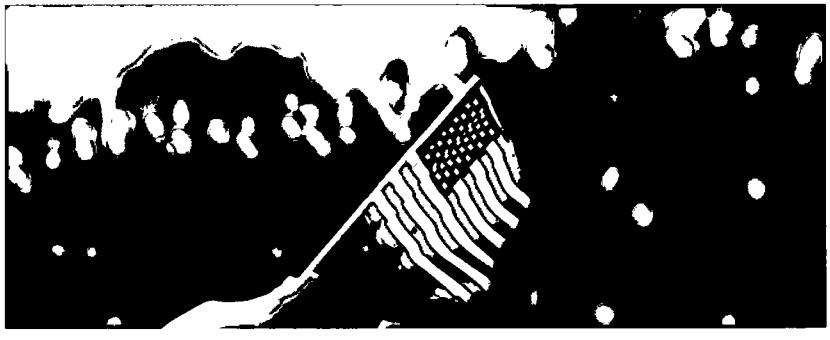
For support group leaders, members, and advocates

Susan Fewell

There are a few support groups in North Carolina that are specifically for military service members and their family members. One of these groups, Fort Bragg Wounded Warrior & Family Support Group, meets in Fayetteville. To learn more about how this group operates, BIANC interviewed Lee Cook, point of contact for the Wounded Warrior Project (WWP) that currently helps to sponsor the group.

When/where does the support group meet? The group meets on the 2nd Tuesday of each month at 6:30 pm, at the Embassy Suites in Fayetteville, NC.

How would you describe the group? A unique group of active duty & veteran soldiers who have a disability or injury that affects their daily life, and who are looking to learn more about services to help, as well as the VA process, medical care, social networking etc.



How many people attend? Just military or family members also? Currently 175 Wounded Warrior Project Alumni, family members, and other active duty military or Veterans attend monthly. The group started as a TBI overflow group from a meeting at Cape Fear Valley Hospital, started by Becky Bliss, who was the Vestibular Rehab Specialist working with the group. There were between 10-15 individuals when the group started and recruitment was done by group members. As the group got bigger, it was no longer able to meet at the hospital and started meeting for dinner at a local restaurant. At this time Wounded Warrior Project offered to pay for the dinner and be a resource if needed. When the group outgrew local restaurants after approximately a year we moved to the Embassy Suites where we currently meet. When Becky Bliss and her husband PSC'd (Permanent Station Change) to a new location the, WWP took over the dinners officially.

Do you provide refreshments? We provide a meal and drinks - we do not provide alcoholic beverages. Many of the wounded warriors with TBI or PTSD do not like to leave their homes. Having a meal provided once a month gives them a reason to get out into the community and meet others who understand what they are going through.

Do you have speakers or specific topics, or do you leave the discussion open? We do have speakers come in to discuss different topics for TBI, PTSD, and family caregiver issues. Also, WWP speakers talk about programs that are currently available and any new information that would be beneficial to the group. However, the best topics are always ones brought up by the group members. The dinner is designed for the group to help each other and discuss issues that they are dealing with.

Do you put materials out during the meeting? We do have materials available, i.e. program directories and materials that are provided by speakers.

Are most attendees returning or new participants? How do you advertise about the group? It is an even mixture of new and old members coming to the group. The recruitment is done mainly by current members, they may meet a wounded warrior or family member on base or

in public and invite them to join the group. We also send out an email blast through Carol Sharpe to registered WWP Alumni with a link to register. Anyone planning to attend is asked to register in advance so we may plan for food. At this time, we cut off registration at 175.

Where are members getting help for their TBI related issues? Do they report finding help from any specific providers or services? It varies on whether they are on Active duty or not, and also on the severity of the TBI. We have veterans attend our group that have received treatment at Womack Army Medical Center, UNC Chapel Hill, Duke University, Walter Reed National Naval Medical Center, and NICO.

What are members looking for? They are mainly looking for the interaction between other wounded veterans and their families and helping each other. When a severely injured service member is able to help out one of his fellow veterans, it gives them a sense of pride and the camaraderie that they may be missing from their time in the military. ☼

For more information on this support group, contact Jason Pratscher: jpratscher@woundedwarriorproject.org (910-487-0116)or Kathy Bell: kathryn.w.bell@amedd.army.mil (910-497-5900 x 225), group leaders. The address for the Wounded Warrior Project is 4200 Morganton Road, Suite 300, Fayetteville, NC 28314. The Defense and Veterans Brain Injury Center (DVBIC) mission is to serve active duty military, their dependents and veterans with traumatic brain injury (TBI) through medical care, clinical research and educational programs Their website is www.dvbic.org.

Photo source: http://sus.org

BIANC Platinum Members

Neuro Community Care
Erin Calo
Ricky Gibson
Douglas Maynard

BIANC Executive Members

Dale & Jean Andersen
Kimberly Bottoms
Dan Chernesky
Melanie Crawford
Maria Deariso
Victor Dostrow
Susan Fewell
Lynne Garren
Rita Gillis
Lisa Gonzalez
Ann Groninger
Debbie Leonhardt
Jim Lippard
Stephanie McAdams
Karen McCulloch
Francesca Monachino
Stephanie Nissen
Bob & Carol Ornitz
Pier Tarrant
Diane Westbrook
David Wiercisiewski

Rules Eased for Veterans' Brain Injury Benefits

James Dao

The Department of Veterans Affairs will propose new regulations on Friday that will make it easier for thousands of veterans to receive health care and compensation for certain illnesses that have been linked to traumatic brain injury.

The regulations, which will be published on Monday in the Federal Register, lists Parkinsonism, unprovoked seizures, certain dementias, depression and hormone deficiency diseases related to the hypothalamus, pituitary or adrenal glands as eligible for the expanded benefits.

The proposal, which must undergo a 60-day public comment period, could open the door to tens of thousands of veterans filing claims with the Veterans Benefits Administration, which is already struggling to process a huge inventory of such claims.

Since 2000, more than 250,000 service members — some still on active duty — have received diagnoses of traumatic brain injury, or T.B.I., according to the Defense Department. Though T.B.I. is commonly viewed as resulting from blast exposure, the vast majority of those injuries were diagnosed in nondeployed troops who were involved in vehicle crashes, training accidents or sports injuries.

The Department of Veterans Affairs says that a much smaller number of veterans — about 51,000 — are currently receiving benefits for service-connected traumatic brain injuries. However the department acknowledges that thousands more troops with T.B.I. may be eligible for the expanded benefits.

Veterans of prior wars will also be eligible for the benefits, if they can demonstrate that a traumatic brain injury was connected to their military service.

Under current rules, a veteran with one of the five illnesses has to provide medical evidence that the disease is the result of military service in order to receive veterans' benefits.

The new rule would potentially speed up and simplify their cases, provided a veteran could first demonstrate a service-connected traumatic brain injury. Once that is established, the department will accept without further evidence that any of those five diseases was caused by the T.B.I., making the veteran eligible for additional compensation and health care for that particular disease.

The regulations include some significant restrictions on eligibility, however. Veterans with Parkinsonism — a neurological syndrome often resulting in tremors or muscle rigidity — as well as unprovoked seizures, dementias and hormone deficiency diseases will be eligible only if their traumatic brain injury was moderate or severe.

The vast majority of such injuries, about 8 in 10, are classified as mild, with most of the rest moderate and a small number severe. The Institute of Medicine, an independent research unit of the National Academy of Sciences, defines a mild traumatic brain injury as involving a loss of consciousness or memory lasting less than 30 minutes. Severe T.B.I. entails loss of consciousness or memory lasting more than 24 hours.

The Department of Veterans Affairs said in a news release that it based its policy on a 2008 Institute of Medicine study, which concluded that evidence linking mild T.B.I.'s to the diseases was only "limited or suggestive."

"We must always decide veterans' disability claims based on the best science available," the secretary of veterans affairs, Eric K. Shinseki, said in the release. "Veterans who endure health

problems deserve timely decisions based on solid evidence that ensure they receive benefits earned through their service to the country."

The proposed regulations also set time restrictions for some of the illnesses. Dementias must become apparent within 15 years of a moderate or severe traumatic brain injury. Hormone deficiency diseases must manifest themselves within one year of a moderate or severe brain injury. And depression must become evident within three years of a moderate or severe brain injury or within one year of a mild one.

The limits in the coverage are likely to draw criticism from veterans' groups. Still, the announcement clearly pleased advocates who had spent years pushing for expanded benefits for T.B.I.

"Veterans should be pleased with the new regulations," said Paul Sullivan, a leading advocate for the proposed regulations. But Mr. Sullivan, who is director of public relations for a law firm, Bergmann & Moore, that handles veterans' claims, said the department must increase training and staffing to ensure that it can handle the wave of new claims likely to result from the new policy.

The last time the department significantly expanded benefits — in 2010, for several diseases linked to Agent Orange, the defoliant used in Vietnam — it prompted a tidal wave of new claims, significantly adding to the department's backlog. Though the department has cleared most of those Agent Orange claims, it still has an inventory of nearly 900,000 pending claims.

Department officials said they had no plans to hire extra personnel to handle the new regulations, noting that they did not anticipate that the number of additional claims would be very large. ☼

Source: Tao, David. "Rules Eased for Veterans' Brain Injury Benefits" *New York Times* 7 December 2012: A17. Print

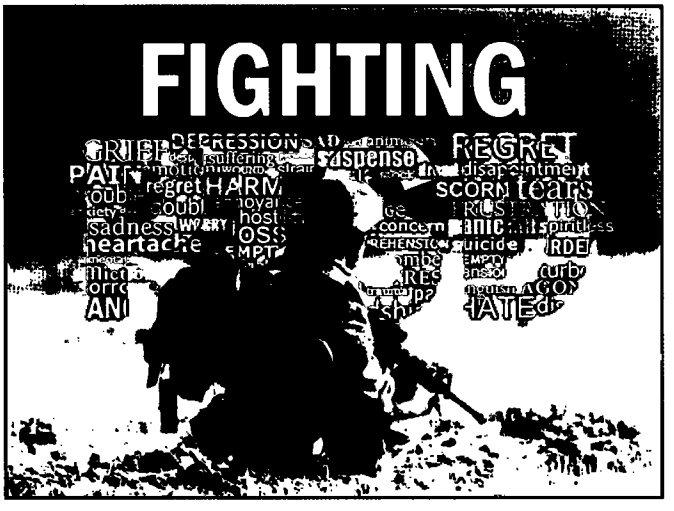
Department of Defense Health Official Updates Status of PTSD, TBI Care

Nick Simeone

A top Defense Department health official told a Pentagon task force yesterday that determining the impact of mental health programs across the military will be a key project this year for the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.

DCoE's director, Navy Capt. Paul S. Hammer, listed accomplishments over the past year as well as areas where improvement is needed, including "streamlining functions that effectively accomplish the stated DCoE mission and vision."

"Our job is to make the system better so that our service members, their families and veterans get better care," he told the Recovering Warrior Task Force, whose mission is to provide DOD with advice on managing care for post-traumatic stress disorder and TBI.



DOD and the Veterans Affairs Department are "collaborating to shape policies and programs with a long term impact on returning warriors, during military service and after transition to civilian life," he added. He called for increased screening and referral of service members believed to be experiencing PTSD, and for improved access to quality care for those being treated.

In addition, he called on DOD as well as the services to adopt strategies to better recognize PTSD among returning warriors and to step up efforts to ensure those who need treatment stick with it.

Hammer told the task force members his organization benefits efforts throughout the Defense Department to help those suffering from PTSD and TBI. "We believe that by serving as the principal integrator and authority on psychological health and traumatic brain injury knowledge and standards for DOD," he said, "we are uniquely positioned to accelerate improvement and care."

Hammer noted that a transition is under way as support responsibility for DCoE shifts from DOD's TRICARE Management Activity to the Army Medical Research and Materiel Command under a Defense Department directive.

"What we need is leadership to really clarify expectations on what they want for us in terms of our roles and functions," he said. "I think the challenge or difficulty is ensuring that we are clear on what our role is and what the relationship is with the services."

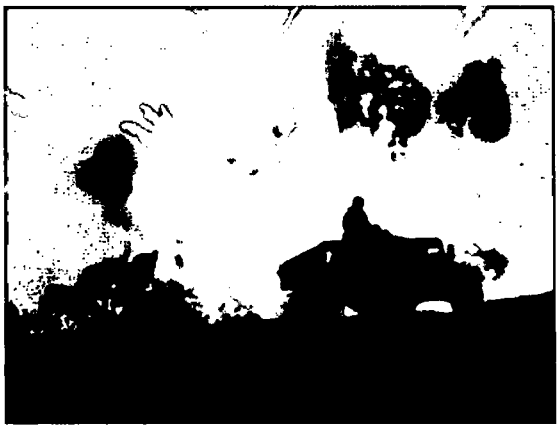
The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury was established in 2007 to develop excellence in prevention, outreach and care for service members with psychological health conditions including TBI. It oversees three centers: the Defense and Veterans Brain Injury Center, the Deployment Health Clinical Center and the National Center for Telehealth and Technology. ☼

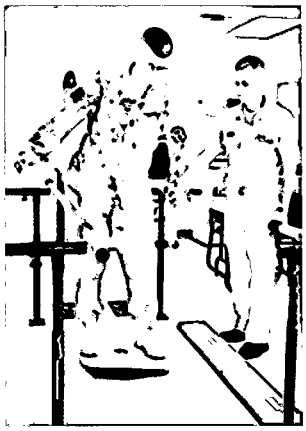
Source: Simeone, Nick. "DOD Health Official Updates Status of PTSD, TBI Care" *defense.gov* 16 January 2013.
Photo Source: http://soldiersforthecause.org

Lobe Lessons

How Does an IED cause a Traumatic Brain Injury?

Jenna Beck





TBI from an improvised explosion device (IED)

A concern for many soldiers and their families is acquiring a TBI from an IED during deployment. IEDs are enemy weapons that cause the greatest number of American deaths and injuries in war. An IED explosion affects all individuals nearby. IED blasts are unique in that they strike twice – the first shock wave of high pressure is followed immediately by another wave of displaced air flooding back into the vacuum under high pressure. These differences in pressure can be up to 1,000 times greater than atmospheric pressure. Severity of the injury can range from a concussion to shattering the skull. If the skull is left intact, the individual may have no noticeable damage on the outside, but could be left with many TBI symptoms.

Symptoms of TBI from IED explosions include excessive sleepiness, headaches, balance problems, hearing problems, difficulty concentrating, impaired memory, faulty judgment, depression, irritability, emotional outbursts, disturbed sleep, decreased libido, difficulty switching between two tasks, and slowed thinking. These symptoms can range from mild to severe. The brain is usually able to heal itself and these symptoms will slowly disappear. However, sometimes the brain cannot adapt to the TBI. The symptoms would then escalate and could result in psychological problems, many times affecting family life.

Treatment of TBI resulting from military activity has recently improved. The Pentagon has now released a policy that mandates a 24-hour rest period after an IED blast and a complete neurological assessment for anyone experiencing 3or more concussions. Congress now requires that all returning service members undergo a neurological screening at military and veterans' hospitals. However, symptoms may not surface until months or years after the injury. Without treatment, TBI sufferers are at an increased risk of developing depression, substance abuse, severe anxiety, OCD, Alzheimer's and suicide. It is imperative to receive a diagnosis and treatment as soon as possible. The best treatment is cognitive rehabilitation therapy, which involves retraining patients for basic tasks and memory. This treatment is very effective and can help a patient recover most prior functioning. ☼

References:
http://defense-update.com/analysis/analysis_270507_blast.htm
http://www.pbs.org/pov/wheresoldierscomefrom/traumatic-brain-injury.php#.UMzVPG9i7X8
http://www.military.com/opinion/0,15202,128806,00.html

2012 Annual Symposium

Sponsored by The Brain Injury Association of North Carolina and Wake AHEC

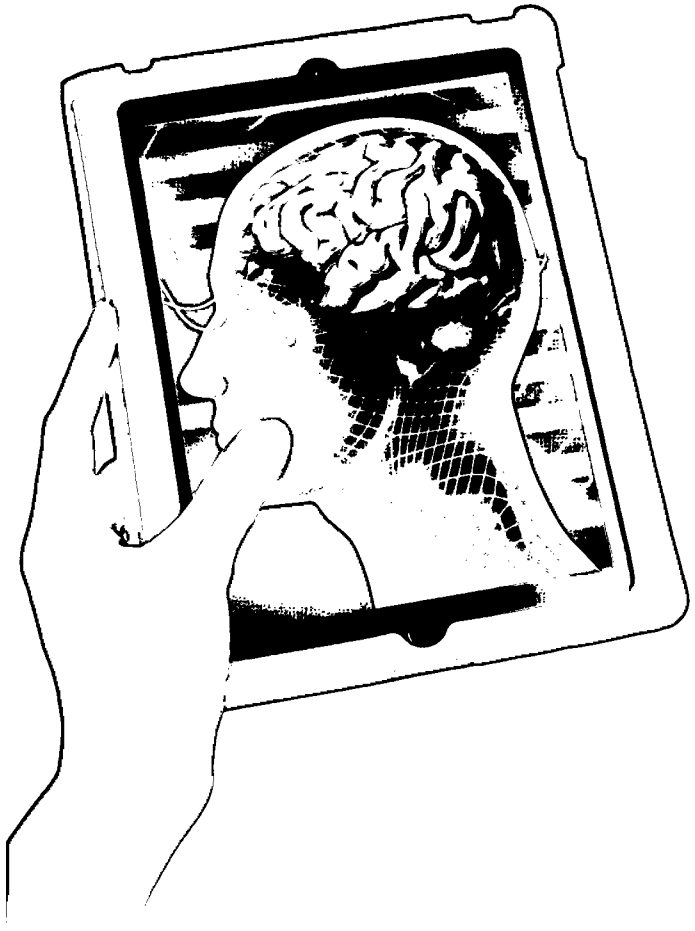
Shawn Chase

We always look forward to our annual Brain Injury Symposium in October. This year's event was held on October 26, 2012 in Cary, and was spectacular! With technology driving our society at such an incredible pace, smart media is playing a huge role in not only training, education, and recognition of brain injury, but also in the treatment.

TRAUMATIC BRAIN INJURY 2012

Innovations in Brain Injury: Is There an App for That?

This year's symposium featured a national panel of speakers. Victoria Youcha and Kelly Deckert from Brainline.org started the day off with a great session on available smartphone and tablet apps focused on TBI and online resources via social media. Dr. Graham Snyder, Medical Director for the Center for Innovative Learning at WakeMed, presented on medical simulation applications in brain injury and provided great insight into simulated medicine and telemedicine as provided at the SIM center at WakeMed.



Jason Mihalik, PhD is an assistant professor at UNC's Department of Exercise and Sport Science, as well as the co-director for the Matthew A. Gfeller Sport-Related TBI Research Center at UNC. Dr. Mihalik provided an in-depth talk and demo on the Concussion Recognition & Response™ smartphone and tablet app that he co-authored. The app is available on both iOS and Android platforms and is designed to help coaches and parents recognize whether an individual is exhibiting/reporting the signs and symptoms of a suspected concussion.

Dr. Kathleen Boncimino from Carolinas Rehabilitation gave an excellent presentation on the role of biomarkers in minor TBI and the research that she is participating in. Marilyn Lash and Marshele Waddell closed out the sessions with a heartfelt talk on military wives and some of the things that families are dealing with when their loved ones return home from battle with TBI and PTSD.

The traumatic brain injury 2012 Symposium was a great success thanks to our attendees, planning committees, a wonderful group of exhibitors from around the country, and our distinguished panel of presenters. Stay tuned to www.bianc.net for details on our 2013 Symposium this fall! ☼

Veteran's Resources

A list of websites for obtaining resources

North Carolina has a large military and veteran population. Many Military service members are returning to their home communities needing services that are aimed at easing the transition from the front line to back home. The Brain Injury Association of North Carolina wants to reach out to all branches of military service, citizen soldier, and wounded warrior groups, as well as families who are trying to learn more about brain injury. Please call one of our Brain Injury Resource Centers, let us know your experience, and we will be happy to mail or email information, help you look up resources, or meet with you in person to help you find support and services. You may also explore some of the following websites on your own for resources. ☼

Brain Injury Resource Centers

Asheville: 828-337-0208
Charlotte: 704-960-0561
Greenville: 252-717-3347
Raleigh: 919-833-9634
Triad (Volunteer Center): 336-882-1911
Toll Free: 1-800-377-1464

Online Resources

BIANC Resource Book: www.bianc.net
Charlotte Home Bridge: charlottebridgehome.org
Warrior Gateway: www.warriorgateway.org
National Resource Directoy: www.nrd.gov
Veterans Job Bank: www.nrd.gov/jobSearch
Defense and Veteran's Brain Injury Center: dvbic.org

BIANC Presented at Substance Abuse Conference

"The 28th Annual Substance Abuse Services State of the Art Conference: *Empowering Professionals and Embracing Change*"

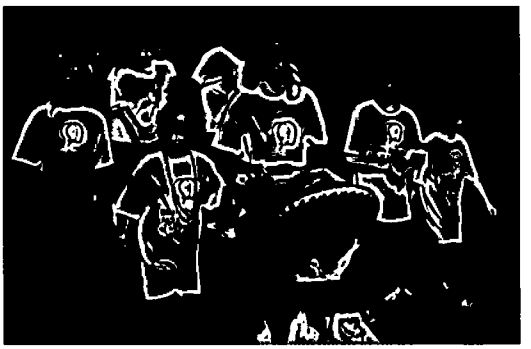
This was an awesome conference in Greenville you didn't want to miss, but if you did, look for it again next year. The conference (November 7-8, 2012) featured expert speakers, great resources on exhibit, and a multitude of networking in the eastern part of our state. Over 240 attendees were present at the conference. The conference featured sessions on "Treatment of PTSD and Substance Use Disorders in Returning Veterans", "Human Trafficking in NC", "Effectively Implementing Evidence-Based Prevention Programs in Schools and the Community", "PTSD – Past the Symptoms: A Human Experience", and much more.

Rose Griffin from Project Star in Charlotte presented at the conference with Shawn Chase and Sandie Worthington from BIANC. Their presentation was titled "Traumatic Brain Injury (TBI) and Its Relationship to Substance Abuse and Mental Health." Topics covered during the session included the connection between Substance Abuse Services/Mental Health Services and Traumatic Brain Injury, TBI and its causes and consequences, modifications necessary for a consumer with a TBI in a Substance Abuse/Mental Health program, and information on brain injury resources available in our state. Feel free to contact your local Brain Injury Association of North Carolina Resource Center if you would like more information about this or any other upcoming events. ☼

2013 Walk & Roll-athons

Awareness events in Asheville, Concord, Raleigh, and the Triad

The Brain Injury Association of North Carolina (BIANC) is gearing up for our annual Walk & Roll-athons. This is one event you don't want to miss out on! Whether you are a returning participant or this will be your first year joining us - you're sure to have a great time.



Your support will help us provide prevention awareness surrounding concussions and other sports related injuries, trainings for professionals, and support towards families, military, and caregivers.

What is a Walk & Roll-athon?
Walk & Roll-athons are awareness and BIANC fundraising events held at local parks across North Carolina. They honor survivors, family members, and military personnel who are dealing with the challenges of living with a brain injury. The walks are on a short paved or smooth course where everyone can walk or roll in a wheel chair together. Each event has music, fun activities for kids and the whole family, and opportunities for exercise and learning more about brain injury. All events include lunch and event t-shirts. Donations are tax deductible and for a worthy cause.

You may register for the Walk & Roll-athons as an individual or as a team. You can also collect pledges to pay for your entry fee or just as additional donations!

Where is my local Walk & Roll-athon?
The Brain Injury Association of North Carolina is holding four Walk & Roll-athons across North Carolina. One will be held in Concord, NC on March 23, 2013 at Frank Liske Park; in the Triad on April 13, 2013 at High Point City Lake Park in Jamestown, NC; in Asheville, NC on April 13, 2013 at Carrier Park; and a Walk & Roll-athon will be held in Raleigh on April 20, 2013 at Dorothea Dix Campus. Those who typically attend the event in Greenville should join us in Raleigh again this year!

What is the cost and how do I register?
The price for each Walk & Roll-athon is $20 per participant if you sign up at least one week prior to the event, and is $25 per participant on the day of the event.
You may choose to register online for any of our Walk & Roll-athons by visiting our website at www.bianc.net. You may also download a registration form to print off and mail in from our website.

If you have any questions please visit our website at www.bianc.net or call us toll-free at 1-800-377-1464. ☼

Wounded Warrior, Wounded Home: New Book Transparent about Combat TBI

Marshele Carter Waddell

I hate what war did to my family. I hate what two wars did to the man I married and what a third threatens to do to our son. And, with the same measure of hatred, I loathe what war did to the rest of us who love these two men.

Martin Luther wrote, "If you want to change the world, pick up your pen and write." I accepted that challenge by co-authoring Wounded Warrior, Wounded Home: Hope and Healing for Families Living with PTSD and TBI (Baker Publishing Group, March 2013). I have picked up my pen, a weapon which is said to be mightier than the sword, opened my laptop and my heart in order to change the world for millions, one life at a time, who love a combat veteran and who live in the wake of the sword.

When my Navy SEAL husband returned from Iraq with only a broken leg, I praised God that he was home safe and sound. In the months that followed his homecoming, I sensed that his leg was the least of our concerns. Although he was recovering physically, his soul still walked with a limp. His unseen wounds, caused by war zone experiences, went unmentioned, unnoticed and untreated. Slowly but surely, these invisible injuries infected our marriage, our children and our family life. He was home with us in body; but, in his spirit a war still raged. From irritability and irrationality to nightmares and emotional paralysis, it became very clear to me that my veteran husband was suffering from post-traumatic stress. For two years my husband denied any need for help and unintentionally led our family into a land of silent suffering.

For more than two decades, our marriage had survived everything that a special operations career could throw at us: frequent deployments, long separations for training and real world conflicts, serious injuries and surgeries as well as multiple overseas family moves. The stress of my husband's job was nothing new for either of us. That may explain why my husband's frustrations and underlying anxieties caused me no new concerns at first. It was "all systems normal" and "steady as she goes," or so I thought. *Hope for the Home Front: Winning the Emotional and Spiritual Battles of a Military Wife* and its companion Bible study were penned before I knew anything about the beast that would raise its ugly head when Mark returned from the frontlines. Military Life 101 was cakewalk compared to the challenges that came home in Mark's mental rucksack. Our "normal" defined our life and activity. We were living it; but we didn't understand it. Mysteries rarely make formal introductions, but move in uninvited and we live among them sightless for a time.

There is a segment of well meaning subject matter experts out there that glosses over the horrors of posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI), attempting to soothe the sting and silence the cry of a nation's soul by saying it's all good. They applaud the attainment of a sullen, resigned thankfulness as evidence of a full and admirable recovery. They even go so far as to rename it post-traumatic *growth*. Well, it's *not* all good. There's a reason those who pass through this dark place call it hell on earth.

I still wake up every morning hating what war did to my family. Plain and simple. I didn't ask for this. I don't like the stigma and struggle of it one bit. Please don't misinterpret me. I believe I'm moving in the general direction of being able to honestly say one day that war's aftermath on the home front delivered priceless treasures of tried and true character, that it forged and fortified my dearest relation-

ships and refined us all to an impenetrable, polished perfection.

Please hear my heart. I hold a fragile hope of personal and family wholeness with the utmost care. I cup it gingerly in the palm of my heart and lift it heavenward daily, asking God to continue to give it life and breath. I see God in the smallest steps of progress. I hear His love for us in our sluggish forward motion toward wholeness. Even so, combat-related PTSD and TBI on the home front remain the ugliest and longest battle we who share this address have ever known.

There is much talk about a "new normal" for returning veterans and their families. We know full well that the place we used to live is no longer on the map. We've tried to find it, but the inner, nasal GPS voice repeats "recalculating" as we try to navigate the post-combat, civilian landscape.

Wounded Warrior, Wounded Home is written for those whose lives are connected to the life and service of a combat veteran. The home front needs the hope found in the true stories of real families living victoriously in the aftermath of war and overcoming an invisible enemy, the signature wounds of the present conflicts: posttraumatic stress disorder and traumatic brain injury. We, the spouses and family members who love and live with these combat veterans, fight the good fight from unfamiliar foxholes against enemies no one prepared us to face. Military marriages, extended families, churches and entire communities are caught in the crossfire of stress caused by our loved ones' wartime experiences.

When a veteran suffers from posttraumatic stress and traumatic brain injury, every member of his/her immediate family experiences the effects and, in many cases, suffers what is known as secondary acute stress. This secondary traumatic stress resembles the universal and potentially complicated process of grief. Spouses, parents and children of warriors pass through phases of shock and confusion, hurt, anger, guilt, fatigue, fear, and finally, acceptance.

Even with faith and courage, the results of war can be emotionally scarred homes, major depression, addictive behavior, substance abuse, divorce or suicide. *Wounded Warrior, Wounded Home* provides a glimpse into the mind and heart of the warrior, based on the latest research and on personal interviews with veterans, family members and medical professionals, and gives family members a deeper understanding of their own challenges: secondary traumatic stress and compassion fatigue.

The bravest people I know are the women who agreed to share their stories with us for the purposes of this book. They are people who are on a similar journey from combat stress toward individual and family wholeness. We are grateful for their courage and transparency. We also appreciate the generous input of various credentialed professionals and organizations that contributed to the accuracy of the clinical content.

I hate what war did and still does to my family. Yet, I am committed to finding the growth, the good, and the hidden gifts that God alone can reveal over time. I invite you to travel with us through *Wounded Warrior, Wounded Home.*

For more information, visit www.woundedwarriorwoundedhome.com and www.hopeforthehomefront.com.

(This article is an adapted excerpt from the introduction of *Wounded Warrior, Wounded Home: Hope and Healing for Families Living with PTSD and TBI*, Revell Books, a division of Baker Publishing Group, March 2013.)

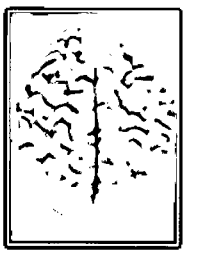
Marshele recently moved to NC. She has been leading a team conducting weekend retreats for the Wives of Wounded Warriors around the country.

1 Chris Adsit, Rahnella Adsit, and Marshele Carter Waddell, *When War Comes Home: Christ-centered Healing for Wives of Combat Veterans* (Newport News: Military Ministry Press, 2008), 7-8.

KNOWLEDGE. SKILL. EXPERIENCE.

RESULTS!

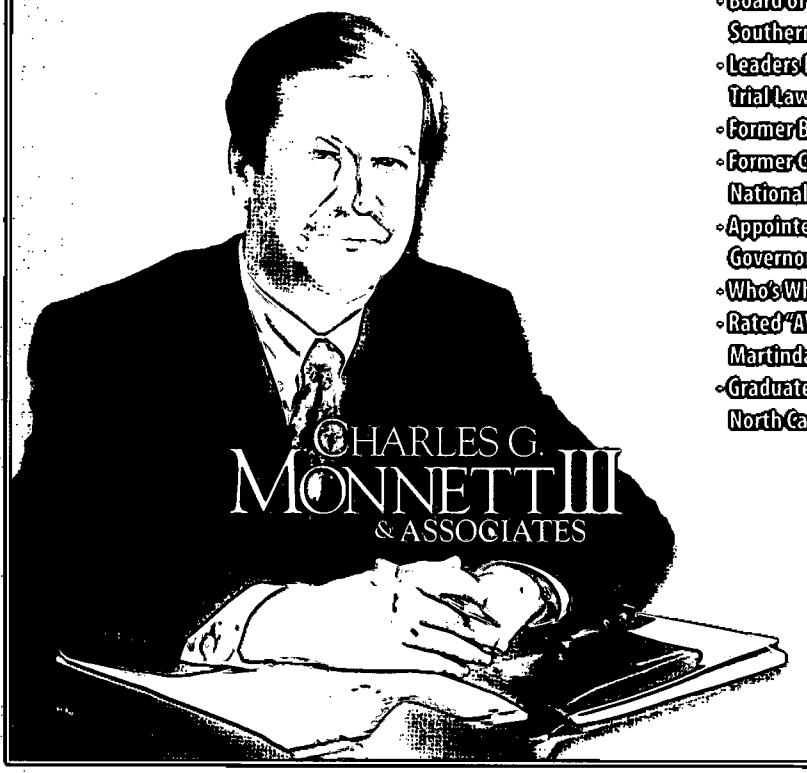
If you or someone you know has experienced a TRAUMATIC BRAIN INJURY you need advice you can rely on from someone you can trust: Charles G. Monnett III & Associates



At Charles G. Monnett III & Associates we believe that personal injury deserves personal attention.

When a traumatic brain injury occurs, many people will offer advice. Advice that is sometimes confusing, many times contradictory and very often wrong. When a traumatic brain injury has changed your life, you need advice you can rely on from someone you can trust. Choose only the best, a qualified trial attorney with demonstrated expertise in representing people who have experienced life altering injuries.

So, if you've been injured, ask your friends and loved ones about us. We believe you'll like what you hear. When you're ready, call us, we're here to help you. We handle cases throughout the state of North Carolina and have attorneys licensed in NC, SC, GA and TN.



- A speaker at legal seminars relating to traumatic brain injuries throughout the country
- Board of Governors: NC Academy of Trial Lawyers and Southern Trial Lawyers Association
- Leaders Forum Member: NC Academy of Trial Lawyers and The American Association for Justice
- Former Board Member of The Brain Injury Association of NC
- Former Chair & Current Executive Committee Member of the National Traumatic Brain Injury Litigation Group
- Appointed by Governor Easley to the Governor's Traumatic Brain Injury Advisory Council
- Who's Who in American Law
- Rated "AV," the highest possible rating by Martindale-Hubbell Law Directory
- Graduate of the University of North Carolina School of Law

www.carolinalaw.com

1-800-977-3077

200 Queens Rd., Suite 300
Charlotte, NC • 704-376-1911
Conveniently Located across from Carolina Neurosurgery and Spine Associates PA

Local Chapters and Support Groups

Additional information on support group meeting places and times are available at www.bianc.net

Ashe/Watauga Counties *High Country*
Debbie Absher 336-246-4542

Asheville *WNC BI Support Group*
Erica Engelsman 828-274-0570
wncbraininjurynetwork@gmail.com

Boone *Boone TBI Support Group*
Jules Roberts 828-262-2185 or 828-265-5026
robrtsjp@appstate.edu

Cary *Cary Hospital Support Group*
Susan Fewell 919-618-3003
susan.fewell@bianc.net
Dave Baack 919-460-9094

Chapel Hill *UNC Rehabilitation BI Support Group*
Karla Thompson 919-966-8813
Karla_Thompson@med.unc.edu

Charlotte *Charlotte Area BI Alliance*
Sally Rickard 704-355-1502
sally.rickard@carolinashealthcare.org

Family Education/Couples Night Out /Spouse Support
704-355-4354

Cleveland County *Cleveland County BI Support*
Carolyn Costner 704-434-5624
scostner3@carolina.rr.com

Concord *Concord Area BI/Spinal Cord Injury*
Margaret Love 704-784-2503
luv3@ctc.net

Durham *BI Support Group*
Shani Cohen 919-419-9955 ext. 3019
scohen@learningservices.com

Fayetteville *Fayetteville BI Support Group*
Ellen Morales 910-486-1101
ellen.morales@dhhs.nc.gov

Fort Bragg *Wounded Warrior & Family Support Group* (for military only)
Kathy Bell 910-497-5900 ext. 225
Kathryn.w.bell@amedd.army.mil
Jason Pratscher 910-487-0016
jpratscher@woundedwarriorproject.org

Gaston County *TBI-To Be Included*
Patricia (Pat) Haithcox 704-865-8819
pathaithcox@comserve.org

Fractured Friends
Elisha Giesey 704-692-1623
ekgiesey@gmail.com

Caromont Stroke and Brain Injury Support Group
Celeste Thompson 704-671-5730
celestethompson@caromonthealth.org

Goldsboro *Brain Injury Support Group*
Sandra Pendergraft 919-288-1616
spendergraft@communitypartnerships.org

Greensboro *BI Support Group*
Lucy Hoyle 336-832-7450
lucy.hoyle@conehealth.com

Greenville *BI Support Group*
Mark White 252-737-2076
whitem@ecu.edu

Pediatric Brain Injury Support Group
Montigne Hassett 252-847-6971
Montigne.Hassett@vidanthealth.com

Henderson *Kerr Lake BI Support Group*
Nina Kalleh 252-432-7159
ninataylorkalleh@gmail.com

Hickory *Catawba Valley BI Association*
Travis Glass 828-781-0778
travis@crossroadscounseling.org

High Point *BI Alliance of High Point*
John Peeler 336-887-0745

Lake Norman *BI Support Network*
Sylvia Whitmire 704-224-6069
sylvia@brainrehabspecialist.com

New Bern *Coastal BI Support Group*
Amy Davis 252-514-2970 or 252-670-6625

Raleigh *Triangle BI Support Group*
Monica McGrath 919-833-9634
Separate Caregiver Group Available

Rocky Mount *Over the Bridge BI & Stroke*
Tabitha Jackson 252-962-3711 tnjackson@nhcs.org

Rowan County/Salisbury *Rowan County*
Nadine Cherry 980-622-7732 ncherry@ctc.net

Stanly County *BITS of Stanly County*
Margaret Owen 704-485-2483

Statesville *Surviving Angels*
Kim Wolf 704-873-7635 kim-wolf@att.net

Union County *Union County Area*
Laura Gray 704-578-5043
lauragraySLP@gmail.com

Whiteville *Columbus County*
Carla Brown 910-642-1717

Wilmington *Brain Injury Support Group*
Morgan Lankford 910-343-7062
juxon.lankford@nhrmc.org

Winston-Salem *Back on Track*
*In transition: please call 336-713-8582

The Brain Injury Association of North Carolina
PO Box 10912
Raleigh, NC 27605

BRAIN INJURY ASSOCIATION OF NORTH CAROLINA

Offering help, hope, and a voice for people with brain injury and their families

Annual Report

2012

Board & Staff

Board of Directors

Karen McCulloch
Co-Chair

Katrina Miller
Co-Chair

Susan Baker

Cindy Boyd

Marie Britt

Kim Delisle

Steven J. Elizondo

Tami Guerrier

Pam Guthrie

Marian Hartman

Thomas Henson

Francesca Monachino

James O'Brien

Johna Register-Mihalik

Mike Sink

Pier Tarrant

Mark White

Staff

Sandra Farmer
President

Sheri Bartel
Resource Coordinator

Shawn Chase
Statewide Training Coordinator

Sarah Davis
Communications & Development Coordinator

Susan Fewell
Outreach and Training

Karen Keating
Resource Coordinator

Chelsie Rigsbee
Assistant Resource Coordinator

Jonna Roy
Business Manager

Sandie Worthington
Resource Coordinator

2012

Dear Friends and Colleagues,

Sandra Farmer
Executive Director/CEO, BIANC

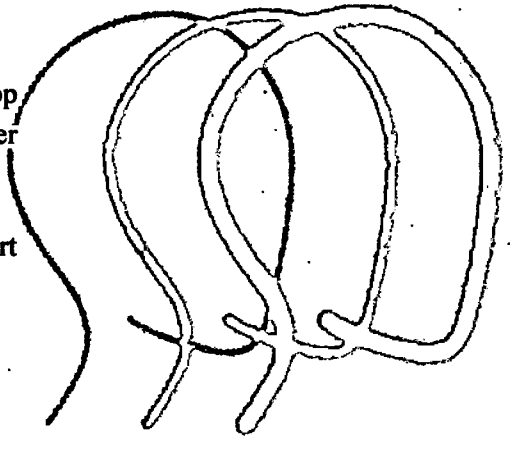
I would like to thank our partners and supporters for assisting the Brain Injury Association of North Carolina (BIANC) in helping people with brain injuries and their families achieve a better quality of life. Your contributions to the brain injury community are critical to our success. We offer this report to update you on BIANC's continuing efforts.

Founded over 30 years ago by a small group of families in the Winston Salem area, the Association has grown to include four regional resource centers and one volunteer center which serve the estimated 180,000 people in North Carolina living with the effects of traumatic brain injury. BIANC supports the citizens of our state by providing brain injury prevention activities, as well as education programs on innovations and best practice guidelines for professionals, families and community agencies. The Association also provides referral and resource coordination, and collaborates with researchers investigating new avenues of brain injury treatment. As an affiliate of the Brain Injury Association of America (BIAA) we participate in a nationwide network dedicated to improving the lives of the 1.7 million Americans living with brain injuries.

Katrina Miller
Co-Chair, BIANC Board of Directors

The continuing efforts of BIANC, BIAA and our community partners have led to improved services for people with brain injuries. BIANC provides specialized materials for rehabilitation hospitals to share with families as they transition through the acute phases of brain injury recovery. We provide training for professionals to become Certified Brain Injury Specialists (CBIS), allowing them to work more effectively with people who have sustained a brain injury. BIANC facilitates over 30 regional support groups that assist families with information and community integration. We offer a weekend health and wellness retreat for survivors and regional day outings. BIANC provides technical assistance to Clubhouse/day programs for people with brain injuries, including military service members. As we learn more about the impact of sports-related concussion, falls in the expanding older adult population, and combat-related brain injury, we realize we still have much to accomplish.

BIANC looks forward to partnering with our supporters to help us develop new services. As we seek to maximize available funding, we hope to offer expanded opportunities for public outreach, education, and awareness.



We are happy to share our annual report with you. Thank you for your support and guidance. We could not do our jobs without you.

Best Regards,

Sandra Farmer

Special Thanks

The Brain Injury Association of North Carolina graciously thanks the following individuals and organizations for their support.

Our Major Funders

NC Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
Federal Health Resource Services Administration Grant

Corporate Sponsors

Charles G. Monnett, III and Associates
www. carolinalaw.com

Carolinas Rehabilitation
www.carolinasrehabilitation.org

CarePartners
www.carepartners.org

HensonFuerst, PA
www.lawmed.com

Wake Forest Baptist Health
www.wakehealth.com

Law Offices of Michael A. DeMayo LLP
www.demayolaw.com

Hinds' Feet Farm
www.hindsfeetfarm.org

Learning Services
www.learningservices.com

Seven Lakes Eye Care
www.sevenlakeseyecare.com

Event Sponsors

Bank of the Carolinas
Bayada Home Health Co
BHR Pharma, LLC
Bill Black Chevrolet Cadillac
Bodford Family Foundation
Carolinas Hyperbarics
Cone Health Inpatient Rehab
David Gantt Law Office
Greater Media Charlotte, Inc.
Greensboro Sports Commission
Ilderton Conversion Co.
Latham Group
Liberty Street Baggage
Lippard Lodge
Metro Nursing Inc.
Moose Drug Company
NC Neuropsychiatry
Novant Health
Pilot Clubs of North Carolina
Provident Living Inc
York Properties

Special Thanks

The Brain Injury Association of North Carolina graciously thanks the following individuals and organizations for their support.

Donors

Alpha Omega Sorority
Ron Avery
Philip Baddour Jr.
George & Chris Bambolis
Larry & Joan Bissett
Blue Ridge Roller Derby
Elizabeth Botta
Benjamin Brown
James & Vicky Brown
Toni Brown
Bulldog Express
Carrie Bury
Beth Callahan
Maile Carpenter
Mr. & Mrs. Edward Clement
Gail & Phil Cooley
Custom Postal Services
Jane Dallas
Ron Daniel Jr.
Karen Deveaux
Brenda DeWalt
Jeanne Dibbert
Sunjaykumar Donda
Em Doyle
Kevin & Nancy Duffy
Joe & Dorcas Epley
Gifts n More
Tom & Fran Gregg
Janice Hairr
Jim Harris
Marian Hartman
Carolyn Heilman
Bonnie Helm
Linda Hilton
Margaret Hinson
Mark & Michelle Hollar
Chris & Steve Hold
Harvey Jacobs
Margaret Jennings
Robert Juliano
Phillip Kirk
Bob Kishline
Deanna Kleiss
William & Deborah Kodros
Widgie Kornegay
Lash & Associates Publishing
Jon & Melissa Lewis
Betty Lilyquist
Stacey Lindsay
Logan Stroud Foundation
Rachael Malmberg Harper
John Mandinec
Kelvin Mayfield
Charles McCamy
Mark McElroy
Brandon Melton
Robert Menard
Betsy Merriman
Russell Morgan
NC Association of Rehab Professionals
Nearly New Fish, LLC
Devon & Jayme Nelson
Brenda Newman
Carol Ornitz
Packaging Depot LLC
Packaging Express
Vijayalakshmi Pandui
Vickie Pennington
Postal Center Inc.
Ilene Price
PulleyWatson
Qwik Pack & Ship
Cedric Rogers
Thomas Rosse
Anne Sanford
Andrea Sapienza
Laura Scales
Ship on Site
Southern Rehab Network
Lynn & Ken Stark
Diane Stokes
Robert Taylor
Winston-Salem Foundation
Louise Umscheid
Anna Ure
Debra Valentine
Susanne Vergara
Billy Vickers
Alex Volansky
Toby & Elizabeth Ward
We Ship It!
Sharon Wheeler
Janice White
Wilkinson Supply Co.
Carrier Williams
John & Gwen Winn
Elizabeth Woodman
Wrap, Pack & Ship

Achievements

Education and Training

- **109** individuals attended BIANC's Family Conference in High Point
- **148** individuals attended our Annual Symposium in Cary
- **86** professionals attended a Certified Brain Injury Specialist training
- BIANC responded to **441** professional assistance inquires
- A monthly eBlast news update was distributed to an average of **600** individuals
- **24** Brain Injury Training sessions were attended by **675** individuals. These training sessions are specialized to meet an identified need.
- *Starting Point,* BIANC's quarterly newsletter, was distributed to **2,000** members, support group attendees, and rehab professionals

BIANC provided 3 CBIS training classes to train 86 new Certified Brain Injury Specialists. Thanks to our hosts for the training at Wake Forest Baptist Health, Cone Health, and Learning Services Corporation.

"BIANC has offered us resources to aide in my husband's recovery and has given our family a place in our community to belong. Staff have offered us encouragement when we've needed it, and given us hope through support groups, resources, and events throughout the year."
Amy Root, Caregiver

Achievements

Outreach and Support

- Resource and Outreach Coordinators visited **Two** Military Bases, as well as the Defense and Veterans Brain Injury Center
- **Six** support groups received grants for local events from the Brain Injury Association of North Carolina
- BIANC provided training to **125** support group leaders and members
- **334** survivor assistance inquiries were answered by BIANC
- **204** brain injury survivors and/or family members were referred to local support groups
- **210** brain injury survivors, family members, and volunteers attended Camp Carefree
- Local support groups held outings attended by over **450** individuals
- **1,240** resource emails were answered, as well as **1,024** resource calls

Smiles could be found on almost every face during BIANC's 18th annual Camp Carefree retreat. Each cabin selected their own name for the weekend. Pictured here are the campers from the "Chick Shack."

"The Wilmington Brain Injury Support Group had an outing downtown with help from a BIANC Support Group grant. It was a big success! We went on a narrated sightseeing tour on the river, rode the horse-drawn carriage tour, and enjoyed yummy frozen yogurt."
Morgan Lankford, Support Group Leader

Achievements

Public Awareness and Prevention

- The Brain Injury Association of North Carolina published **two** revised Skill Packs for Rehab hospitals
- BIANC made **eight** new media connections
- Partnerships were established between BIANC and **28** Pilot Clubs across North Carolina to help with their *"protecting your brain for life"* mission
- A **grant** was received from Carolina Panthers Charities to provide concussion education to local youth sport coaches
- BrainMinders puppet shows were performed for **208** children and parents
- Five annual fundraising and awareness events had over **950** participants
- BIANC exhibited at **15** conferences across North Carolina reaching **3,210** attendees
- www.bianc.net received over **23,000** visitors and over **745,000** hits
- BIANC increased its social media presence with **2,810** friends on Facebook, **206** Likes, and **1,351** followers on Twitter
- **178** students and coaches received training surrounding a concussion recognition and response app for iPhone and Andriod.

"BIANC has been instrumental in helping me find resources & programs to help my son, Jon. After Jon's accident in 2002 resulting in TBI, I didn't know where to turn to find help. BIANC helped me find a local support group and provided workshops & training opportunities that helped me handle issues we were facing. When I started considering residential placement options for Jon, BIANC helped me find the few placement options that are available for TBI survivors in NC. The annual camp BIANC holds for TBI survivors, Camp Carefree, has been a wonderful opportunity for Jon and other survivors to enjoy recreational activities. Jon has also enjoyed participating in the Walk & Roll-athons BIANC holds. As a parent, I would have been lost without BIANC's help over the past 10 years, and I am truly grateful for all the help they have provided."

Linda Herbert, Caregiver

Achievements

Advocacy

- BIANC employees attended Governor's Brain Injury Advisory Council meetings
- MemberClicks, a membership management software, was incorporated into our existing website in order to better reach members
- The Brain Injury Association of North Carolina maintained **four** Brain Injury Resource Centers and **one** volunteer driven Brain Injury Resource Center
- Over **200** individuals participated in an education day at the NC Legislature
- The Brain Injury Association promoted the development of day programs for brain injury survivors
- BIANC provides support to **12** Ombudsmen with personal brain injury experience
- Over **30** individuals participated in our ALSTARS program (Alliance of Legislators and Survivors Together Achieving Responsible Services)
- **Two** residential/rehab providers meetings had **42** attendees who gathered to learn about NC programs

Sandra Farmer, Executive Director/CEO, presents an appreciation award to Representative Dale Folwell for his work on the Gfeller Waller Bill at the Legislative Brain Injury Education Day, surrounded by staff, Ombudsman volunteers and advocates for brain injury.

Goals for 2013 and Beyond

- Strive to see that brain injury is addressed in our health care system as a major public health concern with significant financial and social impact
- Provide training and support for Military service members and their families
- Support activities, programs, and services that will enhance access to appropriate, timely, and affordable treatment to improve systems of care
- Partner with Pilot Clubs of North Carolina and other advocacy groups to increase brain injury awareness and prevention activities
- Provide specialized training that will better equip North Carolina schools to appropriately serve children with a brain injury in the classroom
- Increase our outreach to youth sport groups to address the need for information about concussion prevention and post-concussion care
- Provide tools for support group leaders to help with programs targeting specific behaviors and issues for survivors and family members
- Address the need for additional health and wellness retreats for people with brain injuries
- Expand legislative initiatives to educate elected officials about the need for additional resources and services

"We are glad to be a part of your organization." Sonya Seaberry, Caregiver.

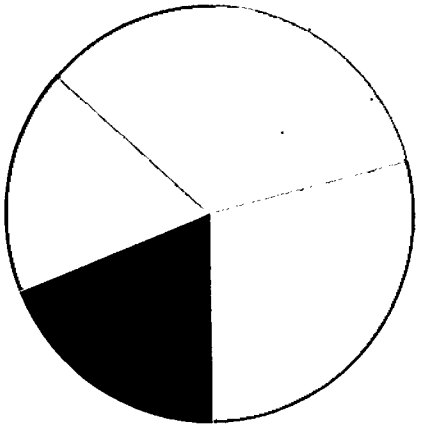
Sonya is pictured here with Jeff, a military service member who has attended Camp Carefree for many years.

"I had a simply smashing time at Camp Carefree this year! How could I not with such wonderful company?"

Eric, Brain Injury Survivor pictured with Ole Mae, Volunteer from the Pilot Club of Raleigh

Revenues and Expenses

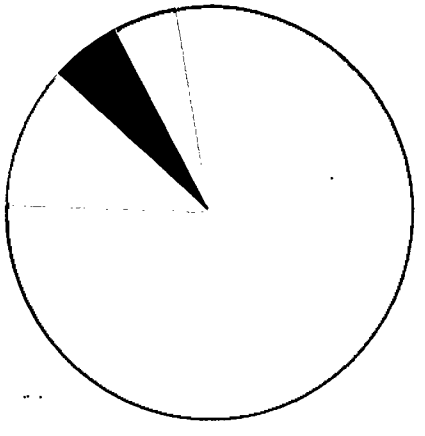
Expenses
January 1, 2012 - December 31, 2012



- Education.....$112,854
- Outreach/Family Support.....155,713
- Public Awareness/Prevention.....102,351
- Advocacy.....95,511
- Admin/Fundraising.....71,975

$538,404

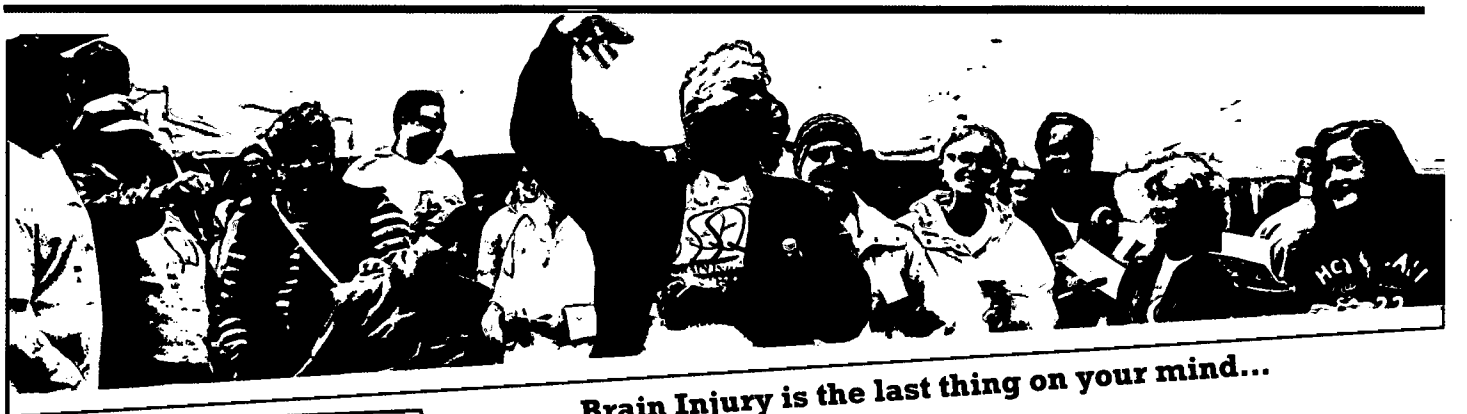
Revenue
January 1, 2012 - December 31, 2012



- Grant/Contract Income.....$417,031
- Donations.....61,844
- Conferences/Training.....30,924
- Membership/Corporate Sponsors.....28,236
- Special Events.....14,014
- Dividends/Interest.....277

$552,326

The Brain Injury Association of North Carolina
PO Box 10912
Raleigh, NC 27605



Brain Injury is the last thing on your mind...

until it's the only thing on your mind.

Join us at one of our Walk & Roll-athons!!

Brain Injury Association of North Carolina
Walk & Roll-athon

Concord - March 23rd

Asheville - April 13th

Triad - April 13th

Raleigh - April 20th

A series of walks to benefit the Brain Injury Association of North Carolina

For more information and to learn how to register: www.biancnet or 800-377-1464

The Arc of NC
LIFEguardianship Supports and Services
January 29, 2013

1) **The entity's mission, purpose, and governance structure.**

The Arc of North Carolina is a private, non-profit 501C3 organization. The mission of The Arc of North Carolina is to secure for all people with intellectual and developmental disabilities the opportunity to choose and realize their goals of where and how they learn, live, work and play.

The Board of Directors amended its charter with the Secretary of State in the early 1980s to provide guardianship. The board designated the responsibility for guardianship to a standing committee, referred to as the LIFEguardianship Council, and staff. All members (minimum of 16) of the Council are volunteers and at least one-half or 50% have to be family members or consumers. The other members are volunteers with expertise relevant to guardianship such as attorneys, bankers, social workers, physicians, Program Managers, etc. The council meets quarterly to discuss overall goals and objectives for the program and has three subcommittees that meet monthly to make major decisions on behalf of each ward/protégé. These subcommittees are referred to as Protégé Review Committees (PRC), and are similar to that of an Admissions, Human Rights, and Ethics committee. Volunteers on these three committees live in each part of the state (named the East PRC, Central PRC, and West PRC) and hold their meetings accordingly.

2) **A description of the types of programs, services, and activities funded by State appropriations.**

The LIFEguardianship Program provides guardianship of the person, of the estate, and general (of the person and of the estate) to individuals declared legally incompetent by the Clerks of Superior Court. The Arc of NC is appointed Corporate Guardian by the Clerks, and volunteers and staff act as representatives on its behalf. The program advocates and supports individuals with intellectual and developmental disabilities, severe and persistent mental illness, substance abusers, and/or the elderly. Most of the wards have a combination of these disabilities. Representative payee services are provided to manage individual's government benefits (i.e., Supplemental Social Security Income) that have absolutely no one else to do so. Resident agent services are also made available for out of state guardians in need of a processing agent. Staff advocate, network, coordinate and serve as a liaison to ensure that the wards needs are met in the least intrusive manner possible; that their human; civil rights are not violated, their health and safety are protected, and ensure informed consents. Additionally staff monitors and provide oversight to ensure that the medical, dental, residential, programmatic, habilitative and rehabilitative needs are being met. Case management is also provided when there is absolutely no other source to do so.

Volunteers for the wards and overall program are recruited, trained, and retained on an ongoing basis. Volunteers serve on the LIFEguardianship Council in an advisory capacity for the overall program and help develop policies and procedures relevant to guardianship. The Council volunteers also serve on one of three Protégé Review Committees (East/Central/West) to screen referrals to the program for guardianship, ensure face to face meetings with potential wards; decide if there is a need for guardianship and if so the type, provide consents for major decisions on behalf of each ward (i.e., medical, do not resuscitate, dental surgery, residential placements, behavior plans with aversives, restoration of rights,

etc.). Volunteers who cannot serve on the Council but a Protégé Review Committee (PRC) are also recruited, trained and retained by the program. When possible, wards are matched with a volunteer friend to spend quality time with them and assist in being the "eyes and ears" for the program between visits by staff. Staff visit each ward monthly, every other month, or quarterly, based on individual needs. Visits are made in the residential facilities, jails/prisons, day programs, on the job, or wherever the wards' are located. Those that are homeless are sought out and placements found to address their need even if it is temporarily in a hotel or motel. Between visits indirect contacts by phone, letter or email are made by staff with the ward or on their behalf (i.e., with psychiatrist, nurse, social worker, dentist, etc). Staff is responsible for routine consents and moderate level consents as well. Again major decisions are made by a PRC such as DNRs, change in residential placements, surgeries, etc.

Staff is responsible for attending all annual person centered planning meetings for each ward and other important ones on their behalf as well. Reports on abuse, neglect and exploitation have to be made by staff, or if an agency is involved they have to verify that the agency does so.

The program provides education, training, consultation and assistance on Guardianship, Alternatives, and Restoration of Rights, as requested. Additionally it works diligently to restore, partially or fully, the rights of wards who no longer need a guardian or only on a limited basis.

During fiscal year 2010-2012, a large number of guardianship needs had to be addressed in a short period of time based on Local Management Agencies becoming Managed Care Organizations and no longer being able to provide guardianship nor able to contract with Corporate Guardians to do so. Staff worked hard to process the large number of referrals received as a result of this, and the staffing size of the program had to be increased to address these needs.

3) **Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.**

The program admitted and served 96 new wards during FY 2011-2012. It also served 24 wards that died during this time, restored the rights of 6 individuals, and had 3 family members to succeed or replace The Arc of NC as guardian. On June 30, 2012, LIFEguardianship was supporting 762 wards and available in all 100 counties across the state. Many individuals were placed out of large congregate facilities such as psychiatric hospitals, Regional Centers for people with IDD to smaller, more homelike settings; residences for wards in need were located, consents provided for various types of medical treatments, including whether to put do not resuscitate orders in place; pre-need burial plans put in place, and annual status reports and financial accounting provided to Clerks of court for all wards (762) served plus financial accountings were submitted to Social Security offices for Representative Payeeships for 23 wards. The program trained and maintained 66 different volunteers, provided approx. 20 presentations & consultations on guardianship to the general public reaching about 400 people.

4) **Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.**

Guardianship is a continuing activity based on the need for informed decision making on behalf of those unable to do so. The need continues to grow, however a small number can have their rights restored.
Limited guardianships were also put in place for approximately 24 wards which is less restrictive. This ensure that these individuals are able to make decisions in areas that they can, and the guardian only has decision making authority in specific areas designated by order of the court.

In addition to the outcomes stated in number 3 above, the program served as resident/processing agent for 6 out of state guardians, and has been asked by 8 families in codicils of wills to succeed/replace them as guardian of their family member, upon their death or disability. Family member guardians and others are concerned about what will happen to their son or daughter or close friend, when they are no longer able to make decisions on their behalf. LIFEguardianship address this concern as families and other individual guardians plan for the ward's future.

The program has a waiting list (30 individuals) for guardianship due to lack of funding available to cover the services and supports. Grants have been denied in that guardianship is viewed as a role of families (unless there is abuse, neglect or exploitation) or the state.

The needs of each ward are addressed on a person centered basis, and are too numerous to share here. A few examples include that a ward was taken out of state without consent or knowledge of the staff. The ward had to be found and returned to North Carolina from another state by staff, to ensure their health and safety was protected. Referrals were made to the program and they were no longer living at the addresses provided. Staff went into homeless shelters and neighborhoods where they would most likely be, located these individuals, and placed them in residential settings after being appointed guardian.

5) A detailed program budget and list of expenditures including all positions funded and funding sources.

Salaries / Wages / Benefits **$166,862**

Personnel Breakdown	Pro-Rated Salary	Percentage	Benefits
♦ Executive Director	$ 7,178	5%	1,795
♦ Finance Officer	$ 4,677	5%	1,170
♦ Assistant Dtr QA/QI	$ 3,265	5%	815
♦ Accounting Specialist	$ 1,821	5%	455
♦ Program Director	$16,005	20%	2,995
♦ Administrative Assistant	$ 8,200	20%	1,434
♦ Regional Specialist	$ 8,350	20%	1,503
♦ Area Specialist	$ 7,000	20%	1,309
♦ Regional Specialist	$ 9,200	20%	1,652
♦ Area Specialist	$ 7,100	20%	1,269
♦ Area Specialist	$ 8,099	20%	1,446
♦ Area Specialist	$ 8,464	20%	1,547
♦ Area Specialist	$ 7,400	20%	1,111
♦ Area Specialist	$ 7,371	20%	1,358
♦ Area Specialist	$ 8,265	20%	1,475
♦ Regional Specialist	$10,703	20%	1,391
♦ Area Specialist	$ 7,360	20%	1,352
♦ Area Specialist	$ 6,502	20%	1,135
♦ Area Specialist	$ 1,875	5%	344
♦ Regional Specialist	$ 2,093	5%	378
	$140,928.00		25,934

2) Professional Services $ 3,000
3) Total Personnel Services $169,862

Supplies and Materials
4) Office Supplies and Materials (paper, folders, pens, labels, ink cartridges, etc.) $ 12,500
5) Computer Supplies and Software $ 3,500
8) Total Supplies and Materials $ 16,000

Operational Expenses
10) Travel $74,686
(NOTE: $.50 per mile @ approximately 149,372 miles for staff members to visit protégés, attend Meetings and workshops, etc.)
12) Communications $ 20,000
(Includes telephones in home based offices and faxes; cell phones for 24 hour availability and for emergency situations and consents. Internet services are also included for staff)
14) Printing & Binding $ 2,500
16) Computer Services $ 8,500
17) Employee Training $ 6,500
(training for guardians, attendance at conferences and conventions, National, State and local levels, used to increase overall knowledge)
18) Advertising $ 2,000
Brochures on guardianship and informational literature
19) Total Operational Expenses $114,186

Fixed Charges and Expenses
***20)* Office Rent** $ 4,800

(Space for 2 LIFEguardianship employees located in one building in Raleigh. Formula Included measuring the total square footage for the 2 employees, and allocating it by the total office square footage used by The Arc of NC for its entire staff in Raleigh. **NOTE**: Approximately 44% of the total annual cost for the 2 LIFEguardianship employees was used or $4,800.00 for the fiscal year. The cost per square foot is $15.50)

***23)* Dues and Subscription**	**$ 750**
(Includes (includes annual membership dues for North Carolina Guardianship Association, AAIDD, National Guardianship Association, etc.)	
25) Total Fixed Charges & Other Expenses	**$ 5,550**
31) Total of Direct Costs	**$305,598**
33) Total Budgeted Expenditures	**$305,598**

6) The source and amount of any matching funds received by the entity.

In FY 2011/12 The Arc had a $99,275 operating deficit for the LIFEguardianship program as a whole . Our June 30 financial statements indicate revenues of 1,707,316 with expenditures of 1,806,591. The Arc of North Carolina offset this deficit with funds from its reserve accounts including its Guardianship endowment.

The Arc of North Carolina, Inc.
Statement of Activities w/Revenue Percentage
LG Summary
For the Twelve Months Ended June 30, 2012

	Period to Date		Year to Date	
	Actual	% Of Revenue	Actual	% Of Revenue
Support and Revenue				
GOE Commission	$1,621.48	0.57%	$9,032.20	0.53%
LG Fees - Private Pay	525.00	0.19%	9,712.50	0.57%
LG Fees - Guilford	787.50	0.28%	10,500.00	0.62%
LG Fees - Johnston Co	525.00	0.19%	6,300.00	0.37%
LG Fees - LifePlan Trust	3,150.00	1.11%	6,300.00	0.37%
LG Fees - Lutheran	0.00	0.00%	1,575.00	0.09%
LG Fees - Omnivisions	262.50	0.09%	3,150.00	0.18%
LG Fees - Pathways	3,132.00	1.11%	37,975.50	2.22%
LG Fees - Piedmont	149,100.00	52.71%	160,845.75	9.42%
LG Fees - SE Regional	8,622.50	3.05%	102,634.00	6.01%
LG Fees - Wake Co.	14,777.25	5.22%	182,359.50	10.68%
LG Fees - Western Highlands	3,825.00	1.35%	45,900.00	2.69%
LG Fees - Cumberland	1,086.40	0.38%	13,036.80	0.76%
LG Fees - Durham	0.00	0.00%	150.00	0.01%
LG Fees - Eastpointe	525.00	0.19%	6,300.00	0.37%
LG Fees - Five Co.	1,837.50	0.65%	22,050.00	1.29%
LG Fees - OPC	262.50	0.09%	3,150.00	0.18%
LG Fees - Sandhills	6,759.38	2.39%	66,150.08	3.87%
LG Fees - Smoky	17,947.07	6.34%	197,953.72	11.59%
LG Fees - ECBH	20,818.00	7.36%	242,737.90	14.22%
LG Fees - Mecklenburg	3,806.25	1.35%	45,675.00	2.68%
LG Fees - Beacon	3,412.50	1.21%	38,587.50	2.26%
LG Fees - Onslow	3,675.00	1.30%	36,658.16	2.15%
LG Fees - Southeastern Center	2,625.00	0.93%	30,318.73	1.78%
LG Fees - Centerpointe	18,060.00	6.38%	208,320.00	12.20%
LG Fees - New Hanover	262.50	0.09%	262.50	0.02%
MH/DD/SAS	25,466.51	9.00%	305,598.00	17.90%
Services Provided in Excess of Funding	(10,000.00)	(3.54%)	(85,916.50)	(5.03%)
Total Support and Revenue	282,871.84	100.00%	1,707,316.34	100.00%
Total Support & Revenue & Net Asset Rel.	282,871.84	100.00%	1,707,316.34	100.00%
Expenses				
Salaries	75,964.76	26.85%	896,532.63	52.51%
Overtime	956.07	0.34%	6,468.30	0.38%
Vacation	4,090.28	1.45%	45,448.39	2.66%
401(k) Contribution	1,292.83	0.46%	16,851.65	0.99%
Payroll Taxes	5,801.81	2.05%	68,019.01	3.98%
Unemployment Insurance	1,273.50	0.45%	14,557.32	0.85%
Insurance-Medical	11,500.00	4.07%	126,675.00	7.42%
Insurance-Short Term Disability	169.47	0.06%	2,289.05	0.13%
Insurance-Long Term Disability	284.97	0.10%	4,461.70	0.26%
Insurance-Dental	308.62	0.11%	3,693.70	0.22%
Insurance-Vision	51.65	0.02%	1,003.34	0.06%
Insurance-Life	246.13	0.09%	4,042.66	0.24%
Insurance-Business Specific	375.00	0.13%	6,578.00	0.39%
Professional Fees	16,420.00	5.80%	197,985.00	11.60%
Computer Supplies	64.04	0.02%	786.67	0.05%
Office Expense	3,346.32	1.18%	29,116.14	1.71%
Advertising	0.00	0.00%	5,357.65	0.31%
Telephone Service	1,850.98	0.65%	21,125.75	1.24%
Utilities	83.84	0.03%	1,851.51	0.11%
Postage	537.66	0.19%	4,410.68	0.26%
Office Rent	1,072.35	0.38%	12,868.20	0.75%
Travel	12,233.60	4.32%	121,391.65	7.11%
Training	115.00	0.04%	1,771.84	0.10%
Arc/NC Convention Expense	0.00	0.00%	28.00	0.00%
Conferences & Conventions	0.00	0.00%	645.00	0.04%
Protege Emergency Fund	0.00	0.00%	(196.52)	(0.01%)
Equipment & Furniture	0.00	0.00%	222.81	0.01%
Wireless Phone Service	3,467.50	1.23%	34,924.65	2.05%
Background Checks	38.00	0.01%	199.15	0.01%
Investment Mgt & Bank Svc Fees	0.00	0.00%	72.06	0.00%
Admin Expense Allocation	31,049.90	10.98%	177,230.01	10.38%
Miscellaneous Expense	0.00	0.00%	180.46	0.01%

The Arc of North Carolina, Inc.
Statement of Activities w/Revenue Percentage
LG Summary
For the Twelve Months Ended June 30, 2012

	Period to Date		Year to Date	
	Actual	% Of Revenue	Actual	% Of Revenue
Total Expenses	$172,594.28	61.02%	$1,806,591.46	105.81%
Income (Loss) from Operations	110,277.56	38.98%	(99,275.12)	(5.81%)
Other Income and Expenses				
Increase (Decrease) in Net Assets	110,277.56	38.98%	(99,275.12)	(5.81%)

The Arc of North Carolina, Inc.
Statement of Activities w/Revenue Percentage
Life Guardianship MH-Administration
For the Twelve Months Ended June 30, 2012

	Period to Date		Year to Date	
	Actual	% Of Revenue	Actual	% Of Revenue
Support and Revenue				
LG Fees - Private Pay	$525.00	0.19%	$9,712.50	0.57%
LG Fees - Guilford	787.50	0.28%	10,500.00	0.62%
LG Fees - Johnston Co	525.00	0.19%	6,300.00	0.37%
LG Fees - LifePlan Trust	3,150.00	1.12%	6,300.00	0.37%
LG Fees - Lutheran	0.00	0.00%	1,575.00	0.09%
LG Fees - Omnivisions	262.50	0.09%	3,150.00	0.19%
LG Fees - Pathways	3,132.00	1.11%	37,975.50	2.24%
LG Fees - Piedmont	149,100.00	53.01%	160,845.75	9.47%
LG Fees - SE Regional	8,622.50	3.07%	102,634.00	6.04%
LG Fees - Wake Co.	14,777.25	5.25%	182,359.50	10.74%
LG Fees - Western Highlands	3,825.00	1.36%	45,900.00	2.70%
LG Fees - Cumberland	1,086.40	0.39%	13,036.80	0.77%
LG Fees - Durham	0.00	0.00%	150.00	0.01%
LG Fees - Eastpointe	525.00	0.19%	6,300.00	0.37%
LG Fees - Five Co.	1,837.50	0.65%	22,050.00	1.30%
LG Fees - OPC	262.50	0.09%	3,150.00	0.19%
LG Fees - Sandhills	6,759.38	2.40%	66,150.08	3.90%
LG Fees - Smoky	17,947.07	6.38%	197,953.72	11.66%
LG Fees - ECBH	20,818.00	7.40%	242,737.90	14.29%
LG Fees - Mecklenburg	3,806.25	1.35%	45,675.00	2.69%
LG Fees - Beacon	3,412.50	1.21%	38,587.50	2.27%
LG Fees - Onslow	3,675.00	1.31%	36,658.16	2.16%
LG Fees - Southeastern Center	2,625.00	0.93%	30,318.73	1.79%
LG Fees - Centerpointe	18,060.00	6.42%	208,320.00	12.27%
LG Fees - New Hanover	262.50	0.09%	262.50	0.02%
MH/DD/SAS	25,466.51	9.05%	305,598.00	17.99%
Services Provided in Excess of Funding	(10,000.00)	(3.56%)	(85,916.50)	(5.06%)
Total Support and Revenue	281,250.36	100.00%	1,698,284.14	100.00%
Total Support & Revenue & Net Asset Rel.	281,250.36	100.00%	1,698,284.14	100.00%
Expenses				
Salaries	75,964.76	27.01%	896,532.63	52.79%
Overtime	956.07	0.34%	6,468.30	0.38%
Vacation	4,090.28	1.45%	45,448.39	2.68%
401(k) Contribution	1,292.83	0.46%	16,851.65	0.99%
Payroll Taxes	5,801.81	2.06%	68,019.01	4.01%
Unemployment Insurance	1,273.50	0.45%	14,557.32	0.86%
Insurance-Medical	11,500.00	4.09%	126,675.00	7.46%
Insurance-Short Term Disability	169.47	0.06%	2,289.05	0.13%
Insurance-Long Term Disability	284.97	0.10%	4,461.70	0.26%
Insurance-Dental	308.62	0.11%	3,693.70	0.22%
Insurance-Vision	51.65	0.02%	1,003.34	0.06%
Insurance-Life	246.13	0.09%	4,042.66	0.24%
Professional Fees	14,100.00	5.01%	167,625.00	9.87%
Computer Supplies	64.04	0.02%	786.67	0.05%
Office Expense	3,346.32	1.19%	29,116.14	1.71%
Advertising	0.00	0.00%	5,357.65	0.32%
Telephone Service	1,850.98	0.66%	21,125.75	1.24%
Utilities	83.84	0.03%	1,851.51	0.11%
Postage	537.66	0.19%	4,410.68	0.26%
Office Rent	1,072.35	0.38%	12,868.20	0.76%
Travel	12,233.60	4.35%	121,391.65	7.15%
Training	115.00	0.04%	1,771.84	0.10%
Arc/NC Convention Expense	0.00	0.00%	28.00	0.00%
Conferences & Conventions	0.00	0.00%	645.00	0.04%
Protege Emergency Fund	0.00	0.00%	(196.52)	(0.01%)
Equipment & Furniture	0.00	0.00%	222.81	0.01%
Wireless Phone Service	3,467.50	1.23%	34,924.65	2.06%
Background Checks	38.00	0.01%	199.15	0.01%
Investment Mgt & Bank Svc Fees	0.00	0.00%	72.06	0.00%
Admin Expense Allocation	31,049.90	11.04%	177,230.01	10.44%
Miscellaneous Expense	0.00	0.00%	180.46	0.01%
Total Expenses	169,899.28	60.41%	1,769,653.46	104.20%

The Arc of North Carolina, Inc.
Statement of Activities w/Revenue Percentage
Life Guardianship MH-Administration
For the Twelve Months Ended June 30, 2012

	Period to Date		Year to Date	
	Actual	% Of Revenue	Actual	% Of Revenue
Income (Loss) from Operations	$111,351.08	39.59%	($71,369.32)	(4.20%)
Other Income and Expenses				
Increase (Decrease) in Net Assets	111,351.08	39.59%	(71,369.32)	(4.20%)

SEE ACCOUNTANTS' COMPILATION REPORT

The Arc of North Carolina, Inc.
Statement of Activities w/Revenue Percentage
Life Guardianship GOE-Administration
For the Twelve Months Ended June 30, 2012

	Period to Date		Year to Date	
	Actual	% Of Revenue	Actual	% Of Revenue
Support and Revenue				
GOE Commission	$1,621.48	100.00%	$9,032.20	100.00%
Total Support and Revenue	1,621.48	100.00%	9,032.20	100.00%
Total Support & Revenue & Net Asset Rel.	1,621.48	100.00%	9,032.20	100.00%
Expenses				
Insurance-Business Specific	375.00	23.13%	6,578.00	72.83%
Professional Fees	2,320.00	143.08%	30,360.00	336.13%
Total Expenses	2,695.00	166.21%	36,938.00	408.96%
Income (Loss) from Operations	(1,073.52)	(66.21%)	(27,905.80)	(308.96%)
Other Income and Expenses				
Increase (Decrease) in Net Assets	(1,073.52)	(66.21%)	(27,905.80)	(308.96%)

The Arc of North Carolina
Community Resource Consultant Program [Wilmington]

1] Mission, Purpose and Governance Structure

The Arc NC is a private, non-profit advocacy and service organization for people with Intellectual and developmental disabilities. The Arc NC is governed by a 30 member board of directors elected by the membership from our 30 affiliated chapters. The Arc was founded in 1956 by parents of children with IDD in order to improve the quality of life for their children. Currently The Arc through its affiliates or through our direct service programs has a presence in all 100 North Carolina counties.

2] **Description of Services Funded by State Appropriation**

The Arc applied for through a Division of MHDDSA request for proposal the opportunity to provide the Community Resource Consultant Service for people with IDD. This service is intended to support individuals and families in "self directing' services under the CAP/IDD waiver. We are currently in the third year of this contract which had the ability to serve up to 8 individuals or families. During the entire contract period we have had five referrals.

In this project our role was to teach individuals and families to manage their services and provide clinical oversight.

3] Statistical and Demographical Information-

In FY 2011-12 we served 5 individuals. Two in Wake county one in New Hanover County one in the Sandhills Center catchment area and one in the Smokey Mountain Center catchment area.

4] Outcome

For this program the best outcome measure is if the individual continues in Self directed Services. For the 5 families we supported three continue to self-direct their services. One individual is no longer eligible for the CAP program and another individual is supported by another provider. The three remaining families will be transferred to the MCO's .The Arc will not have this contract once all MCO's go live.

5] Budget

For FY 2011-12 The Arc billed 11,657 dollars for the service. In order to receive the funding we must bill in 15 minute increments at a rate of 14 dollars per 15 minutes.

The Arc did not receive a "grant" for this program.

6] Matching

The Arc did not match this funding in FY 11-12

needs of the protégés and can let The Arc of North Carolina and local service providers know what those needs are. In addition, the volunteer personal representatives and personal partners provide companionship that is sometimes not available in institutional, community-based residential or programmatic settings.

The Arc of North Carolina will agree to assume guardianship responsibilities only when it is determined that the organization is the best source to ensure that an individual's rights are protected. In no instance does The Arc of North Carolina attempt to exercise authority in any area in which the individual is capable of making his/her own decisions in a responsible manner.

The Arc of North Carolina's team of volunteers makes LIFEguardianship Supports and Services a more person-centered alternative when no individual guardian can be appointed.

HOW CAN I HELP?

Volunteers and financial supports are needed. Expansion of LIFEguardianship Supports and Services is necessary due to the growing need.

Two factors for expansion are:

First: More individuals must volunteer to serve as personal representatives and personal partners. Almost anyone can be a volunteer. They only have to be willing to devote six hours per month to their duties, be caring individuals, and agree to be trained and to a driving and criminal record check.

Second: Funding is required. Currently, funding is provided through grants from public and private sources. In an effort to raise additional funds, The Arc of North Carolina has established a fund called the LIFEguardianship Endowment. Donations will provide a firm financial base for LIFEguardianship Supports and Services in future years.

As the fund and the number of individuals agreeing to serve as volunteers grows, The Arc of North Carolina will be able to meet the needs of more people, restore rights of current protégés/wards and promote alternatives to guardianship.

WHAT IS The Arc OF NORTH CAROLINA?

The Arc of North Carolina is a non-profit advocacy organization committed to securing for all people with intellectual and other developmental disabilities the opportunity to choose and realize their goals of where and how they learn, live, work and play. The Arc of NC is an affiliated chapter of The Arc of the United States.

What began as a grassroots organization in 1953 now lists approximately 5,000 members in 39 chapters across the state. Through the years, The Arc of NC has successfully advocated for early intervention programs for infants and toddlers, inclusive educational opportunities for children with disabilities, supports and services that enable people to live in the community, compensatory education programs in the community colleges, employment opportunities, self-determined housing options and the passage of state and federal laws that advance the rights of people with disabilities.

The Arc

*LIFE*guardianship Supports and Services
343 E. Six Forks Road, Suite 320
Raleigh, North Carolina 27609
1-800-662-8706 or 919-782-4632
Fax: (919) 782-4482
Website: www.arcnc.org

Artwork reprinted by permission of Martha Perske from PERSKE: PENCIL PORTRAITS 1971-1990 (Nashville: Abingdon Press, 1998).

LIFE GUARDIANSHIP

The Arc of North Carolina

A LIFETIME COMMITMENT:

Self-Determination & Outcomes = Alternatives to Guardianship and Restoration of Rights

WHAT IS GUARDIANSHIP?

Guardianship describes a legal relationship in which an individual, corporation, or public agent such as the local Department of Social Services or Local Management Entities (LME) are authorized to make decisions on behalf of another.

The preferred legal priority for appointment of guardians is first that of an individual, second is a corporation if allowed by its charter, and third is a public agent.

When any citizen reaches age 18 in North Carolina, they are considered competent and able to manage their own affairs, regardless of whether or not they have a disability.

Guardianship is a "restrictive procedure" and should not be taken lightly. Giving decision-making power to a substitute involves taking it away from the original person, thus depriving them of their independence and civil rights.

The majority of persons with disabilities can manage their own affairs with informal assistance from family, friends, advocates, or agency support personnel. For some people however, the severity of their disability makes the formal appointment of a guardian necessary.

Basic types of guardianship for adults with disabilities involve duties pertaining to the person and those over the estate.

Guardianship of the person is the responsibility to care for the individual needs of the incompetent adult/ward such as where they should live, whether they should participate in vocational or habilitation programs, consent for medical treatment and decisions about leisure activities. It does not involve control of the ward's property. Guardianship of the estate involves decisions about the ward's monetary holding, personal and real property. It does not include responsibility for day to day personal welfare.

For individuals who require a guardian for both the person and the estate, a general guardian would be appointed. The general guardian is responsible for protecting all interests, personal and monetary, of the ward and exercises all rights on their behalf.

Guardians may be appointed to make decisions about all aspects of the ward's life or they can be appointed to handle specific affairs and limited guardianship may be established. In the latter case, the guardian may make decisions only in those areas in which the individual cannot act.

WHO NEEDS GUARDIANSHIP?

It is every parent's concern: "What will happen to my son/daughter after I'm gone?" This question is especially difficult for parents whose family members have severe disabilities. These parents have often worked very hard to help their family member reach a certain level of independence - an independence that could be lost without continued support and guidance.

In the past, adults in need of guardians who had no family members or other persons able or willing to accept responsibility for them have been assigned by the courts as wards of public agencies. Such guardianship is costly for taxpayers and sometimes places these agencies in the position of making difficult choices between the best interests of the individual and those of the agency.

In response to this growing need, The Arc of North Carolina organized a corporate guardianship program called LIFEguardianship Supports and Services.

WHAT IS *LIFE*guardianship SUPPORTS AND SERVICES?

In 1984, The Arc of North Carolina amended its charter to enable the corporation to be named as guardian for persons with disabilities. This was done to ensure parents that when they are no longer able to do so; their family member could receive the kind of caring guidance and advocacy they themselves would like to provide.

LIFEguardianship Supports and Services is available to individuals, 17.5 years or older, in any county of the state. Individuals receiving services live in their own communities in settings such as apartments, houses, group homes, nursing homes, family care homes, and Intermediate Care Facilities, or in Psychiatric Hospitals (i.e. Broughton, Dorothea Dix, Cherry or John Umstead) or in regional centers like Caswell, Murdoch, O'Berry, J. Iverson Riddle Developmental Center or Black Mountain.

The LIFEguardianship Council, appointed by The Arc/NC Board, consists of volunteers who serve on Protégé Review Committees (PRCs). Staff include several Guardianship Specialists who rotate their schedules to ensure someone can be reached 24 hours a day.

The three PRCs meet monthly and make major decisions about the wards using a person-centered approach.

The volunteers and LIFEguardianship staff work as a team to make decisions that will ensure that the individual needs of each protégé are being met in the least restrictive manner possible.

Coordinators of Volunteers help to recruit, train, and retain Volunteer Personal Representatives and Personal Partners. These volunteers serve as two-way advocates, both for the protégés and for The Arc of North Carolina. Through a continuing relationship, they identify

Contribution Form

Enclosed is my contribution for:

____ $500	____ $50
____ $250	____ $30
____ $100	____ $15
____ $75	____ other

Thank you for your generous contribution to The Arc of North Carolina. Your tax deductible donation will help build the future for people with developmental disabilities.

Name _____

Phone _____

Address _____

E-mail _____

I'd like information about:

- ____ **Joining The Arc**
- ____ **Advocacy Opportunities**
- ____ **Chapter Development**
- ____ **Employer of Record**
- ____ **Housing Options**
- ____ **LIFEguardianship**
- ____ **Life Plan Trust**
- ____ **Self-Advocacy**
- ____ **Sponsorship Opportunities**
- ____ **Support Brokerage**
- ____ **Supported Employment**
- ____ **Supported Living**
- ____ **Volunteer Opportunities**

Please make checks payable to:

The Arc of North Carolina
343 E. Six Forks Road
Suite 320
Raleigh, NC 27609

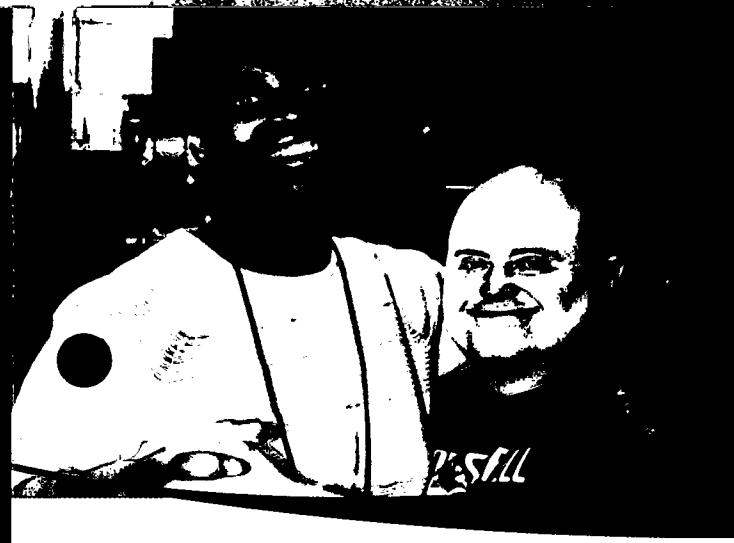
Mission

The Arc of North Carolina is committed to securing for all people with intellectual and developmental disabilities the opportunity to choose and realize their goals of where and how they learn, live, work and play.

The Arc.
North Carolina

The Arc of North Carolina
343 E. Six Forks Road
Suite 320
Raleigh, NC 27609

919-782-4632
800-662-8706
919-782-4634 *fax*
info@arcnc.org
www.arcnc.org



Advocating with and for people with developmental disabilities

The Arc.
North Carolina

www.arcnc.org

Advocacy

History – Founded in 1953, The Arc of North Carolina is a 501(c)(3) membership organization. We are governed by a volunteer board of directors who are primarily people with disabilities or family members. With a distinguished history of providing services and advocacy, The Arc of North Carolina has been involved in every significant piece of legislation passed to improve the lives of people with intellectual and developmental disabilities.

Public Policy – Through individual, group and systems advocacy, The Arc of North Carolina and its chapters work to promote public policy in the interest of protecting and enhancing the vital supports and services for people with developmental disabilities and their families. Acting as a liaison with chapters and members, we provide information about state and federal legislative activities. Through our online newsletters, Action Alerts, and policy blog, we connect our members and other concerned citizens with the issues and with their legislators.

Education/Information/ Referral – Educational efforts focus on inclusive community opportunities, person-centered planning, developing advocacy skills, and community collaboration. The Arc of North Carolina and its chapters provide information and support to individuals, families and professionals through phone and personal contact, workshops, conferences, online and print media.

Affiliates

The work of The Arc in NC is accomplished by a network of affiliated chapters and The Arc of NC. Chapters of The Arc provide services and advocacy as diverse as the communities in which they are located. All chapters share the same Core Values of The Arc and work each day to assure people with disabilities are connected to and participants in their communities. To contact a chapter in your area, please visit our website **www.arcnc.org** or call us at 800-662-7806.

Individualized Supports

In some areas of the state, The Arc of North Carolina provides innovative supported employment, living and other personalized supports. Through a joint venture with First In Families, we also work to secure resources within the community which otherwise would not be available through the existing service system. We believe all people are entitled to the quality lifestyle of their choice. Therefore, our services are designed to help people with intellectual and developmental disabilities live successful, meaningful lives in the community.

Employer of Record Services

The Arc of North Carolina's Employer of Record Services were created in response to individuals and families desire to be more involved in the service delivery process. We offer an innovative approach, rooted in the principals of self-determination. Our goal is to involve participants in the process so they can experience more control. As the enrolled provider we ensure all the regulations are followed and work with participants to manage the staff.

Housing

The Arc of North Carolina believes that all people should be empowered to live in accessible, affordable housing in inclusive communities of their choice. Through our Regional Housing Resource Coordinators and Property and Asset Management Departments, we promote self-determined housing choices through education and training, community outreach, and the development of new housing projects. We currently own over 250 properties throughout the state, including group homes, small apartment buildings, and scattered-site duplexes and condominiums. These residences are operated by local partner organizations and provide housing for more than 1300 people.

Guardianship

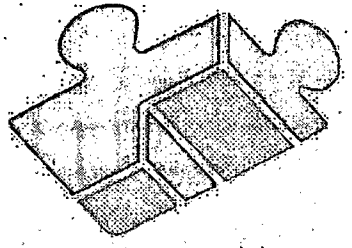
Through The Arc of North Carolina's groundbreaking LIFEguardianship Program, we provide guardianship services to adults with developmental disabilities, mental illness, substance use disorders and the elderly across North Carolina. Our efforts are to provide outcome based guardianship in the least intrusive, most individualized manner. A component is also designed to educate families and the public about alternatives to guardianship, limited guardianship, and the restoration of rights. Specific services and supports include advocacy, guardianship of the person or of the estate or both as well as training, education, consultation and technical assistance.

Support Brokerage Services

The Arc of North Carolina's Support Brokerage is an advocacy-based case management service. We provide Support Brokerage for more than 3500 adults and children with developmental disabilities in over 80 counties. Support Brokers work with individuals and families to assist in planning for meaningful lives, maximizing natural supports, and designing complementary services to meet each person's needs.

Joint House and Senate HHS Appropriations Subcommittee

Tracey Sheriff, CEO
February 21, 2013



Autism Society
of NORTH CAROLINA

Background Information

- Who is the Autism Society of North Carolina (ASNC)?
- What is Autism Spectrum Disorder?
- How prevalent is Autism Spectrum Disorder?

ASNC Services

- Advocacy and Chapters
- Clinical Training and Public Education
- Direct Care Provision

Who ASNC Advocates and Chapters Served

- **6,184** people were helped last year by Parent Advocates. These encounters include phone calls and in person meetings in **93** of 100 NC counties.
- **49** Chapters/Support Groups covering **66** counties
- Chapters support an average of **430** family members each month in face-to-face group meetings.
- Chapters support an additional **9,660** family members through a variety of electronic formats that allow information sharing and family-to-family support.
- Chapter volunteers contribute more than **700** hours a month of service.

Autism Society of NORTH CAROLINA

Who ASNC Trained

- **218** workshops reached **4,666** people.
- Trainings were held in **43** different counties but open to people in all **100** counties.
- Annual Conference reached **750** parents and professionals.

What ASNC Trained On

- First Responders - **9** workshops given to **243** first responders.
- Healthcare and Service Professionals - **19** workshops given to **360** healthcare, childcare and library professionals.
- Understanding and Responding - **72** workshops given to **1,024** parents and professionals.
- Teacher Trainings - **23** workshops given to **711** teachers from preschool to secondary schools.

Autism Society of NORTH CAROLINA

What ASNC Trained On

- Community Awareness - **20** workshops on autism given to **600** people.
- Increasing Clinical Skills - **23** workshops given to **493** professionals.
- Improving Education Plans - **41** workshops to **310** parents.
- Early Intervention - **7** workshops given to **175** professionals.

ASNC Outreach Provided

- Website had over **100,000** unique visitors, monthly email newsletter to **16,000** email addresses.
- Twice annual printed newsletter to **44,000** readers.
- **20,000** pieces of educational materials including pamphlets and brochures printed and distributed to promote autism awareness and local resources.
- Outreach and education to **650** statewide media outlets during Autism Awareness Month campaign and throughout the year.
- Community awareness events across the state through Run/Walks reaching over **5,700** individuals.

Autism Society of NORTH CAROLINA

ASNC Direct Care Provided

- Respite care - **479** individuals from **53** counties accessed respite and recreation through Camp Royall.
- Therapeutic Recreational Supports - **645** people participated in our programs.
- Housing for adults - **101** adults received residential services from **23** counties.
- Social Skills Training -**170** participants in programs in Wake, Cumberland, Buncombe, Pitt and Guilford counties.
- Day programming - Pre/vocational services to **56** individuals in Wake, Guilford and Cumberland counties.

Outcomes from Advocacy & Chapters

2,090
individuals received problem-solving and advocacy consultation.

1,638
individuals received referrals and connections to local resources.

1,565
individuals received mentoring, coaching, and support.

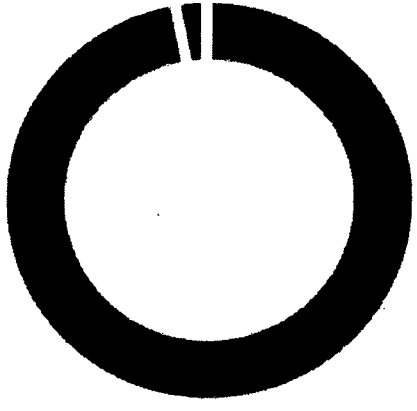
1,125
individuals received information (website, articles, books, packets).

549
attended meetings in a support role with family members/ self-advocates (IEP, post-diagnosis, crisis, etc.).

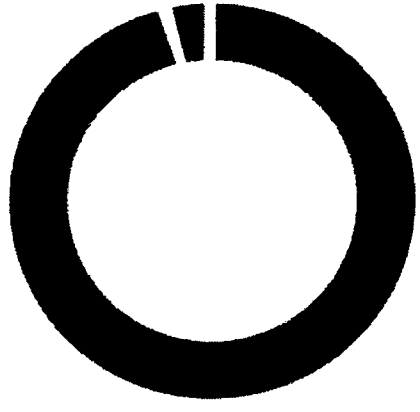
231
referrals were made by phone call to other agencies or resources.

Autism Society of NORTH CAROLINA

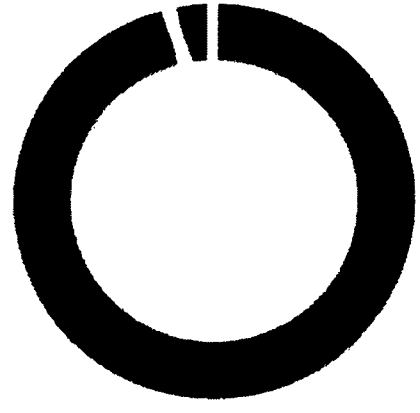
Outcomes from Clinical Training and Public Education



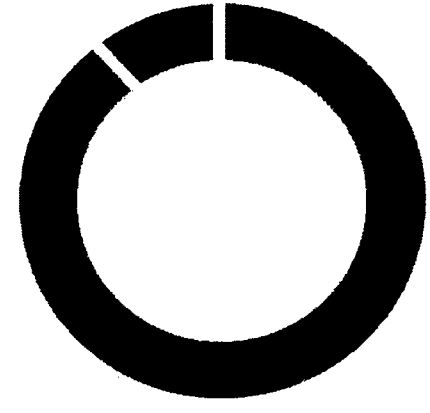
99%
indicated they **planned to improve** and make changes to their work with autism as a result of the training



98%
indicated the workshops **increased** their knowledge base on the subject material covered



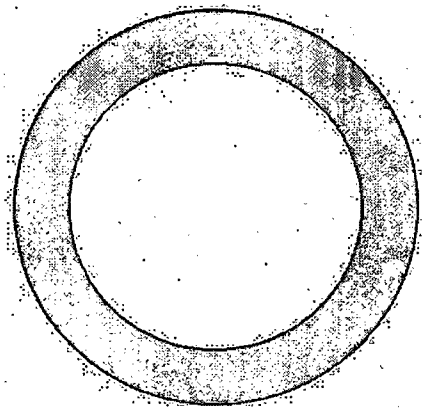
98%
indicated their ability to explain and demonstrate information covered to others **increased** as a result of the training



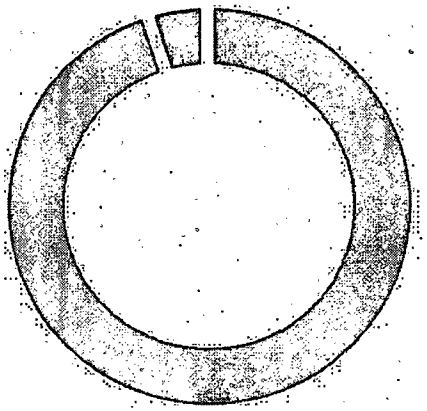
90%
indicated **satisfaction** with communication materials and advocacy

Autism Society of NORTH CAROLINA

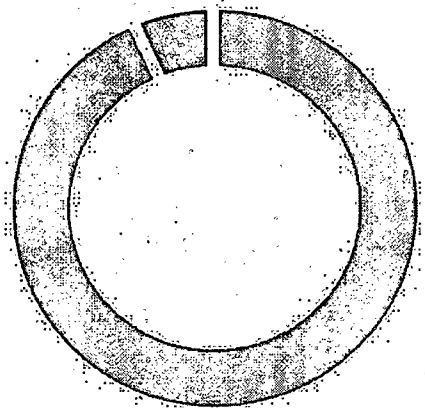
Satisfaction with Direct Care Provision



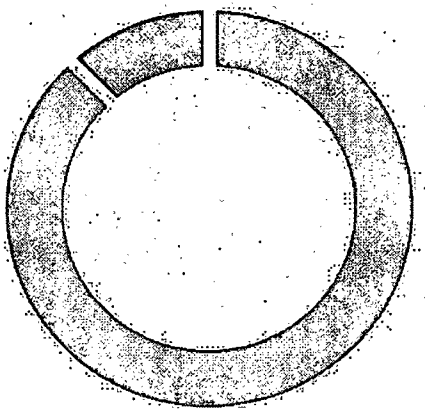
100%
said their experience with services was excellent



96%
said their child tried new activities



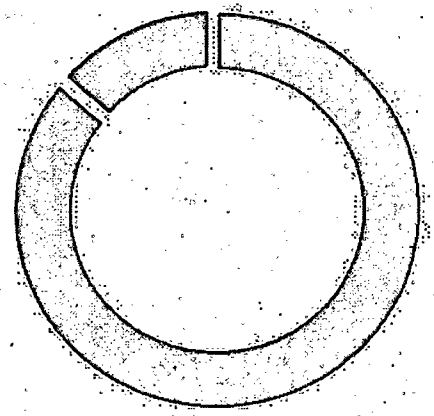
95%
said they would definitely send their camper back to Camp Royall again



89%
said that Camp Royall provided needed respite for their family

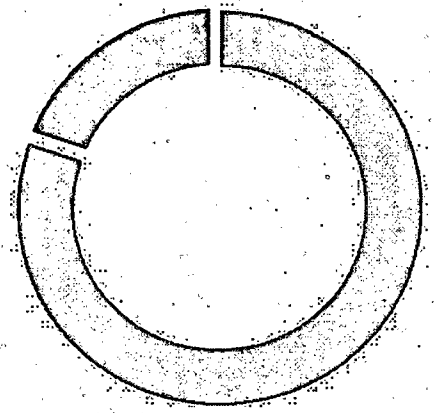
Autism Society of NORTH CAROLINA

Outcomes as a Result of Direct Care Provision



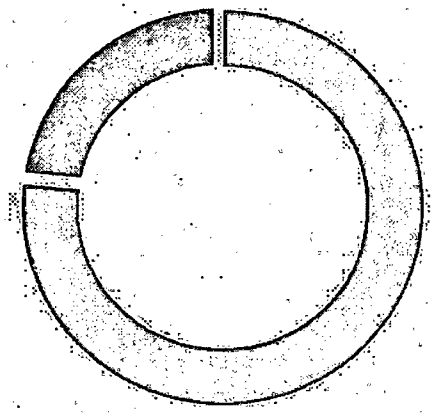
87%

indicated they were **satisfied/very satisfied** with services from ASNC



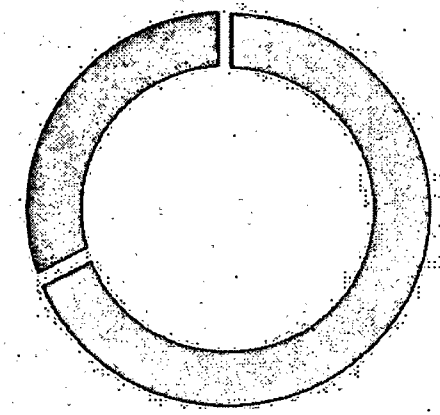
83%

said their child tried a **broader** range of activities



80%

indicated they have seen an **increase** in their child's expressive communication and social interaction since receiving services from ASNC

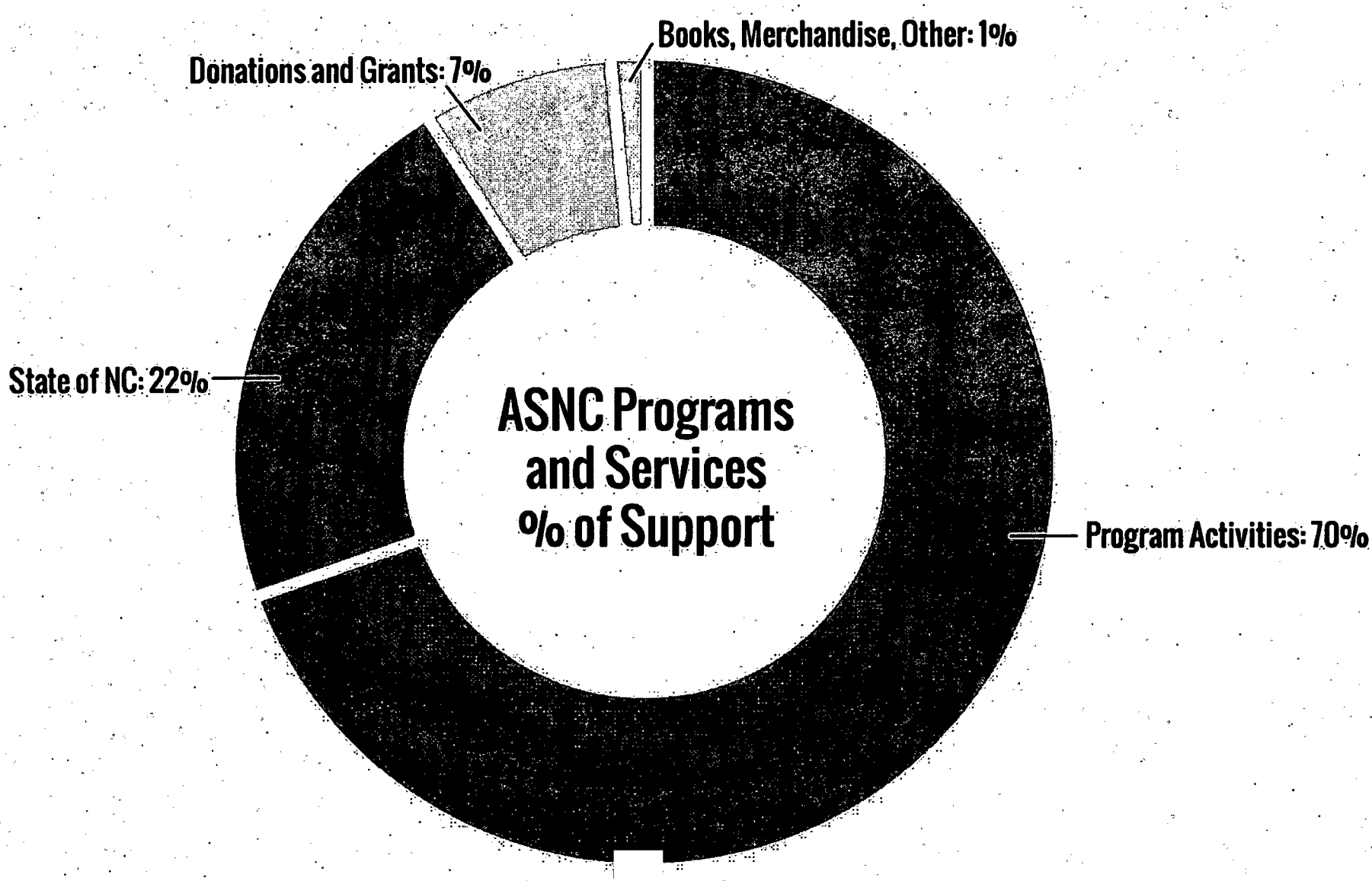


70%

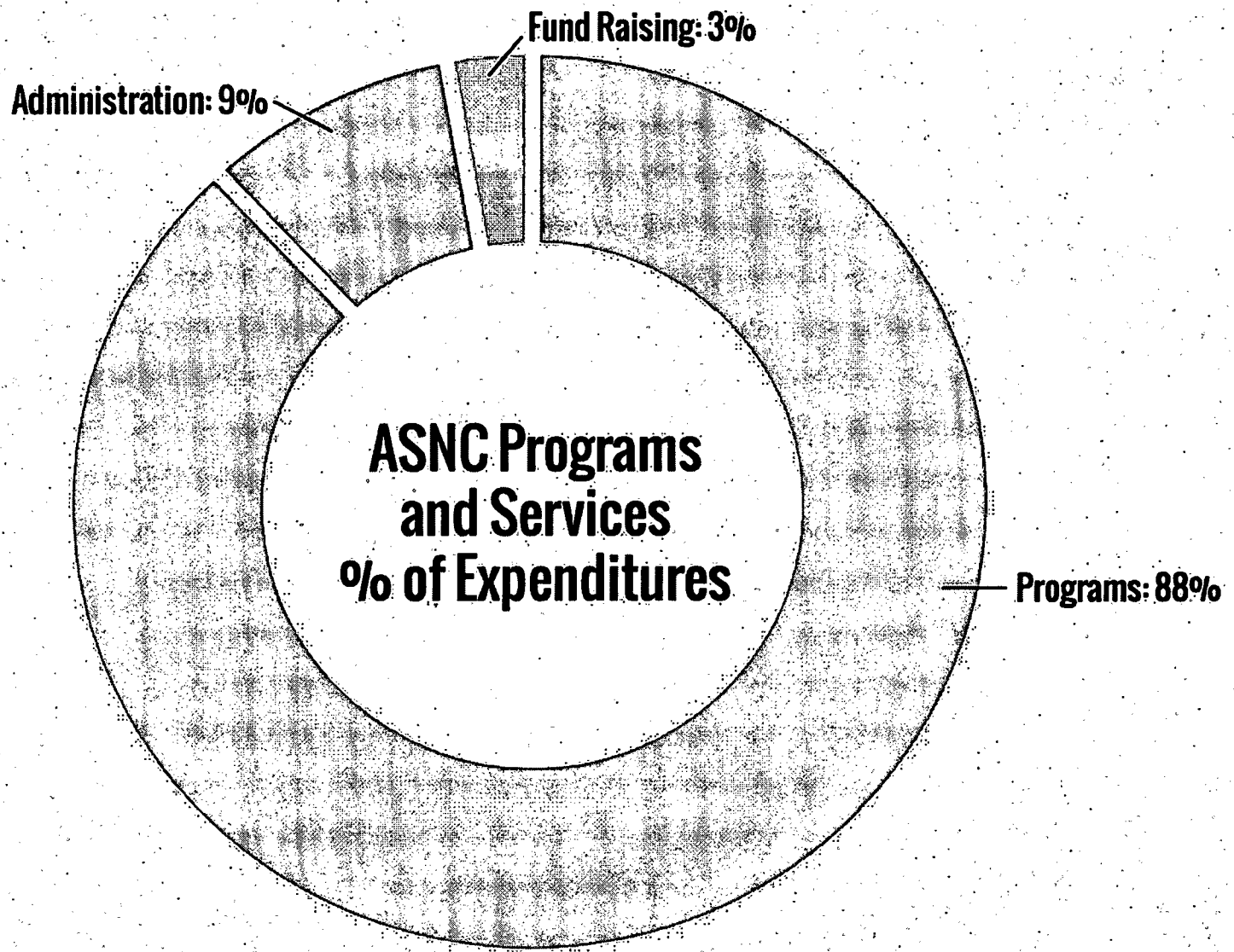
said their child's independence **increased** as a result of services

Autism Society of NORTH CAROLINA

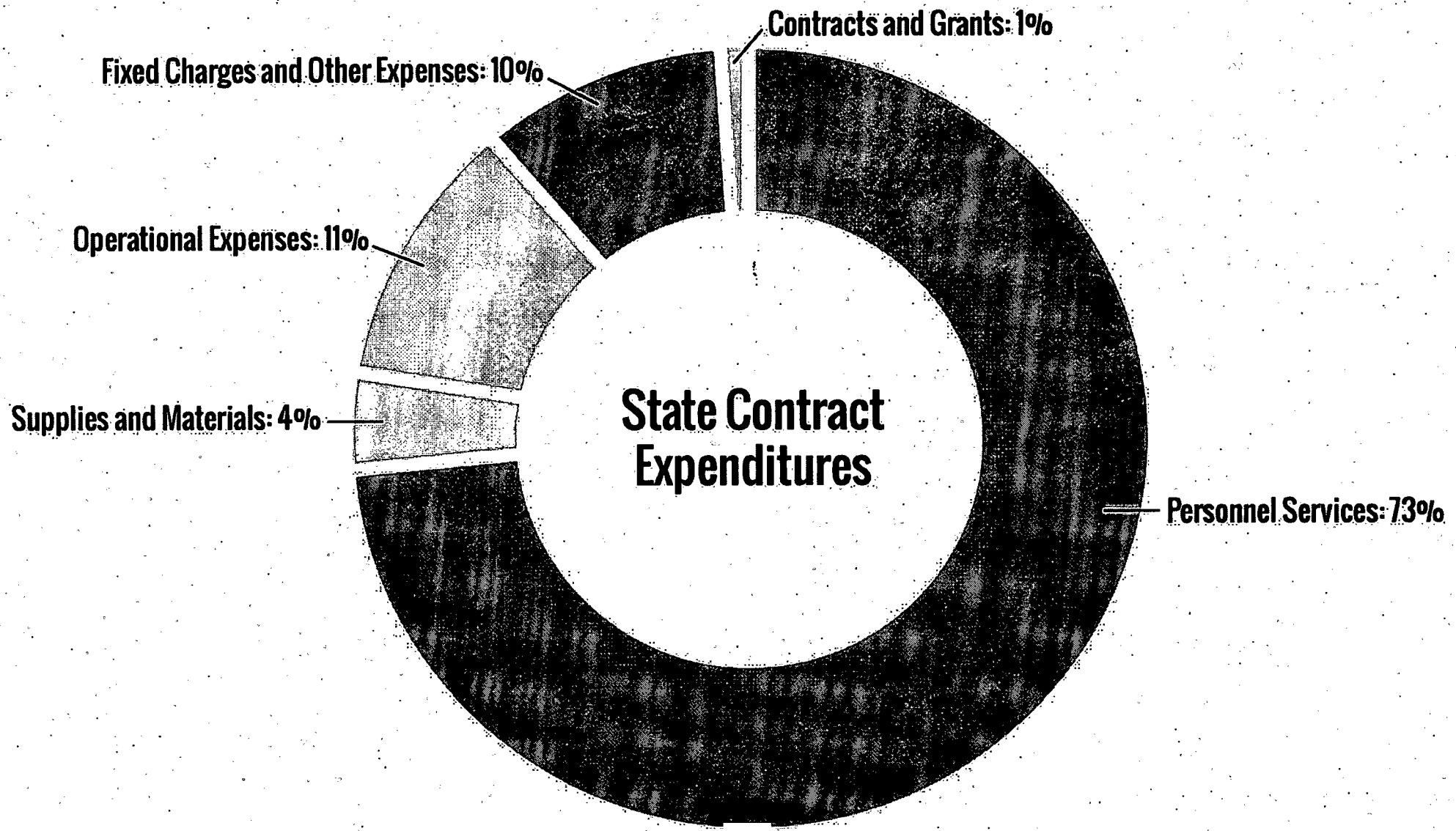
Financial Data- Total ASNC Revenue



Financial Data- All of ASNC



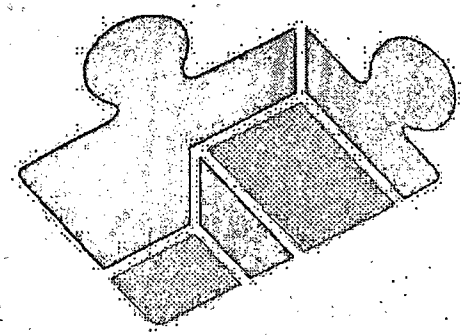
Expenditure Data



Summary

- Efficient- **$.88** of every dollar goes to program services, more than **700** hours of volunteer service monthly, over **$1 million dollars** in donations to advance our mission.

- Effective- Nearly **11,000** served in all counties with exceptionally high levels of satisfaction and good outcomes



Autism Society
of NORTH CAROLINA

November 27, 2012

Mark Trogdon, Director
Fiscal Research Division
Suite 619, Legislative Office Building
Raleigh NC 27603

Dear Mark Trogdon:

Enclosed you will find the requested documents for House Bill 950, Session Law 2012-142 requiring the Department of Health and Human Services to have all non-state entities receiving direct state appropriation to submit under Section 10.19.(b).

The Mariposa School has received $339,879.00 from the State of North Carolina for Early Intervention for Children with Autism. Provided you will find our mission, purpose, governance structure, description of the programs and services that we provide, statistical and demographical information, outcome measures; and the grant budget, and positions funded by grant. A 2011-12 school budget can be provided upon request.

While The Mariposa School did not receive matching funds by another organization for this grant, we are continuing to raise funds to help support the school. A total of $38,888 raised for the 2011-12 school and $17,635.82 has been raised so far this 2012-13 school year.

Should you have any questions or need anything else from us, feel free to contact me at the below information.

Sincerely,

Jessica Harwell

Jessica Harwell
Office Manger

cc: Rep. Marilyn Avila, Co-Chair, Appropriations Subcommittee on Health and Human Services
Senator Stan Bingham, Co-Chair, Appropriations on Health and Human Services
Senator Louis Pate, Co-Chair, Appropriations on Health and Human Services
Rep. Justin Burr, Joint Legislative Oversight Committee on Health and Human Services
Senator Louis Pate, Joint Legislative Oversight Committee on Health and Human Services

MARIPOSA SCHOOL • 203 GREGSON DRIVE • CARY, NC 27511
phone: 919.461.0600 · fax: 919.461.0566 · www.MariposaSchool.org · email: info@MariposaSchool.org

Rep. Justin Burr, Co-Chair, Appropriations on Health and Human Services
Senator Harris Blake, Co-Chair, Appropriations on Health and Human Services
Senator Ralph Hise, Appropriations on Health and Human Services
Senator Nelson Dollar, Co-Chair, Joint Legislative Oversight Committee on Health and Human Services
Jalaine Moore, Contract Manager Financial Operations, DHHS

MARIPOSA SCHOOL • 203 GREGSON DRIVE • CARY, NC 27511
phone: 919.461.0600 · fax: 919.461.0566 · www.MariposaSchool.org · email: info@MariposaSchool.org

Mission Statement

To provide intensive instruction in a supportive environment designed to improve communication skills and therefore quality of life for children with autism and other developmental disabilities and their families.

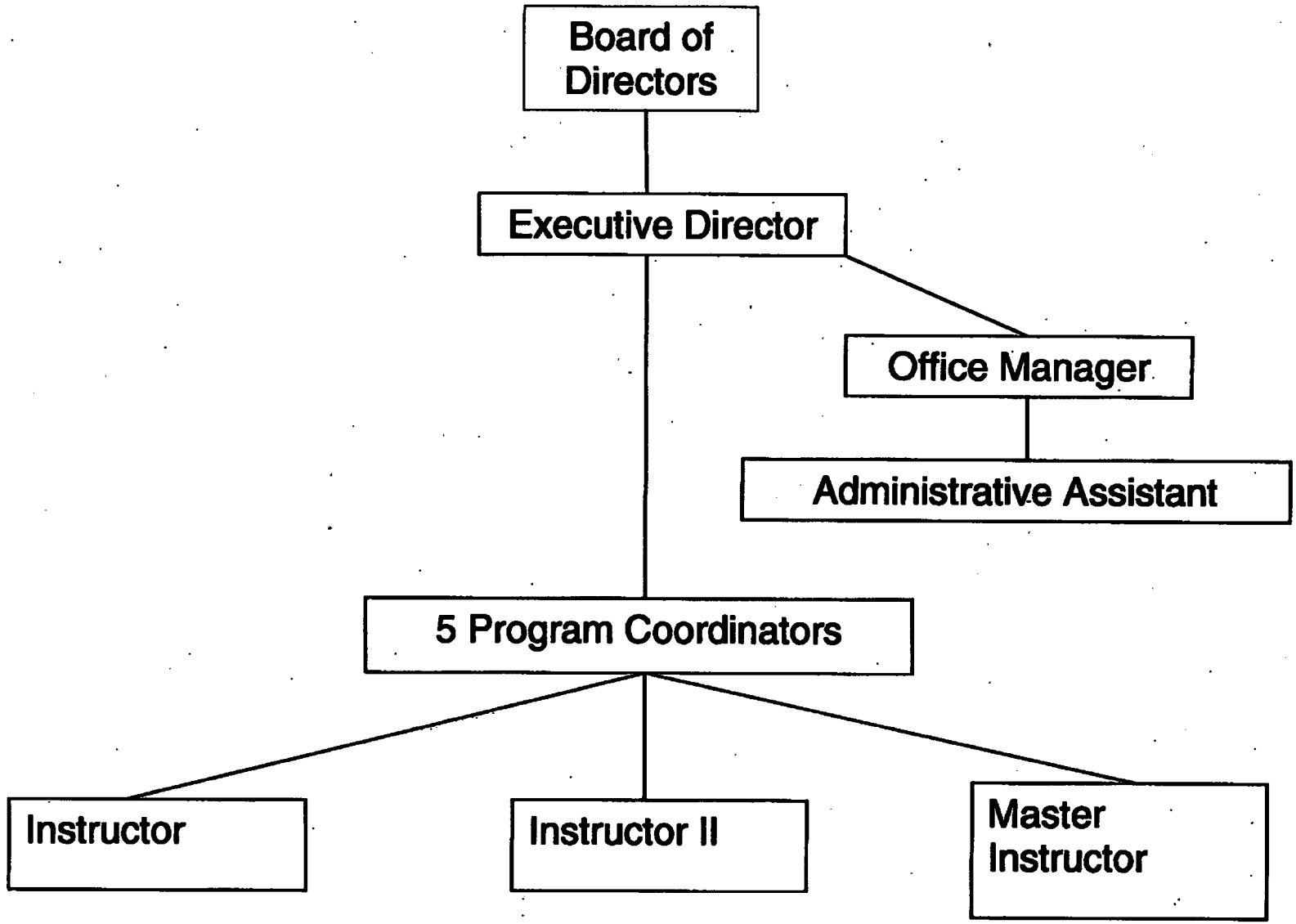
Vision Statement

The Mariposa School strives to be a regional leader in providing education to children with autism and other developmental disabilities. Out goal is to build positive relationship among families, staff and the greater community to help each child achieve his/her maximum potential.

Core Values

- **Respect for all individuals:** We will treat all students, their families, and staff with respect at all times.
- **Learning in the natural environment:** Learning takes place in a safe environment closely mirroring day-to-day situation children encounter at school, home and in the community. We strive to create an environment where learning is rewarding consistent and fun for teachers, students and their families.
- **The whole child:** We use a tailored approach to address the individual needs of each student allowing each child to reach his/her full potential.
- **Use of evidence-based methodologies:** We incorporate cutting-edge research in the development and implementation of new and ongoing programs.
- **Qualified Professionals:** We will continue to recruit, hire and retain quality individuals. We will provide ongoing, productive training and supervision for our teachers and management staff.

MARIPOSA SCHOOL • 203 GREGSON DRIVE • CARY, NC 27511
phone: 919.461.0600 · fax: 919.461.0566 · www.MariposaSchool.org · email: info@MariposaSchool.org


Board of Directors
Executive Director
Office Manager
Administrative Assistant
5 Program Coordinators
Instructor
Instructor II
Master Instructor

MARIPOSA SCHOOL

FOR CHILDREN WITH AUTISM

Facts about Student Enrollment

June 2012

Student Grant Facts

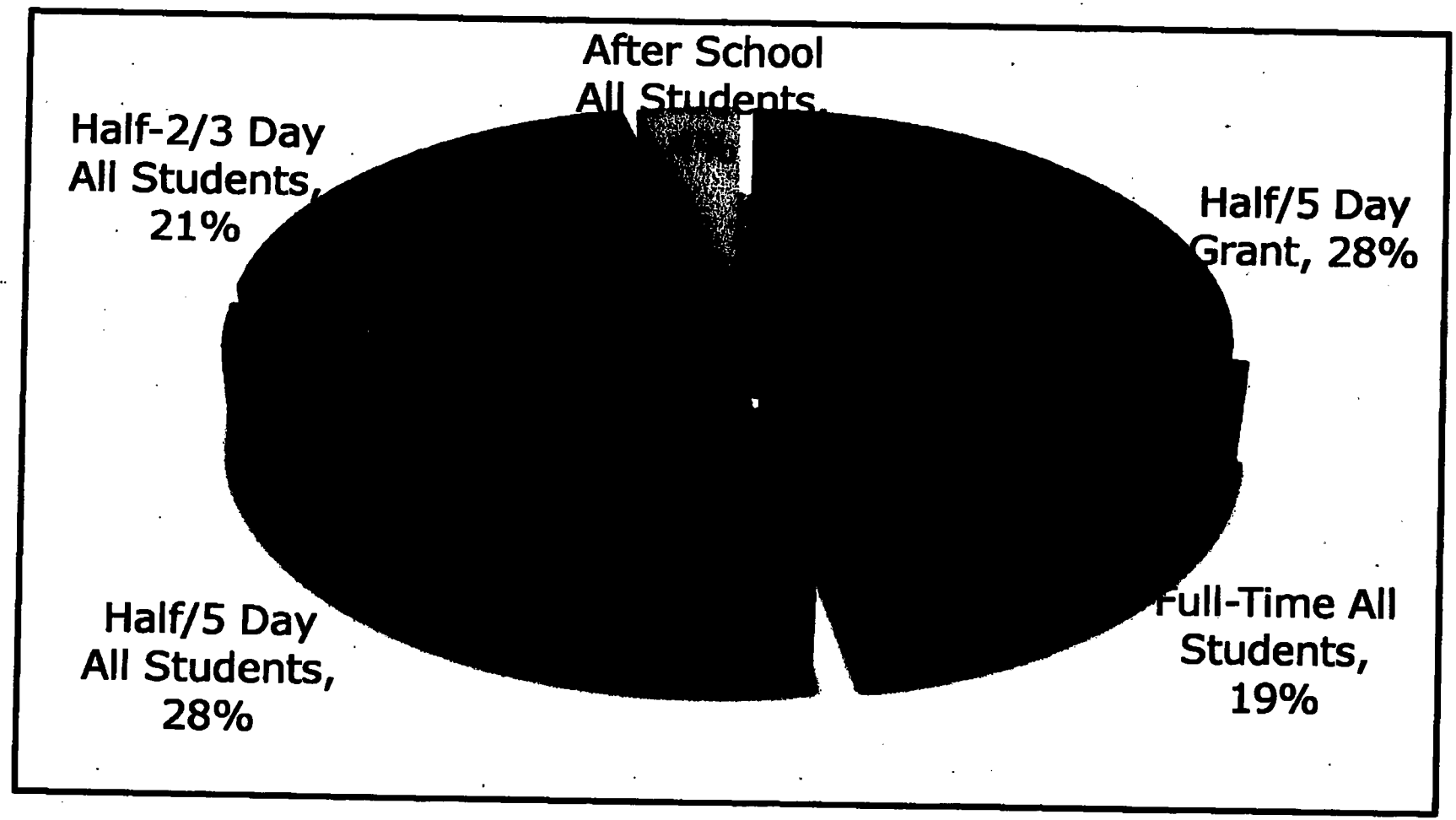
•All students served by The Mariposa School were treated here ate the school's location: 203 Gregson Drive, Cary, NC, 27511 of Wake County.

•A total of 15 students were served by the grant from July 2011 - June 2012 but no more than 12 were served at any one time.

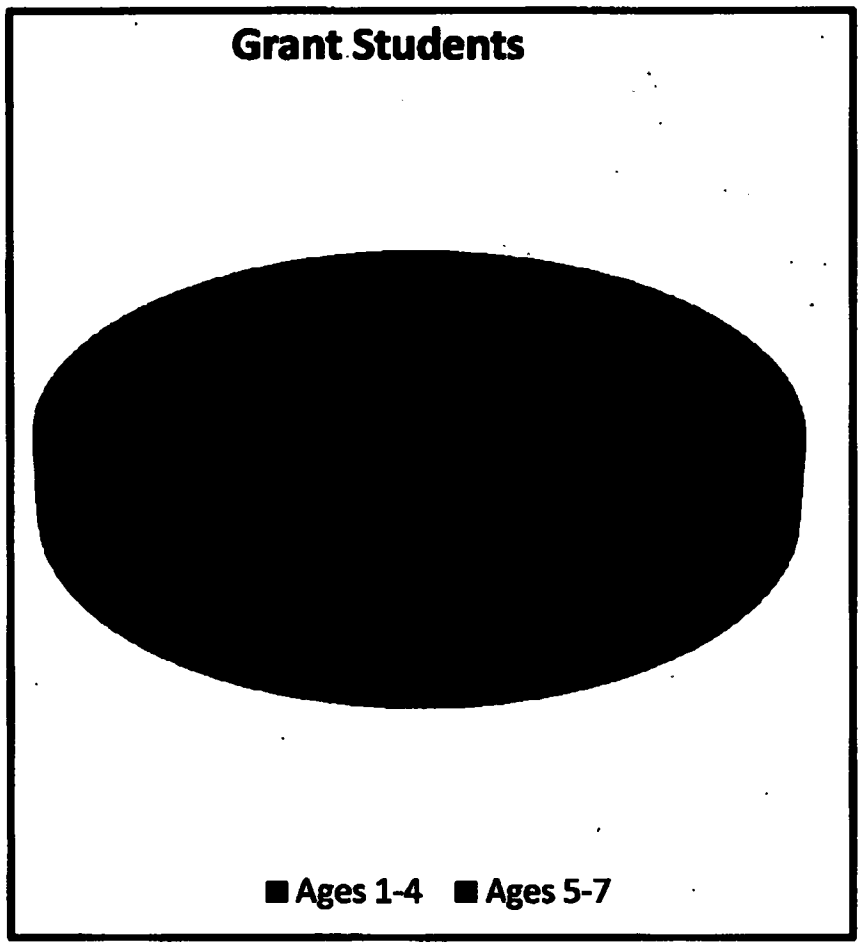
•Students served by the grant received one-on-one therapy by instructors with at least a four-year degree and trained in Applied Behavior Analysis and Verbal Behavior.

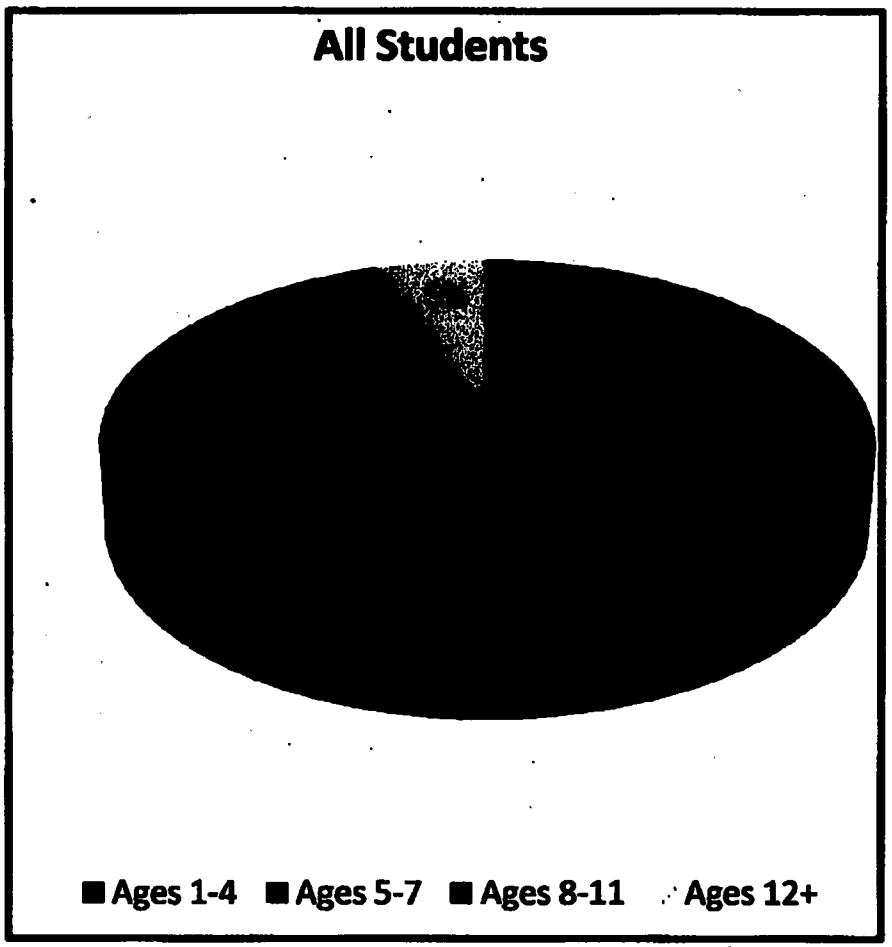
•Each grant family received monthly meetings with their Program Coordinator and Instructor as well as training sessions.

Program Distribution

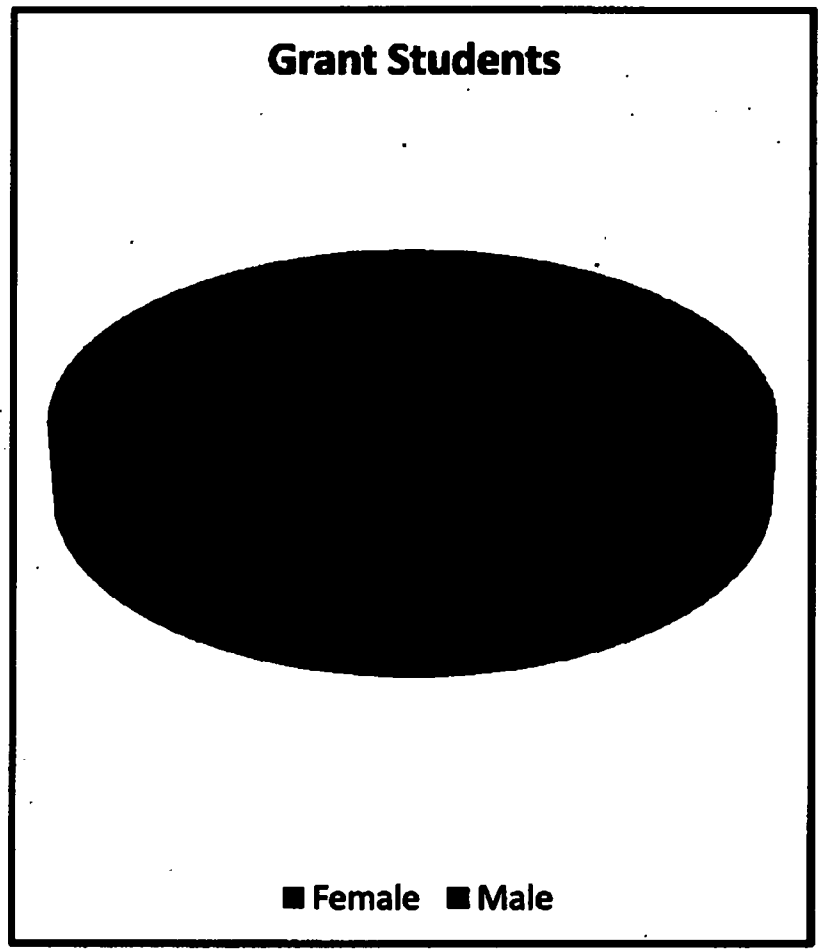


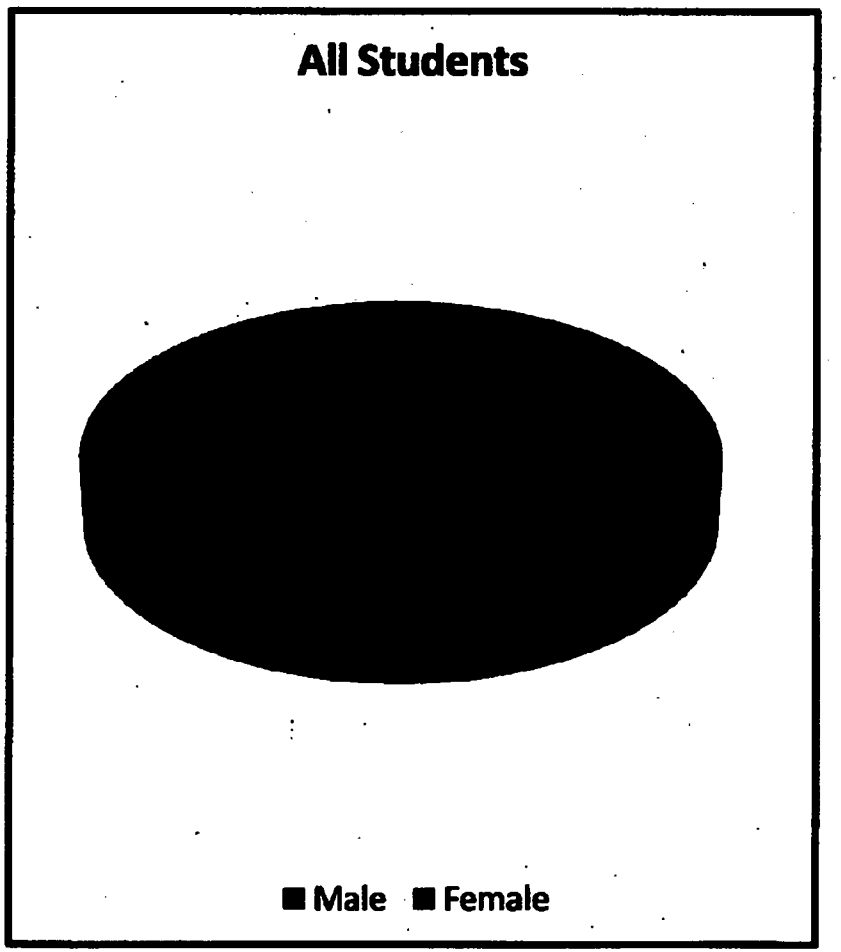
Age Distribution



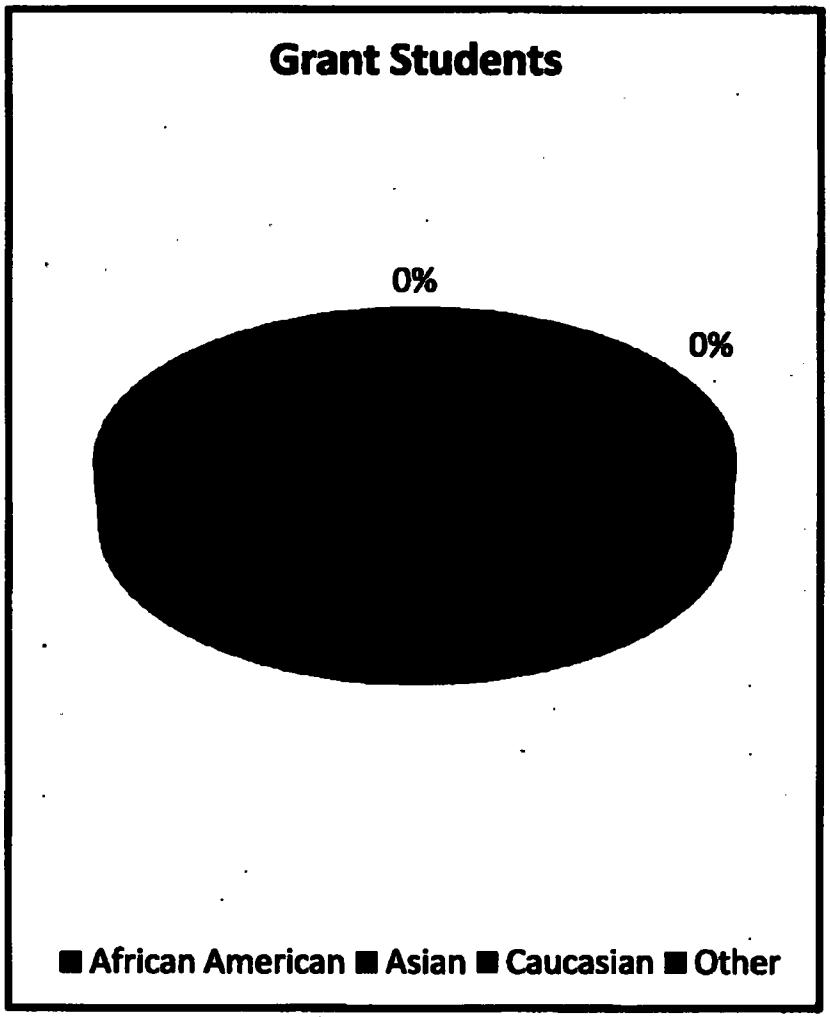


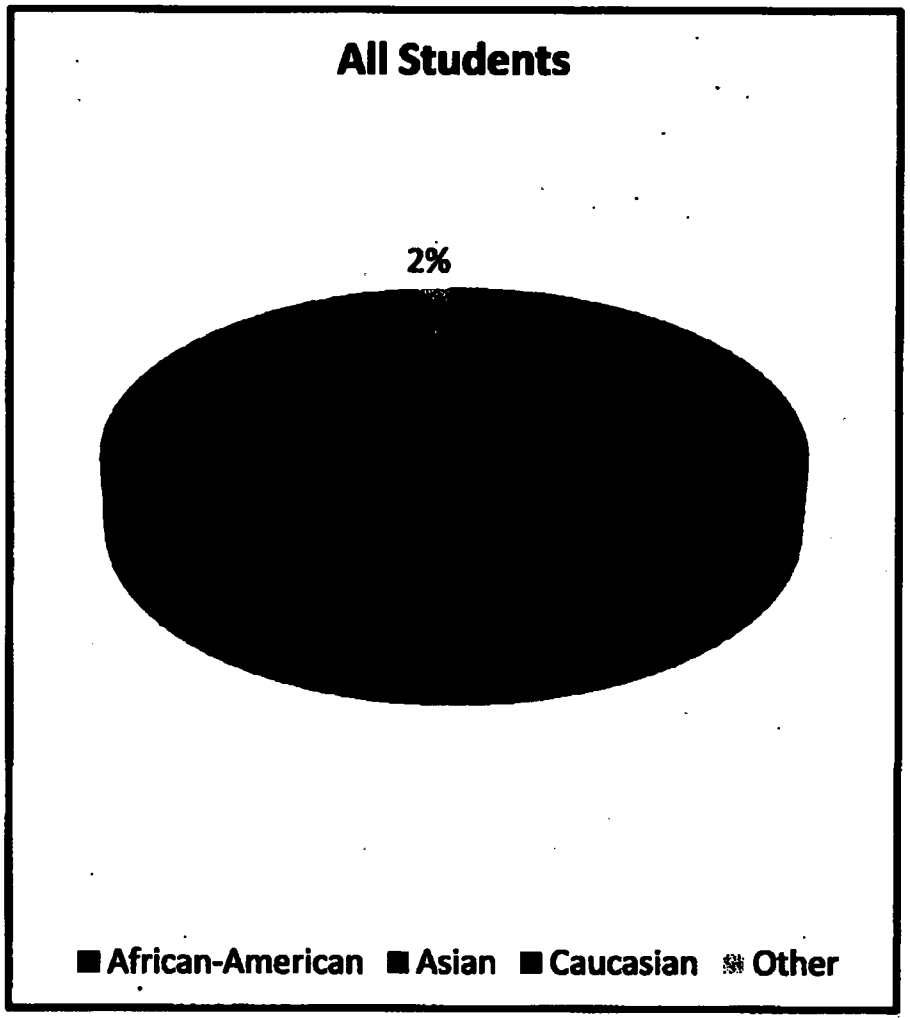
Gender Distribution





Race Distribution





	Contractor	
	Contract #	
	Description	**Amount - Current**
	Personnel	
1)	Salary/Wages/Benefits	$287,104.00
2)	Professional Services	$1,600.00
3)	**Total Personnel Services**	**$288,704.00**
	Supplies and Materials	
4)	Office Supplies and Materials	$2,500.00
5)	Computer Supplies & Software	$225.00
6)	Janitorial Supplies	$0.00
7)	Educational/Medical Supplies	$2,550.00
8)	**Total Supplies and Materials**	**$5,275.00**
	Operational Expenses	
10)	Travel	
11)	Board Member Expense (Travel, Per Diem)	
12)	Communications (Telephone, Postage, etc.)	$2,500.00
13)	Utilities	$5,000.00
14)	Printing and Binding	$500.00
15)	Repair and Maintenance	$1,500.00
16)	Computer Services (Accting, Payroll, etc.)	$3,600.00
17)	Employee Training	$0.00
18)	Advertising	$500.00
19)	**Total Operational Expenses**	**$13,600.00**
	Fixed Charges and Expenses	
20)	Office Rent (Land, Buildings, etc.)	$28,000.00
21)	Furniture Rental	$0.00
22)	Equipment Rental (Phone, Computer, etc.)	$0.00
23)	Dues and Subscriptions	$300.00
24)	Insurance and Bond	$4,000.00
25)	**Total Fixed Charges & Other Expenses**	**$32,300.00**
	Capital Outlay	
26)	Office Furniture	
27)	Computer Equipment	
28)	**Total Capital Outlay**	
29)	Subcontract	
30)	**Total SubContracts**	**$0.00**
31)	**Total of Direct Costs**	**$339,879.00**
32)	**Indirect Costs**	
33)	**Total Budgeted Expenditures**	**$339,879.00**

Mariposa School®
FOR CHILDREN WITH AUTISM

Salaries Covered By Grant

There were a total of 15 students that were on the grant scholarship, but no more than 12 students at any one time. Below is a table showing the portion of salaries that the grant covered.

Position	Salary	Salary Grant Covers	Salary Fringe Benefits
15 Instructors	394,756.80	172,445.02	17,341.21
Executive Director	75,000	21,772.54	2,126.65
Office Manager	20,000	9,093.47	613.81
4 Program Coordinators	161,000	57,786.94	5,914.36
Subtotal	$650,756.80	$261,107.97	$25,996.03
TOTAL		**$287,104.00**	

Mariposa School

FOR CHILDREN WITH AUTISM

Program Description

The Mariposa School is a non-profit (501(c)3) organization created specifically to offer children with autism and other developmental disabilities year around, intensive instruction using evidence-based teaching techniques founded on the methodology of Applied Behavior Analysis (ABA). We serve students up to 18 years of age, though all students receiving services from the State Grant range from 2-6 years old. All these children receive 15 hours of one-to-one instruction per week.

Upon acceptance into the program, each student is assigned an instructor who will work one-on-one with the child and a Program Coordinator. The Program Coordinator reviews the child's information, oversees an initial assessment, sets specific goals, develops a treatment plan and overall guides the child's learning program. The Program Coordinator, who is highly skilled in Applied Behavior Analysis, collects data on an ongoing basis, meets with families on a monthly basis to review the child's progress and any concerns, and makes adjustments to the goals and treatment plan as needed.

The Program Coordinator and Instructor work together to create a program tailored to fit the individual needs of each student so that the student may realize his/her maximum potential. Progress is tracked and is measurable and we reassess each student's skills on a daily basis to monitor progress and modify teaching strategies as needed. When problems occur, we do not merely identify them, we look for ways to solve them. Our teaching techniques are based on what research has shown to be most effective. Truly individualized and intensive, our 1:1 program focuses on teaching functional language skills based upon each student's motivation and current skill level.

Mariposa School
FOR CHILDREN WITH AUTISM

Outcome Measures

Our primary assessment and curriculum tool is the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP). The skills assessment in the VB-MAPP is an assessment and curriculum for language development which can be used to identify skills for 170 verbal behavior milestones across 3 developmental levels (0 to 18 months, 18 to 30 months, and 30 to 48 months) and 16 different skill areas (i.e. manding (requesting), tacting (naming), listener discrimination (receptive language), visual performance, imitation, play and social skills to name a few). Of the 15 children assessed who benefitted from the grant, all of the children showed improvement from their first assessment to their final assessment with an average improvement of 44.6 points or milestones achieved. Conducting quarterly assessments with the VB-MAPP, we have seen several students' language deficits improve to the point where their language skills have caught up to their chronological age and they have moved on to typical preschool settings.

In addition to the VB-MAPP, students are also assessed with the Symbolic Play Assessment and the Early Social and Communication Scale in a pre- and post-test manner. These assessments yield results based on changes for each individual and the scores cannot be readily grouped into a summary statement appropriate for this report. The reader is referred to the Early Intervention Grant Report July 2011 to June 2012 for details. (We will gladly forward a copy of that report if requested.)

Autism Society of NORTH CAROLINA

December 1, 2012

Mr. Mark Trogdon, Director
Fiscal Research Division
Suite 619, Legislative Office Building
Raleigh, North Carolina 27603

Re: Mandatory Reporting by House Bill 950, Session Law 2012-142

Dear Mr. Trogdon,

Per William Scott's memorandum on October 29, 2012, I am respectfully submitting the Autism Society of North Carolina's report. All of the data is for fiscal year 2012 (July 1, 2011 – June 30, 2012) as requested.

Thank you for the support the NC General Assembly and the Department of Health and Human Services has provided the autism community in NC through this contract. As you likely know, the latest Center for Disease Control and Prevention study cites the prevalence of autism as 1 in 88 children and in North Carolina, the prevalence rate is 1 in 70 so this contract is imperative to serve the needs of the growing autism community.

By reviewing the combined information, I feel you will find ASNC is meeting the needs of individuals affected by autism across NC in the most efficient and effective methods possible. ASNC is always willing to have a tour of any of our programs to fully demonstrate how ASNC utilizes State contract dollars.

I trust you will find all the information you require but please do not hesitate to contact me with any questions.

Best regards,

Tracey Sheriff

Tracey Sheriff,
Chief Executive Officer

505 Oberlin Road, Suite 230 | Raleigh North Carolina 27605 | www.autismsociety-nc.org
(800) 442-2762

Autism Society
of NORTH CAROLINA
505 Oberlin Road, Suite 230
Raleigh North Carolina 27605

Mandatory Reporting by House Bill 950, Session Law 2012-142
December 1, 2012

1) The entity's mission, purpose, and governance structure.

The mission of the Autism Society of North Carolina (ASNC) is to provide support and promote opportunities that enhance the lives of individuals within the autism spectrum and their families. ASNC is the leading organization in North Carolina for connecting people who live with autism and their families with resources, support, advocacy, and information tailored to their unique needs.

The mission of ASNC has remained the same for many years, but the prevalence of autism and the needs of the growing autism community have increased significantly over time. The most recent Center for Disease Control and Prevention (CDC) study cites the prevalence of autism as 1 in 88 children and in North Carolina, the prevalence rate is 1 in 70.

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™

Identified Prevalence of Autism Spectrum Disorders
ADDM Network 2000-2008
Combining Data from All Sites

Surveillance year	Birth year	Number of ADDM Sites reporting	Prevalence per 1,000 (range)	This is about 1 in X children
2002	1994	14	6.6 (3.3-10.6)	1 in 150
2006	1998	11	9.0 (4.2-12.1)	1 in 110

ASNC is governed by a 20 person, non-compensated, Board of Directors. There are seven standing Board committees. The Board of Directors meets quarterly with intermittent committee meetings between Board meetings.

The Board members are committed to be active, informed, and independent to oversee the organization's business affairs and senior management. All Board members receive extensive training on Board Roles and Responsibilities that include the fiduciary duties of care, loyalty and obedience.

Autism Society
of NORTH CAROLINA
505 Oberlin Road, Suite 230
Raleigh North Carolina 27605

2) A description of the types of programs, services, and activities funded by State appropriations.

ASNC is a statewide organization with the administrative office in Raleigh and regional offices in Fayetteville, Asheville, Greensboro, Greenville, Raleigh and satellite offices in Dillsboro, Laurinburg, Moncure, Davidson, Wilmington, New Bern and Elizabeth City.

Advocacy – ASNC is the only resource in the state for connecting individuals with autism spectrum disorder (ASD), their families, and professionals with information and support that is tailored to their unique situation. We employ Parent Advocates throughout the state who:

- Answer and respond to calls and emails for assistance.
- Attend school conferences (Individualized Education Program meetings) and other service meetings with families, offering a neutral third party perspective.
- Conduct parent training workshops teaching parents how to better help their child and themselves.
- Meet face to face with families in crisis to provide guidance in hopes of preventing institutionalization of their child in a State run facility or hospital emergency room.
- Present information on autism awareness to community groups.
- Provide support to military families stationed on bases throughout NC to navigate Federal and NC resources.

Chapters – ASNC operates 49 Chapters/Support Groups covering 66 counties across NC. These chapters are led by volunteer parents whose generous spirit and passion for their own children inspire their desire to help other area families facing similar challenges. These parents contribute 700 hours of volunteer service to the Chapters monthly. Professionals working in the field of autism are also often involved and contribute their knowledge and perspective to Chapter meetings and activities.

ASNC Chapters provide a wonderful opportunity for parents/family members who face similar challenges to:

- Offer each other support and encouragement.
- Share experiences, information and resources.
- Raise awareness about the needs and strengths of individuals with ASD.
- Learn realistic, practical solutions for autism-related concerns.
- Have a place where they feel welcome, accepted and understood.

ASNC Advocacy and Chapters benefits the State of NC by:

- Increasing awareness of the signs and symptoms of autism, resulting in earlier diagnosis, earlier treatment, better long term outcomes, and lower lifetime cost of care.

- Increasing meaningful collaboration between parents and school districts by attending school meetings with families and facilitating differences as needed.
- Decreasing the number of individuals with autism who are institutionalized by helping families keep their child in the community where the cost of care is less.
- Empowering families to better help themselves by understanding their options, best practices, and connect with others to share information and support one another.

Clinical Training and Public Education benefits individuals on the autism spectrum, families, teachers, and other professionals. ASNC provides these services through conferences, workshops, and consultation to community organizations such as schools, libraries, churches, medical practices, hospitals, health care and child care providers. There are ongoing efforts to educate the public about autism and the needs of the autism community through awareness campaigns, media relations, our website, social media, and an autism-specific bookstore. ASNC clinical training staff have graduate level degrees and certifications with many years of applicable experience in evidence based best practices. Last year our clinical training and public education included:

- Trainings to other professionals:
  - ✓ Training for police, fire and emergency personnel
  - ✓ Education of medical, dental and other healthcare professionals
  - ✓ Teacher trainings (both workshop and in classroom consultation and advice)
  - ✓ Training with service providers on how to better work with individuals with ASD
  - ✓ Full and multi-day workshops for teachers and other childcare professionals who work with children under the age of 5.
- Camp Royall provides hands-on training for college–aged counselors each summer which builds the skills and attitudes necessary for them to go on to life-long careers serving people with autism.
- Annual educational conference for parents and professionals.
- Monthly email newsletter.
- Comprehensive informational website.
- Twice annual printed informational newsletter/magazine.
- Outreach and education to statewide media outlets during Autism Awareness Month campaign and resource for stories and autism information year round.
- Partnerships and awareness opportunities with various sports organizations.
- Community awareness events across the state through Run/Walks.
- ASNC Bookstore that is the largest worldwide collection of titles pertaining to autism which is staffed by individuals with ASD.

Clinical training and public education through the Autism Society of North Carolina benefits the State of NC in many ways.

- When parents are aware of the signs and symptoms of autism, they are able to seek help for their child at an earlier age and learn practical strategies they can use at home. Research has shown that the earlier a child is diagnosed and can receive treatment and intervention, the less their cost of care over time and in to adulthood.
- Increased public awareness has helped North Carolina to have a lower average age of diagnosis than the national norm.
- By training health care professionals, doctor's offices and hospitals are better equipped to appropriately serve patients.
- By training first responders (Police, Fire and EMT personnel) we reduce the likelihood of significant injury or catastrophic events.
- Clinical training and public education increases the capacity and quality of care for individuals with autism in our state.

Direct Care Service Provision – By offering expertise in autism instruction in a variety of settings (home, work, community), ASNC helps increase the independence and self-sufficiency of individuals on the autism spectrum. Individuals with autism have unique needs and we provide services to best meet their individual needs. While we strive to make everyone to be as independent as possible, in truth, ASNC serves many individuals that have very significant lifelong needs. Our Direct Care Service provision includes:

- Housing for Adults - These residents live in a home/apartment with 24/7/365 supervision and instruction provided by staff. This helps families who can no longer keep their child in their home and enables the residents to learn life skills while remaining in their communities. ASNC collaborates with many providers for effective residential options such as GHA Autism Supports.
- Respite Care - ASNC offers therapeutic respite to children and adults through Camp Royall each summer as well as weekend respite programs throughout the year for individuals and their families. Both individuals and their families are often unable to find any other organization to provide for their unique and specialized needs due to the complex nature of autism.
- Job Training and Day Programming - ASNC helps train individuals with autism for jobs that lead to individuals with autism being gainfully employed and contributing members of society and to the economy.
- Community Based Services – ASNC serves individuals with ASD on a daily basis in a variety of home and community based settings across the State to increase daily living skills, community access, and inclusion.
- Social Groups – ASNC provides several social groups across the state that cater to a specific set of shared interests and are facilitated to develop typical social skills with peers.

Direct Care Service Provision benefits the State in a variety of ways:

- In many instances we have become the provider of necessity or last resort, when the next step is institutionalization. Serving these individuals in a community setting helps the State avoid higher costs of care.
- Our expertise with individuals with ASD allows us to provide housing and job training programs to help lower the cost of care per person by allowing individuals with autism to contribute meaningfully to their local communities and economy.
- Respite care helps families stay together, stay employed and the State save money. Without respite and direct service provision options, many families have also said they would be faced with the choice of a parent having to give up working to care for their child or put their child in a State run facility.
- For many families, the time that their child spends at Camp Royall is the only respite care they receive during the year.
- ASNC provides training and respite care to individuals with behavioral challenges that other providers will not or cannot serve due to the complex nature of autism.

3) Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.

See Appendix 1

Parent Advocates

- 6,184 encounters with individuals were made last year by Parent Advocates. These encounters include phone calls and in person meetings. Advocacy services are available to all 100 counties in NC.
- NC requests for information and assistance came from 93 out of 100 of NC counties.

Chapters

- 49 Chapters/Support Groups covering 66 counties
- Chapters support an average of 430 family members each month in face to face group meetings (based on figures from the current fiscal year).
- Chapters support an additional 9,660 family members through a variety of electronic formats that allow information sharing and family-to-family support.
- Chapter participants contribute more than 700 volunteer hours a month of service.

Training and Education

- ASNC staff held 218 in person training workshops that reached 4,666 people in NC.
- Trainings were held in 43 different counties, however, they are available and draw from participants in all 100 counties.

Autism Society
of NORTH CAROLINA
505 Oberlin Road, Suite 230
Raleigh North Carolina 27605

Trainings fell into these categories—

- First Responders - 9 workshops given to 243 first responders.
- Healthcare and Service Professionals - 19 workshops given to 360 healthcare, childcare and library professionals.
- Understanding and Responding - 72 workshops given to 1024 parents of children with autism and professionals who work with families and children.
- Teacher Trainings - 23 workshops given to 711 teachers from preschool to secondary schools to develop better skills to work with students with autism.
- Community Awareness - 20 workshops on autism given to 600 people.
- Increasing Clinical Skills - 23 workshops given to 493 professionals to increase clinical skills in community settings.
- Improving Education Plans - 41 workshops on education plans (such as IEPs and transition plans) and improving relationships with schools to 310 parents.
- Early Intervention - 7 workshops given to 175 professionals who work with children under 3 years of age.
- Our Annual Conference reached 750 participants in Charlotte.

In addition to workshops, ASNC supports families by providing a great deal of information through various media outlets, printed and electronic material, awareness events and through our comprehensive informational website.

- Last year our website had over 100,000 unique visitors.
- A monthly email newsletter to 16,000 email addresses covering recent research developments in the autism field and other relevant information surrounding ASD.
- Twice annual printed informational newsletter/magazine to 44,000 readers.
- 20,000 pieces of educational materials including pamphlets and brochures printed and distributed to promote autism awareness and local resources.
- Outreach and education to 650 statewide media outlets (including articles in the 5 largest newspapers in NC) during Autism Awareness Month campaign and throughout the year.
- Community awareness events across the state (Raleigh, Asheville, Greenville, Wilmington, Greensboro, Mt. Airy and Concord) through Run/Walks reaching over 5,700 individuals.
- Create partnerships and awareness opportunities with various sports organizations (Autism Awareness Night with Charlotte Knights, Durham Bulls, Burlington Royals, Asheville Tourists, Carolina Railhawks and Carolina Hurricanes. Each event included awareness information presented to game attendees, radio interviews about services and supports, and information table for attendees).
- A bookstore that is the largest worldwide collection of titles pertaining to autism which
  - ✓ 751 titles in inventory
  - ✓ 5,003 books and DVD's sold

Autism Society
of NORTH CAROLINA
505 Oberlin Road, Suite 230
Raleigh North Carolina 27605

Direct Care Service Provision

- Housing for adults - 25 adults reside in our residential programs, 24 males, 1 female, in Buncombe, Wake, Cumberland, Craven and Pasquotank Counties.
- Through GHA Autism Supports, residential services provided to 76 individuals from 23 counties.
- Respite care - 479 individuals from 53 counties accessed respite and recreation through Camp Royall.
- Day programming - pre/vocational services to 56 individuals in Wake, Guilford and Cumberland counties.
- Community Based Services - 448 individuals received direct services ranging from meaningful employment and volunteer support, in home skill building and respite in 37 counties.
- Social Groups -170 participants in programs in Wake, Cumberland, Buncombe, Pitt and Guilford counties.
- Recreational Supports - 645 people attended recreation events through ASNC's Family Fun day programs last year.

4) Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.

Advocacy – of 6,184 encounters to provide information, referrals and support, the following were immediate outcomes from Parent Advocate services:

- 2,090 individuals received problem solving and advocacy consultation.
- 1,638 individuals received referrals and connections to local resources.
- 1,565 individuals received mentoring, coaching and support.
- 1,125 individuals received information (website, articles, books, packets).
- 549 attended meetings in a support role with family members/self-advocates (IEP, post-diagnosis, crisis, etc.).
- 231 referrals were made by phone call to other agencies or resources.

Training and Education

- Outcomes include responses from training participants, of which over 90%:
  - ✓ Indicated they planned to improve and make changes to their work with autism as a result of the training.

- ✓ Indicated the workshops increased their knowledge base on the subject material covered.
- ✓ Indicated their ability to explain and demonstrate information covered to others increased as a result of the training.

Direct Services Outcomes

- 100% of families surveyed said their experience at Camp Royall was good/excellent.
- 96% of parents surveyed said their campers tried new activities while at Camp Royall.
- 95% of families said they would definitely send their camper back to Camp Royall again.
- 90% indicated satisfaction with communication materials and advocacy.
- 89% said that Camp Royall provided needed respite for their family.
- 87% indicated they were very satisfied or satisfied with services from ASNC.
- 83% said their camper developed a broader range of activities.
- 80% of respondents indicated that since receiving services from ASNC they have seen an increase in their child's expressive communication and social interaction.
- 70% said that their child's independence increased as a result of spending time at Camp Royall.

5) A detailed program budget and list of expenditures, including all positions funded and funding sources.

See Appendix 2 a - c

6) The source and amount of any matching funds received by the entity.

See Appendix 3

APPENDIX 1

Autism Society of North Carolina, Inc.
Contract # 2100 Autism Services
2011-2012 Statistical & Demographical Information

County	Parent Advocate Encounters	Workshops/Trainings	Chapter	ASNC Direct Services	GMA	Camp Royall	Totals by County
Alamance County	43	7	Yes	1		6	57
Alexander County	1		Yes			1	2
Alleghany County	2		Yes				2
Anson County	1		No	1			2
Ashe County	5		Yes	1		1	7
Avery County	7		Yes				7
Beaufort County	3		No	1			4
Bertie County	1		Yes				1
Bladen County	2		Yes	1			3
Brunswick County	68	19	Yes			4	91
Buncombe County	291	308	Yes	73		15	687
Burke County	17		Yes				17
Cabarrus County	107	186	Yes		6	8	307
Caldwell County	12		Yes		1		13
Camden County	5		No	1		2	8
Carteret County	4	37	Yes			7	48
Caswell County	4		No				4
Catawba County	31		Yes	2		2	35
Chatham County	19	27	Yes	1	1	38	86
Cherokee County	20	11	Yes				31
Chowan County	2		Yes				2
Clay County	8		No				8
Cleveland County	25	44	No		1		70
Columbus County	9		No			1	10
Craven County	12	50	Yes	6		7	75
Cumberland County	160	42	Yes	78	1	9	290
Currituck County	3		Yes			2	5
Dare County	3		Yes			2	5
Davidson County	72	7	Yes		1	8	88
Davie County	18	3	Yes		1	3	25
Duplin County	1		No				1
Durham County	124	101	Yes	12		25	262
Edgecombe County	18		Yes				18
Forsyth County	132	80	Yes	1		6	219
Franklin County	23		Yes			3	26
Gaston County	71	7	Yes			4	82
Gates County			Yes				0
Graham County	9	46	No				55
Granville County	23		No			5	28
Greene County	1		No	1			2
Guilford County	410	119	Yes	55	2	11	597
Halifax County	20		Yes				20
Harnett County	77	20	Yes	1		2	100
Haywood County	37	76	No			1	114
Henderson County	66		No	7		1	74
Hertford County	7		Yes				7
Hoke County	13		No	3		3	19
Hyde County	0		Yes				0
Iredell County	59	62	Yes			7	128
Jackson County	100	140	Yes	5		1	246
Johnston County	62		Yes			15	77
Jones County			Yes				0
Lee County	16	11	Yes	1	1	6	35
Lenoir County	10		Yes	2		7	19
Lincoln County	31		Yes			4	35
Macon County	21		No	2			23
Madison County	11		No	1			12
Martin County	1		No	2			3
McDowell County	8		No				8
Mecklenburg County	668	557	Yes	4	5	42	1276
Mitchell County	9	24	No				33
Montgomery County	6		Yes				6

APPENDIX 1

Autism Society of North Carolina, Inc.
Contract # 2100 Autism Services
2011-2012 Statistical & Demographical Information

County	Parent Advocate Encounter	Workshop/ Training	Chapter	ASNC Direct Service	EIAA	Camp Royall	Totals by County
Moore County	5	20	Yes	5	2	2	34
Nash County	11	35	Yes	7		5	58
New Hanover County	248	151	Yes		6	11	416
Northampton County	3		Yes				3
Onslow County	31	98	Yes			7	136
Orange County	86	155	Yes	24	4	41	310
Pamlico County		11	No				11
Pasquotank County	4		No	2			6
Pender County	51		Yes			2	53
Perquimans County			No				0
Person County	5		Yes				5
Pitt County	79	64	Yes	53	1	9	206
Polk County	15	62	Yes				77
Randolph County	58	49	Yes	6	1	4	118
Richmond County	10		Yes				10
Robeson County	36		Yes	2	1	2	41
Rockingham County	32		No	1		4	37
Rowan County	33	44	No		4	3	84
Rutherford County	22		Yes		1		23
Sampson County	10		No			1	11
Scotland County	26	10	Yes	1			37
Stanly County	19		Yes		19	1	39
Stokes County	6		No				6
Surry County	24		Yes			1	25
Swain County	50	8	Yes				58
Transylvania County	6	61	Yes	1			68
Tyrrell County			Yes				0
Union County	75	87	Yes		1	2	165
Vance County	11		No				11
Wake County	832	835	Yes	81	14	122	1884
Warren County	4		No				4
Washington County			No				0
Watauga County	20	21	No			1	42
Wayne County	5	15	Yes		1	1	22
Wilkes County	10	96	No			1	107
Wilson County	8		Yes	2	1		11
Yadkin County	6		No				6
Yancey County	23	12	No				35
Qualla Boundary		38	No				38
No County of Record	1217	60				645	1922
Out of State	114						114
Annual Conference - Mecklenburg County		750					750
Totals	6184	4666	66	448	76	1124	10916
Total counties	93*	43**	66***	37	23	53*	94

* Services available in 100 counties

** Training and workshops take place in a particular county, but are generally open to people from other counties

*** Services available in 66 counties through the 49 chapters/support groups

APPENDIX 2a				
Autism Society of North Carolina, Inc.				
Contract # 2100 Autism Services				
2011-2012 Program Budget				
Description	**Advocacy**	**Training/ Education**	**Direct Services**	**Total Budget**
Personnel				
11) Salary/Wages	$689,125	$313,700	$1,023,500	$2,026,325
12) Benefits	$112,284	$31,370	$184,037	$327,691
13) Professional Services	$13,000	$30,000	$37,000	$80,000
14) Board Member Compensation				
15) Other:				
16) Total Personnel Services	**$814,409**	**$375,070**	**$1,244,537**	**$2,434,016**
Supplies and Materials				
17) Office Supplies and Materials	$3,000	$1,500	$37,500	$42,000
18) Computer Supplies & Software	$1,000	$1,000		$2,000
19) Janitorial Supplies				
20) Educational/Medical Supplies	$4,000	$3,000	$72,000	$79,000
21) Automotive Supplies			$20,000	$20,000
22) Other: Video/Audio Equipment				
23) Total Supplies and Materials	**$8,000**	**$5,500**	**$129,500**	**$143,000**
Operational Expenses				
24) Travel	$22,338	$12,500	$89,776	$124,614
25) Communications (Telephone, Postage, etc.)	$23,000	$6,000	$57,000	$86,000
26) Utilities				
27) Printing and Binding		$36,000	$1,000	$37,000
28) Repair and Maintenance			$23,000	$23,000
29) Computer Services (Accting, Payroll, etc.)				
30) Employee Training	$17,500	$43,000	$29,000	$89,500
31) Advertising				
32) Board Member Expense (Travel, Per Diem)				
33) Other - Conference space rental				
34) Total Operational Expenses	**$62,838**	**$97,500**	**$199,776**	**$360,114**
Fixed Charges and Expenses				
35) Office Rent (Land, Buildings, etc.)	$45,000		$273,000	$318,000
36) Furniture Rental				
37) Equipment Rental (Phone, Computer, etc.)	$4,000	$1,000	$12,000	$17,000
38) Vehicle Rental				
39) Dues and Subscriptions				
40) Insurance and Bond				
41) Other:				
42) Total Fixed Charges & Other Expenses	**$49,000**	**$1,000**	**$285,000**	**$335,000**
Capital Outlay				
43) Land/Buildings				
44) Office Furniture				
45) Computer Equipment				
46) Vehicles				
47) Books (Library Reference Materials)				
48) Other:				
49) Total Capital Outlay				
50) Total Contracts and Grants			$44,000	$44,000
51) Total Purchases of Services Costs				
52) Total of Direct Costs	**$934,247**	**$479,070**	**$1,902,813**	**$3,316,130**
53) Indirect Costs				
54) Total Budgeted Expenditures	**$934,247**	**$479,070**	**$1,902,813**	**$3,316,130**

APPENDIX 2b		
Autism Society of North Carolina, Inc.		
Contract # 2100 Autism Services		
2011-2012 Personnel Schedule		
Communications Assistant	0.50	$ 22,550.00
Training Director	1.00	$ 78,100.00
Training Specialist	0.90	$ 56,430.00
Training Specialist	0.10	$ 3,960.00
Training Specialist	0.90	$ 51,480.00
	5.65	$ 345,070.00
Direct Services		
Position Title	FTE	Salary/ Benefits
Director of Services	1.00	$ 80,400.00
Program Director	1.00	$ 54,000.00
Regional Director	0.50	$ 30,000.00
Program Specialist	1.00	$ 39,600.00
Art Specialist	1.00	$ 31,200.00
Recreation Specialist	1.00	$ 26,400.00
Horizon Coordinator	1.00	$ 48,687.00
Regional Director	0.50	$ 31,725.00
Program Director	1.00	$ 49,938.00
Program Specialist	0.75	$ 28,200.00
Regional Director	0.50	$ 29,081.00
Program Director	1.00	$ 45,238.00
Program Specialist	1.00	$ 29,963.00
Recreation Specialist	1.00	$ 38,775.00
Art Specialist	1.00	$ 30,550.00
Program Director	1.00	$ 43,200.00
Lead Residential	1.00	$ 33,600.00
Program Director	1.00	$ 40,800.00
Program Director	1.00	$ 38,400.00
Regional Director	0.50	$ 30,600.00
Lead Residential	1.00	$ 33,600.00
Regional Director	0.50	$ 30,000.00
Program Director	1.00	$ 40,200.00
Program Director	1.00	$ 46,800.00
Program Coordinator	0.75	$ 36,900.00
Operations Director	0.25	$ 21,450.00
Facilities Manager	0.50	$ 33,000.00
Asst. Program Coordinator	0.75	$ 23,850.00
Temporary Summer Staff - Camp Royall	25.00	$ 161,380.00
	48.50	$ 1,207,537.00

APPENDIX 2b		
Autism Society of North Carolina, Inc.		
Contract # 2100 Autism Services		
2011-2012 Personnel Schedule		
Advocacy		
Position Title	FTE	Salary/ Benefits
Chief Executive Officer	0.50	$ 48,875.00
Administrative Associate	0.50	$ 18,975.00
Regional Director	0.50	$ 29,375.00
Regional Director	0.50	$ 31,725.00
Regional Director	0.50	$ 29,963.00
Regional Director	0.50	$ 29,375.00
Regional Director	0.50	$ 29,081.00
Director of Advocacy, Chapters and Governmental Relations	0.75	$ 56,840.00
Chapter Director	0.75	$ 53,756.00
Parent Advocate Director	1.00	$ 50,231.00
Chapter Coordinator	0.75	$ 31,725.00
Regional Chapter Assistant	0.75	$ 29,963.00
Parent Advocate	1.00	$ 47,000.00
Parent Advocate	0.25	$ 11,500.00
Parent Advocate	0.25	$ 11,500.00
Regional Chapter Assistant	0.25	$ 12,650.00
Regional Chapter Assistant	0.20	$ 6,900.00
Regional Chapter Assistant	0.10	$ 2,875.00
Parent Advocate	0.50	$ 23,000.00
Parent Advocate	0.50	$ 23,000.00
Parent Advocate	0.50	$ 25,875.00
Parent Advocate	0.60	$ 27,600.00
Parent Advocate	0.75	$ 30,475.00
Parent Advocate	0.25	$ 10,350.00
Parent Advocate	1.00	$ 40,250.00
Parent Advocate	0.35	$ 14,950.00
Parent Advocate	0.35	$ 18,400.00
Parent Advocate	0.50	$ 20,700.00
Parent Advocate	0.50	$ 19,550.00
Parent Advocate	0.35	$ 14,950.00
	15.70	$ 801,409.00
Training/Education		
Position Title	FTE	Salary/ Benefits
Chief External Relations Officer	0.25	$ 19,250.00
Director of Communications	1.00	$ 79,750.00
Communications Assistant	1.00	$ 33,550.00

Autism Society of North Carolina, Inc.
PROGRAM EXPENDITURES for CONTRACT #2100
CONTRACT YEAR 2011- 2012 - ADVOCACY
APPENDIX 2c

Account	Annual Expenditures
EXPENDITURE CATEGORY	
Personnel Costs	
Salaries and Wages	$706,652.43
Fringe Benefits/Payroll Taxes	$123,656.53
Professional/Consulting/Contracted Services	$13,356.97
Total	$843,665.93
Supplies and Materials	
Office Supplies and Materials	$3,894.07
Computer Supplies & Software	$4,067.90
Educational, Medical and Other Supplies	$5,793.01
Automotive Supplies	$666.52
Total	$14,421.50
Current Obligations/Operational Expenses	
Travel	$28,646.33
Communications	$23,705.88
Printing and Binding	$488.71
Repair and Maintenance	$1,318.09
Employee Training	$23,413.39
Other: Conference Space Rental	$1,170.98
Total	$78,743.38
Fixed Charges and Other Expenses	
Office Rent	$54,888.69
Equipment Rental	$5,576.83
Total	$60,465.52
Contracts and Grants	
Grants	$2,090.00
Total Contracts and Grants	$2,090.00
TOTAL EXPENDITURES	$999,386.33

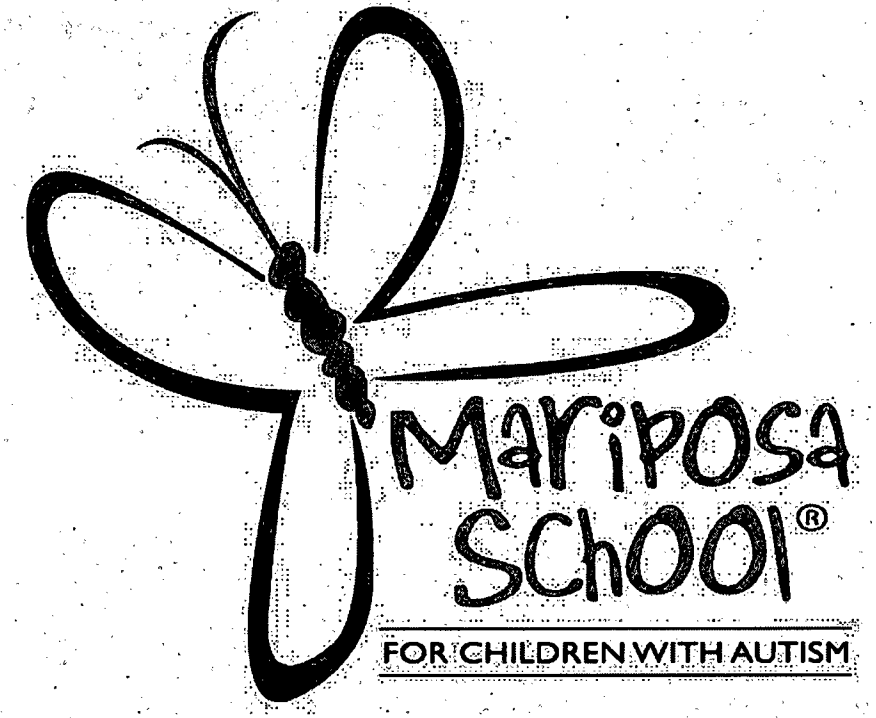
Autism Society of North Carolina, Inc.
PROGRAM EXPENDITURES for CONTRACT #2100
CONTRACT YEAR 2011- 2012 - TRAINING/EDUCATION

APPENDIX 2C

Account	Annual Expenditures
EXPENDITURE CATEGORY	
Personnel Costs	
Salaries and Wages	$335,203.69
Fringe Benefits/Payroll Taxes	$31,476.07
Professional/Consulting/Contracted Services	$30,861.82
Total	$397,541.58
Supplies and Materials	
Office Supplies and Materials	$1,983.91
Computer Supplies & Software	$1,184.24
Educational, Medical and Other Supplies	$7,739.37
Total	$10,907.52
Current Obligations/Operational Expenses	
Travel	$14,267.79
Communications	$6,712.55
Printing and Binding	$41,496.16
Repair and Maintenance	$7.00
Employee Training	$43,732.41
	$106,215.91
Fixed Charges and Other Expenses	
Office Rent	$3,566.42
Equipment Rental	$3,138.65
Total	$6,705.07
TOTAL EXPENDITURES	$521,370.08

APPENDIX 3				
utism Society of North Carolina, Inc.				
Contract # 2100 Autism Services				
2011-2012 Matching Funds				
Description	Advocacy	Training/ Education	Direct Services	Total
Matching Funds				
Contributions & Grants	$309,707	$31,286	$241,778	$582,771
Fees paid by participants	$1,180	$81,852	$339,971	$423,003
Merchandise Sales	$2,641	$3,425	$15,016	$21,082
Contract payments	$11,110	$21,860	$46,442	$79,412
Other	$1,569	$9,340	$59,396	$70,305
TOTAL	$326,207	$147,763	$702,603	$1,176,573

The DHHS Early Intervention Grant and The Mariposa School



Overview

- Mariposa was founded in September, 2001
- The only school in the Triangle area providing 100% Applied Behavior Analysis based treatment to children with autism and related developmental disabilities.
- Main program is one-to-one Early Intensive Behavior Intervention (EIBI).
- Mariposa currently serves 47 children in EIBI and 9 in afterschool Social Skills.
- Currently, 12 children receive assistance through the grant with 10 receiving full tuition coverage and 2 receiving partial tuition.

Early Intensive Behavioral Intervention

- One-to-one instruction
- 15 hours per week for children on the grant
- The programming is based on a criterion-referenced assessment/curriculum known as the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)
- The VB-MAPP assesses developmental milestones related to language and social skills.
- Skills are taught in the sequence in which typically developing children acquire the skills.

Early Intensive Behavioral Intervention

- The United States Surgeon General (1999) concluded, "Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning and appropriate social behavior." (http://www.asatonline.org/treatment/treatments/applied)
- In a meta-analysis by Peters-Scheffer, Didden, Korzilius, and Surmey (2010) reported on 11 studies with 344 children with ASD. Experimental EIBI groups outperformed the control groups on IQ, non-verbal IQ, expressive and receptive language and adaptive behavior. Differences between the experimental and control groups were 4.96–15.21 points on standardized tests. These results strongly support the effectiveness of EIBI. (*Research in Autism Spectrum Disorders*, 5, 60-69)

Early Intensive Behavioral Intervention

- Chasson, Harris, and Neely, in the *Journal of Child and Family Studies* (2007), reported: "The financial implications of the increased prevalence of autism, ... will be extremely important to society. We compared the costs associated with 18 years of special education to the costs associated with the implementation of an average of 3 years of Discrete Trial Training as an Early Intensive Behavioral Intervention (EIBI).... **Our results indicate that the state of Texas would save $208,500 per child across eighteen years of education with EIBI."**

Funding

- The State Grant provides approximately 23% of Mariposa's total funds.
- Students with partial funding (2) receive 40% of their tuition from the grant.
- While fundraising is a continuous effort, only 2% of our funding comes from outside sources. (For fiscal year '12-13 we have raised $30,152.68; leaving approximately $3900 needed to meet our 10% match requirement).
- The remaining cost (approximately 70%) is borne by parents who pay tuition or are fortunate to have insurance that covers the cost. (6 out of 47 students)

Funding

The Mariposa School State Grant Budget

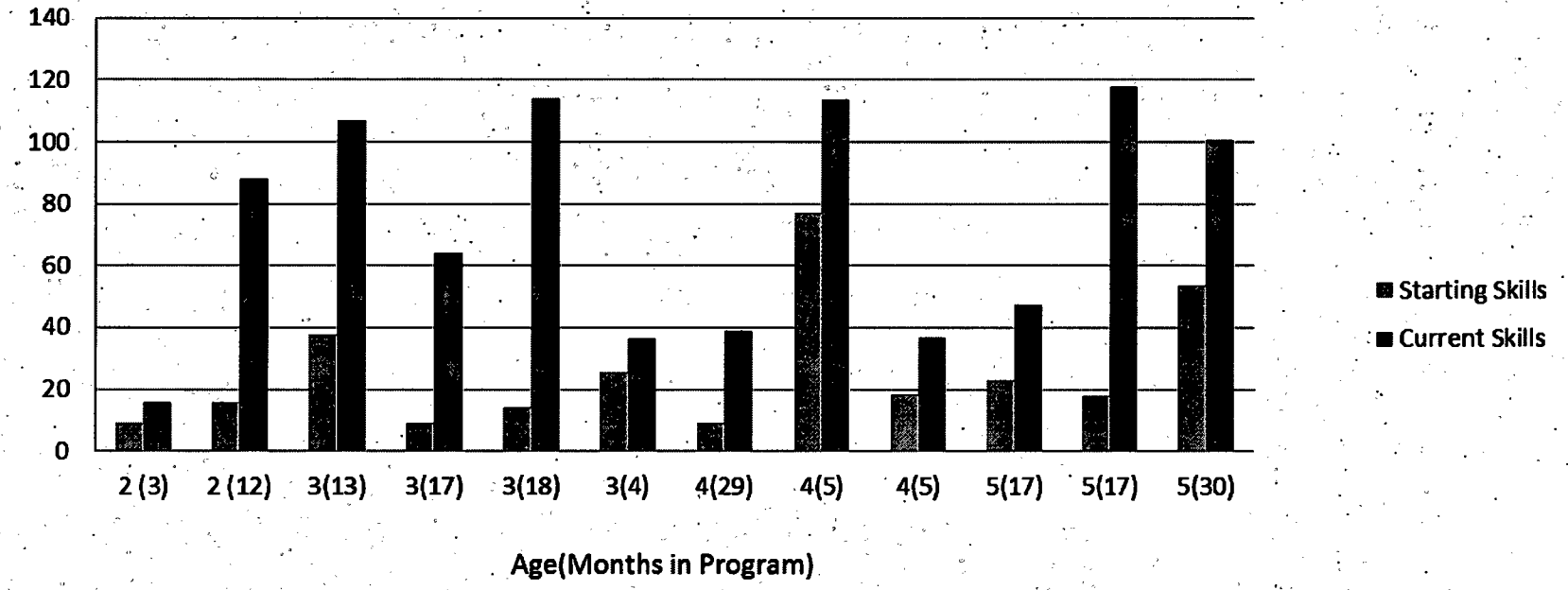
Expenditure Category	Approved Budget	Year to Date Expenditures	Remaining Expenditures
Salary/Wages	262,509.00	151,602.19	110,906.81
Fringe Benefits	25,940.00	15,823.83	10,116.17
Supplies & Materials	5,000.00	2,507.08	2,492.92
Travel	1,300.00	379.02	920.98
Utilities	5,400.00	3,239.58	2,160.42
Repair & Maintenance	1,800.00	1,800.00	
Staff Development	1,500.00	28.07	1,471.93
Rent	29,000.00	19,627.18	9,372.82
Professional Services	4,230.00	3,338.35	891.65
Other	3,200.00	2,819.80	380.20
TOTALS	$339,879.00	$201,165.10	$138,713.90

Results

- A total of 37 children have been funded with the EIBI State grant. Of those 25 received full tuition while 12 received partial tuition assistance.
- Maximum served was 16 in the 2008-'09 fiscal year.
- Following graph includes 11 current students with one added who left in December and one omitted who started in January.
- All students make progress, some make remarkable progress.

Results

Improvement in VB-MAPP Scores by Age and Months in the Program



Results: What the graph doesn't say

- The boy represented at 2(3) could (would) not sit up when he arrived and cried throughout the day. He now sits happily in a chair and on the potty which he is starting to use and uses 4 signs.
- The boy represented by 3(18) did not talk on arrival but left the program in December to attend regular preschool and is generally indistinguishable from his peers.
- In general, a score of 20 or less represents a child who says less than 2 words. A score of 80 or more represents a child who can ask and answer question and make his wants and needs known.

Where would we be without this grant?

- If Mariposa did not receive the grant none of the children depicted on the graph would have received sufficient EIBI services.
- If Mariposa does not receive the grant all of the children will have services terminated.
- If Mariposa does not receive at least 6 employees at the school will lose their jobs.
- If Mariposa does not receive the grant the State of North Carolina may need to provide additional educational services throughout their education—estimated earlier to be over $200,000 per child according to the Texas study.

THANK YOU

- The staff and families of The Mariposa School thank the North Carolina Legislature and the Department of Health and Human Services for providing this grant for the past 4.5 years and we look forward to continuing to providing services under the grant to those most in need at a time in their lives when help is most beneficial.

Easter Seals DISABILITY SERVICES

UCP United Cerebral Palsy™

North Carolina & Virginia

Presentation to General Assembly
February 21, 2013

Developmental Disabilities &
Autism Intervention Contracts

Presented by:
Elizabeth DeBiasi
Easter Seals UCP Board Chair

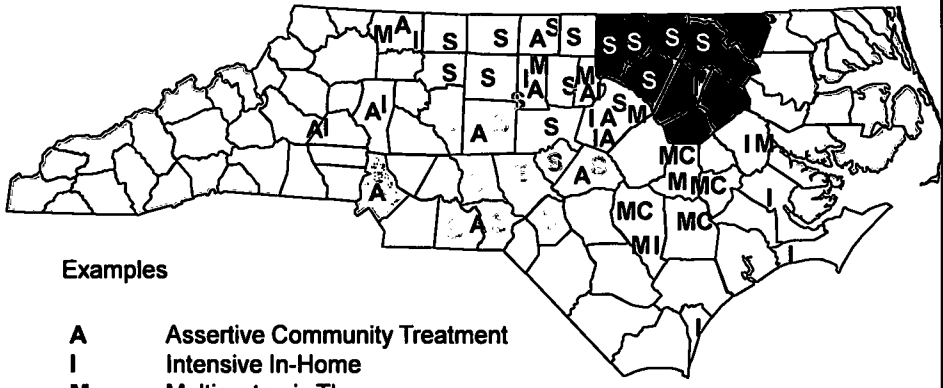
Easter Seals UCP

- A lifelong partner to people managing disabilities and mental health challenges
- Annually, support 20,000 children and adults
  - Over 3.3 million community-based service hours
  - Life span supports – from birth to older adulthood
  - Across every NC region – touching all 100 counties
- Evidence-informed and personal outcome driven agency

CQL The Council on Quality and Leadership

NC CABHA: Critical Access Behavioral Health Agency

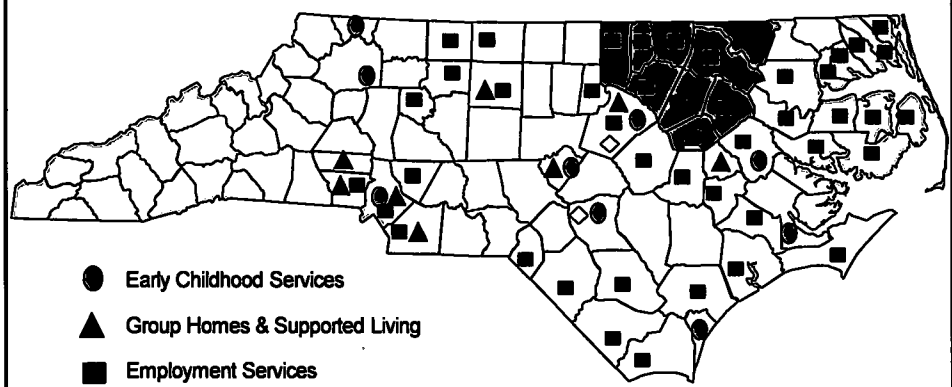
Evidence Informed Services Commitment



Examples

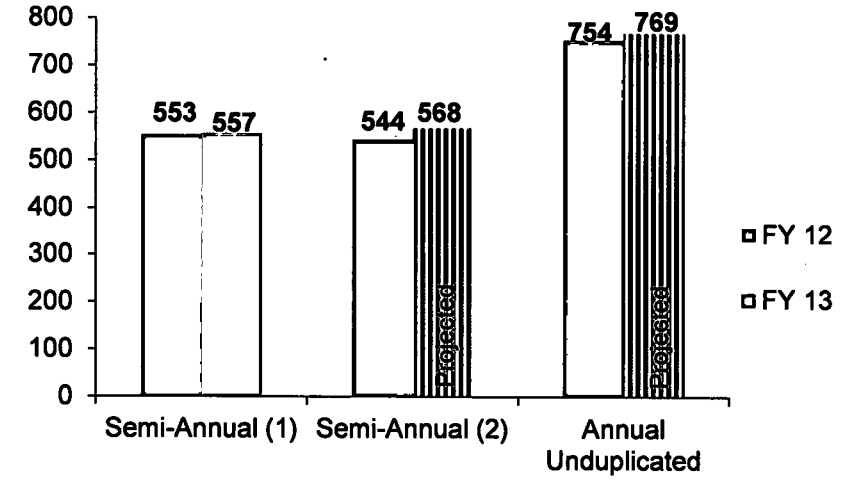
A	Assertive Community Treatment
I	Intensive In-Home
M	Multisystemic Therapy
S	NC START
MC	Mobile Crisis
IA	Intensive Alternative Family Treatment

Locations Related to FY 12 Contracts



- Early Childhood Services
- Group Homes & Supported Living
- Employment Services
- Autism Intensive Early Intervention

People Supported By Contracts



FY 12: 754 represented 29% of people in DD services connected to contracts

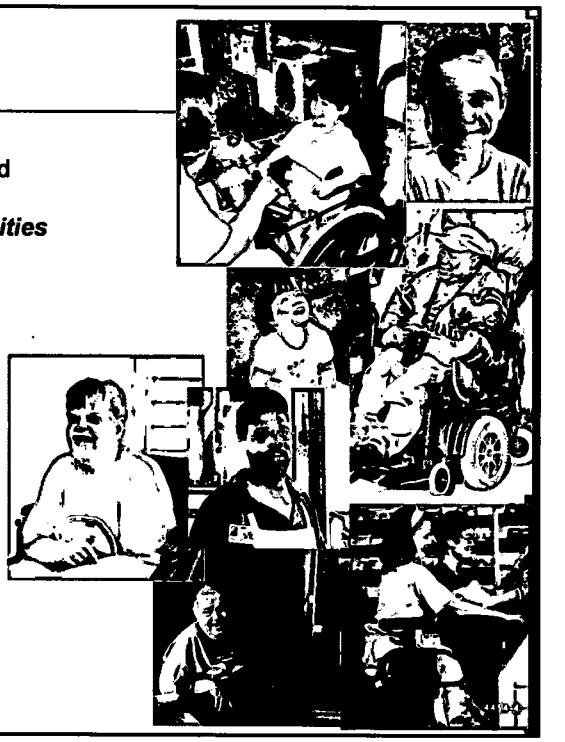
People Served

- Children 3 – 5 years old
- Adults 17 to 75+ years old

Significant Developmental Disabilities

Intensive needs exceed funding

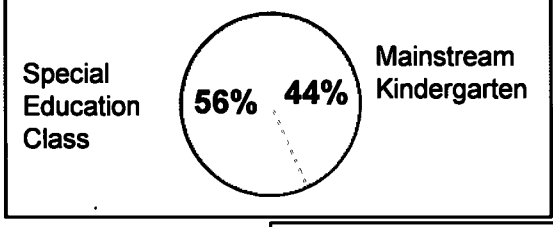
Multiple Co-Occurring Diagnoses
Autism
Cerebral Palsy
Down Syndrome
Intellectual Disabilities
Chromosomal Disorders
Medically Fragile Conditions
Traumatic Brain Injury



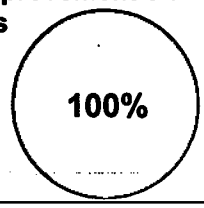
Child Outcomes

Achieve Developmental Progress

Transition to School

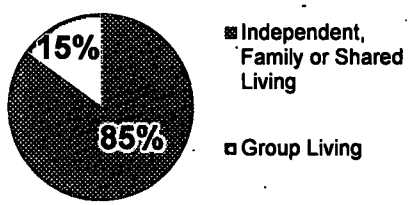


Intensive Autism Early Intervention Measured Improvement on Assessments

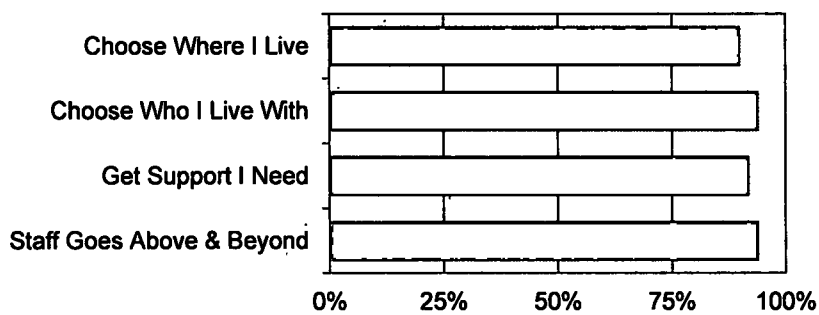


Adult Outcomes

Achieve Community Living



Achieve Personal Outcomes (CQL accreditation)



Adult Outcomes

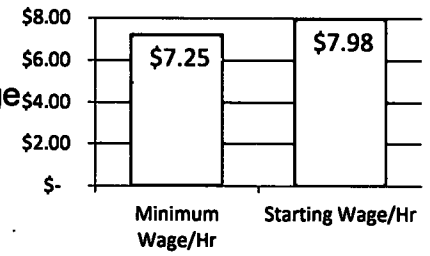
Achieve Employment

374 new jobs in FY 12

15% placed adults earn full benefits

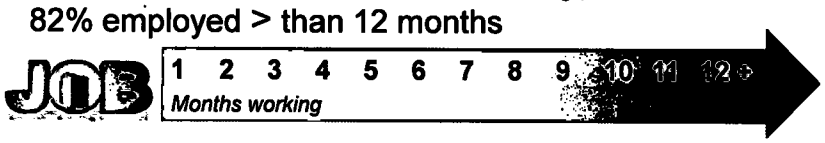
Earn Higher Pay

73 cents > minimum wage

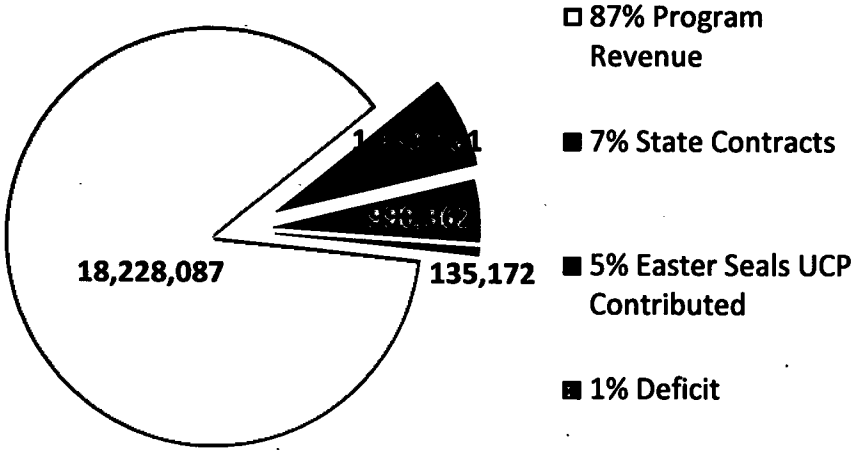


Maintain Employment

82% employed > than 12 months

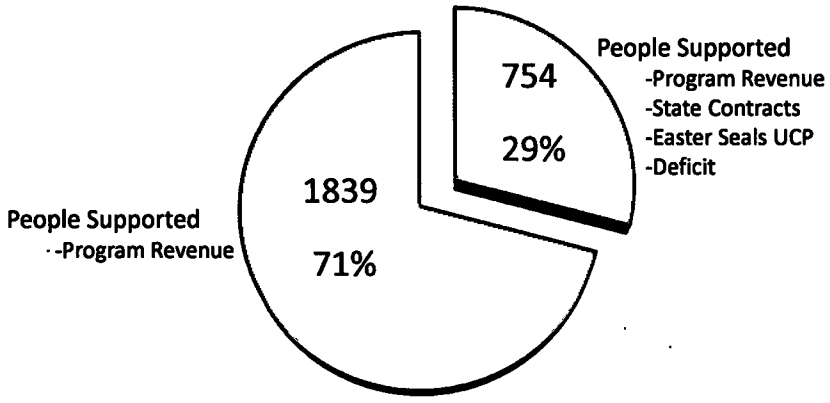


Investment in Services Connected to Contracts



Total Investment: $20,803,782

People in Services Connected to Contracts



FY 12 Total People in Affected Programs = 2,593

Easter Seals UCP North Carolina & Virginia

5171 Glenwood Avenue
Suite 400
Raleigh, NC 27612-3266
Phone: 919.783.8898/ 800.662.7119
Fax: 919.782.5486

Easter Seals UCP North Carolina & Virginia, Inc.
Report for House Bill 950, Session Law 2012-142
November 30, 2012

Re: FY 12 Contract 2080, Developmental Disability Services
FY 12 Contract 2099, Autism Early Intervention Services

Submitted to:

The Honorable Marilyn Avila, Co-Chair
North Carolina House of Representatives
Appropriations Subcommittee on Health
& Human Services
Room 2217, Legislative Building
Raleigh, North Carolina 27601

The Honorable Justin Burr, Co-Chair
North Carolina House of Representatives
Appropriations Subcommittee on Health
& Human Services
Room 538, Legislative Office Building
Raleigh, North Carolina 27603

The Honorable Stan Bingham, Co-Chair
North Carolina Senate Appropriations on Health &
Human Services
Room 2117, Legislative Building
Raleigh, North Carolina 27601

The Honorable Harris Blake, Co-Chair
North Carolina Senate Appropriations on Health &
Human Services
Room 408, Legislative Office Building
Raleigh, North Carolina 27603

The Honorable Louis Pate, Co-Chair
North Carolina Senate Appropriations on Health &
Human Services
Room 406, Legislative Office Building
Raleigh, North Carolina 27603

The Honorable Ralph Hise
North Carolina Senate Appropriations on Health
Human Services
Room 1026, Legislative Building
Raleigh, NC 27601

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee
on Health & Human Services
Room 538, Legislative Office Building
Raleigh, North Carolina 27603

The Honorable Nelson Dollar, Co-Chair
Joint Legislative Oversight Committee
on Health & Human Services
Room 307B1, Legislative Office Building
Raleigh, North Carolina 27603

The Honorable Louis Pate, Co-Chair
Joint Legislative Oversight Committee
on Health & Human Services
Room 406, Legislative Office Building
Raleigh, North Carolina 27603

Mark Trogdon, Director
Fiscal Research Division
Suite 619, Legislative Office Building
Raleigh, NC 27603

Submitted by:

Connie Cochran, President/CEO
919-865-8638
connie.cochran@eastersealsucp.com

Fred Waddle, Chief Compliance Officer
919-865-8722
fred.waddle@eastersealsucp.com

Organizational Overview and Structure

Easter Seals UCP is a 501(c)(3) nonprofit that provides supports and services to children and adults with developmental disabilities and mental health challenges, and their families. Our mission is to create opportunities, promote individual choice and change the lives of people with disabilities by maximizing their individual potential for living, learning and working in their communities. The people supported by this agency have disabilities such as cerebral palsy, autism, mental retardation, developmental disabilities, acquired injuries, aging-related issues and mental health diagnoses. With values of Integrity, Innovation, Respect and Responsibility, we strive to do the right thing for the right reason, to find better ways to support people with disabilities, to regard people with dignity and to manage our resources effectively and transparently. Easter Seals UCP is accredited by The Council on Quality & Leadership, which validates our continual focus on quality, person-centeredness and supporting individuals and families achieve their own personal outcomes. In June 2010, Easter Seals UCP received North Carolina Critical Access Behavioral Health Agency (CABHA) certification, which ensures critical mental health service delivery with clinical competency and medical oversight.

Easter Seal UCP is structured into a programmatic organizational model. There are 13 community regions across North Carolina and Virginia. North Carolinians in each of the 100 counties can access one or more services. Each community region has a Community Director, who serves as the operational leader and primary liaison. This matrix change was driven by a vision for increased community-level focus. The Community Director serves as principal liaison to funding sources, provider and advocacy networks, universities and community initiatives. Through involved community membership, the Director positions the agency to evaluate market, secure resource partners and pursue innovative growth. With programmatic and operational accountability, a Community Director leads the service array in each market and provides supportive oversight to Program Managers. Each Program Manager has autonomy to administer programs, maintain budgets and manage staff with results that are fiscally sound and based on person-centered philosophy of service provision.

A 7 member executive team is comprised of President/Chief Executive Officer, Chief Program Officer, Chief Finance Officer, Chief Human Resources Officer, Chief Communication Officer, Chief Compliance Officer and Chief Development Officer. Connie Cochran has a 17 year tenure as President/CEO. The executive team meets weekly. Executive officer direct their respective departments, and serve as executive facilitators of standing strategic operational and planning teams, which are comprised of Vice Presidents, Service Directors, Medical and Clinical Directors, Community Directors and Program and Administrative Leaders. From headquarters and regional offices, Quality Management, Human Resources, Finance, Communication, Development and Information Technology provide administrative support. Easter Seals UCP has a 20 member Board of Director that meets quarterly as a whole, and maintains ongoing work groups inclusive of executive, finance, program & clinical services, audit, development, government relations, property and nominating committees.

Easter Seals UCP FY 12 Contract Developmental Disability Services

The NC MHDDSAS FY 12 4th quarter community progress report indicates that 122,400 adults and children in North Carolina have an intellectual/developmental disability (I/DD). This accounts for 3.84% of 3-5 year olds, 3.17% of youth ages 6-17, and 0.79% of adults. The report denotes that 34,570 children and adults with I/DD were served by the MHDDSAS system during a one year period (4/1/11-3/31/12).

Through this FY 12 project funding, Easter Seals UCP served 738 North Carolinians with Intellectual/Developmental Disabilities; which represents 2% of the I/DD population served by the MHDDSAS system. Without this contract, these children and adults would otherwise be un-served or underserved, with critical service levels to achieve and maintain community living success through residential, employment and developmental early education supports.

Service	People Served FY 2012
Residential & Community Living	
Licensed Group Living (Low & Moderate)	28
Non-Licensed Group Living	1
Supported Living	2
Supported Employment	509
Developmental Day Early Education	198
	738

This contract is for direct Purchase of Services, and no administrative costs were charged to this funding mechanism. This FY 12 Purchase of Service realized cost ratio of $1,468.10 per person. The total allowable funding was pulled down by March 31, 2012. Easter Seals UCP continued to provide supports and accrue unfunded service units beyond this contract amount.

Individuals with I/DD have a mental or physical impairment or a combination of mental and physical impairments that last throughout life and require a variety of long-term services and supports. Many of these individuals may need supports at one or more points across the life span, from developmental services as children through community residential and employment supports as adults. The contract enables Easter Seals UCP to provide best practices residential, employment and developmental early education supports. Adults are supported in achieving successful, meaningful lives including living in typical homes, working in typical jobs in the community and interacting meaningfully with their peers. Children are better integrated with their typically developing peers at an early age while receiving developmental services that allow them greater success in social interactions, physical functioning, communication and recreation in the community.

Residential & Community Living 31 adults served

This contract enables each person to maintain living in community setting of their choice, and receive highly person-centered, appropriate level of individualized support. In June 2012, agency-wide Easter Seals UCP served 956 adults with I/DD with a comprehensive range of community-based services; of which 15% were in a licensed group home and 85% were supported within non-licensed settings (i.e. supported living, alternative family living, personal family living

This contract supported 3% of all Easter Seals UCP adult I/DD consumers, based on June 2012 service enrollment. Adults supported by contract for residential and community living did not receive CAP or I/DD Waiver funding. This contract is a critical support for adults with disabilities whose cost of care approaches ICF/MR level of care, but do not qualify. For licensed group home livng, the contracted supported 24% of all Easter Seals UCP consumers in adult I/DD licensed group homes.

Adults ranged in age from 24 to 72, with an average age of 48. Adults have intellectual /and developmental disabilities, inclusive of cerebral palsy and mental retardation, as well as dual or multiple diagnoses.

Residential & Community Living Program	County
Licensed Low and Moderate	
Greensboro Group Home	Guilford
Commonwealth Group Home	Mecklenburg
Ashcraft Group Home	Mecklenburg
Elizabeth Street Group Home	Gaston
Snow Hill Group Home	Greene
Sanford Group Home	Lee
Lithia Group Home	Lincoln
Monroe Group Home	Union
Raleigh Group Home	Wake
Non Licensed - Winterpointe	Wake
Supported Living	
Pathways Supported Living	Gaston
Lee Supported Living	Lee

Group living low supports adults who require supervision when in residence. Adults receive residential living services, as well as supports to participate in their home living setting, community and leisure activities, social interaction and other services, such as habiltiative or rehabilitative. This contract enables each person to maintain living in community setting of their choice, and receive highly person-centered, appropriate level of individualized support.

Group moderate is a 24 hour service that provides a community-based group home living for adults with I/DD that require a greater degree of supervision due to dependence or disability

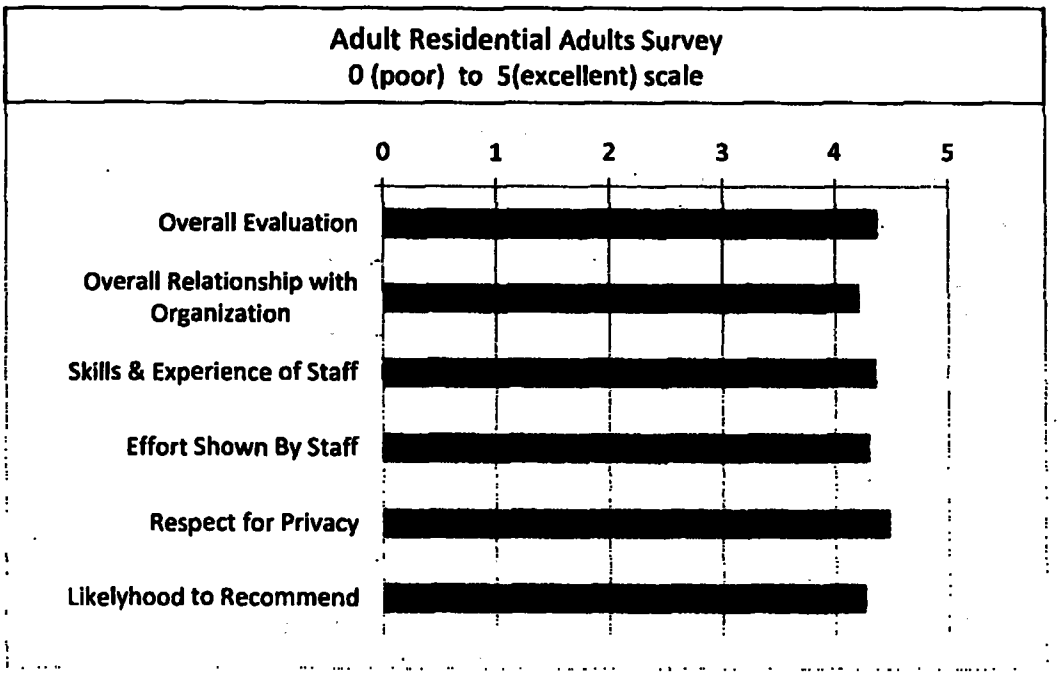
severity. Services include supervision and supports to enable individuals to participate in their home living setting, community and leisure activities, social interaction and other services (habiltiative or rehabilitative), and appropriate day treatment in another setting.

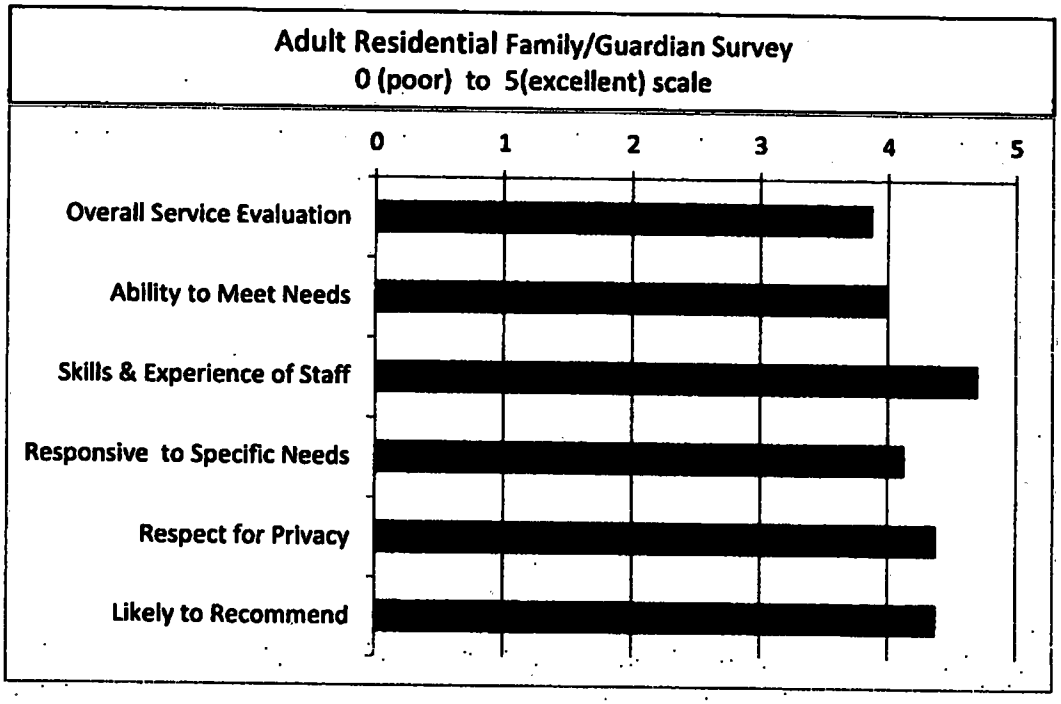
Non-licensed living is a community living arrangement for adults with disabilities who do not require 24-hour supervision. Individuals remain independent for the majority of day, but require overnight due to physical transfer and other assistance needs. This contract supports overnight staff that provides essential to enable individuals to live in a typical community setting, rather than move into a nursing home to receive overnight services.

Supported living assists adults to maintain ability to live independently within a home setting of his/her choice with appropriate level of support. Service may include personal assistance and regular living activity assistance, adaptive and living skill training and other supports. This contract contributes to helping individuals without other sources of funding to maintain community living.

In June 2012, Easter Seals UCP service enrollment for adults with I/DD, included 956 individuals, of whom 15% were supported in a licensed group home and 85% were supported in non-licensed community living (i.e. supported living, alternative family living, personal family living). This contract supported 24% of all Easter Seals UCP adult consumers living in a licensed group homes.

Results from third-party evaluation surveys for Easter Seals UCP's Adult Residential service line demonstrate high levels of individual satisfaction with service and supports.





Employment 509 adults served

Easter Seals UCP provided Supported Employment services to adults with intellectual and developmental disabilities (IDD) to seek, obtain and maintain meaningful work and participation in typical community settings. Supported Employment is a well-defined approach recognized as a best practice, such as by the NC MHDDSAS, NC Vocational Rehabilitation and the NC Evidence Base Practice Center. By federal definition, supported employment is described as "competitive work in integrated work settings...consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals, for individuals with the most significant disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability." To achieve this supported employment for adults with I/DD, Easter Seals UCP provided such services as evaluation, job development, job skills training, adaptive, social and living skills training, job placement, job coaching, employer consultation, long term support and other activities. Services under this contract are related to supporting individuals whose support needs are otherwise unbillable to another funding source.

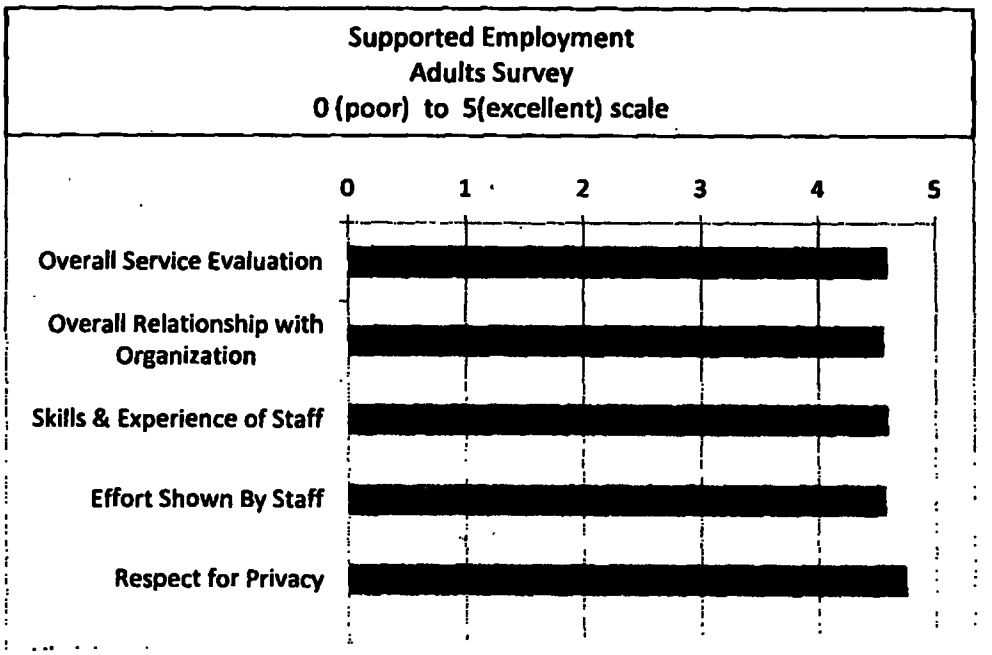
Adults served range in age from 17 to 70+ years old. Their developmental disabilities and/or delays related to a wide range of conditions. Many have co-occurring diagnoses. Disability categories include but are not limited to, Cerebral Palsy, Asperger's, Autism Spectrum Disorder,

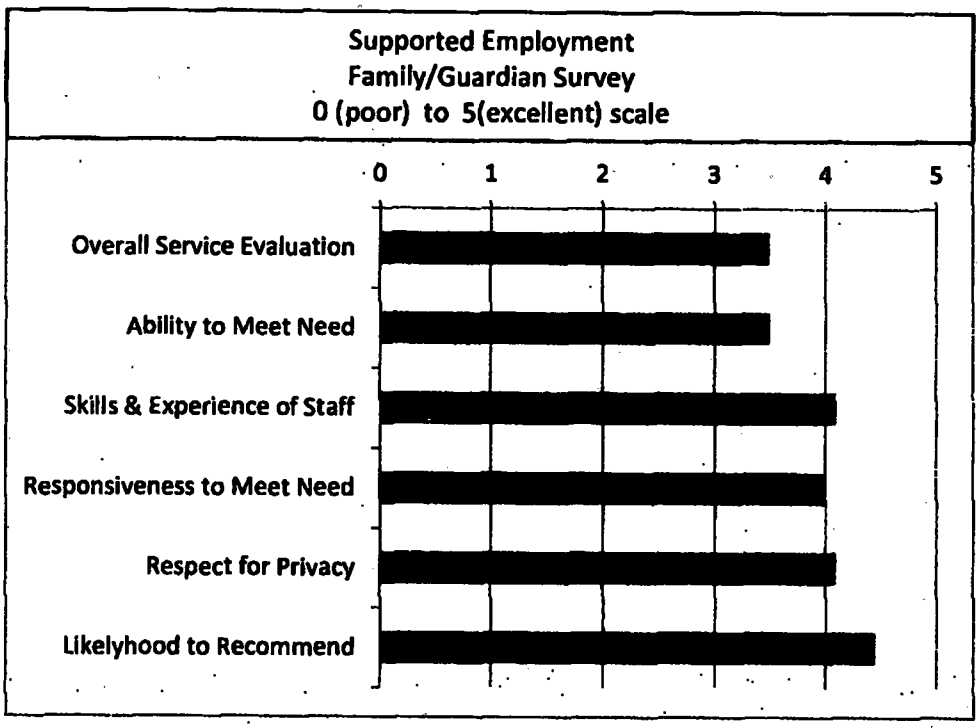
mental retardation, Down Syndrome, Traumatic Brain Injury, Muscular Dystrophy, Spina Bifida, Williams Syndrome.

Easter Seals UCP achieved 374 job placements during FY 12. As a community-based service, programs have an office location, but serve adults in multiple counties within their region. Supported Employment is provided to adults from 40 counties.

Easter Seals UCP program & office location	Counties Served	Job Placements
Charlotte	Mecklenburg, Cabarrus, Union, Gaston	76
Greensboro	Guilford, Forsyth, Rockingham, Stokes	22
Greenville	Pitt, Hyde, Martin, Terrell, Washington, Pasquotank, Chowan, Currituck, Dare, Gates	31
Neuse – New Bern	Craven, Carteret, Jones, Lenoir, Onslow, Wayne	83
Raleigh	Wake, Johnston, Franklin, Granville, Vance, Warren	49
Roanoke Rapids	Edgecombe, Nash, Halifax	17
Wilmington	New Hanover, Brunswick, Pender, Columbus, Bladen, Robeson, Scotland	96
		374

Results from third-party evaluation surveys for Easter Seals UCP's Supported Employment service line demonstrate high levels of individual satisfaction with service and supports.





Developmental Day

198 children (ages 3-5) served

Easter Seals UCP provided individualized programming within inclusive, licensed child development centers for children, ages 3-5, with or at risk for developmental disabilities and atypical development. Children received childcare, early education and intervention, specialized instruction, family support and training and pediatric therapy. Easter Seals UCP Children's Centers hold the highest 5-star licenses from the NC Division of Child Development and are certified to provide Developmental Day services. This contract supported essential hours of services to children not otherwise funded by other sources.

Teachers and therapists facilitate inclusive strategies, modifications and environmental support to ensure children with and without disabilities equally participate in educational, therapeutic and play activities. Easter Seals UCP implements Creative Curriculum, a developmentally appropriate pre-school curriculum approved by the National Association for the Education of Young Children. The curriculum is recognized for its appropriateness to meet the developmental needs of both typical and special needs children. Children served by contract had developmental disabilities and/or delays related to a wide range of conditions, such as but not limited to, cerebral palsy, autism, mental retardation, cognitive delay, visual impairments, chromosomal disorders, traumatic injury and medically fragile conditions.

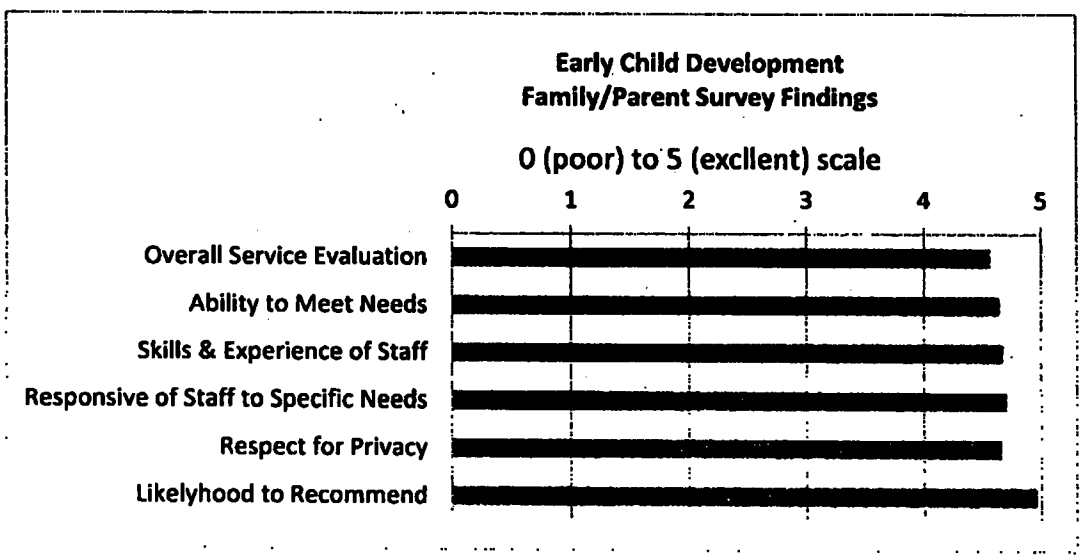
Children Centers' combined typical monthly enrollment for 3 to 5 year olds was 139 (48%) special needs and 148 (52%) typically developing children. Programs are located in both urban and rural counties:

Easter Seals UCP program	Location	Counties Served
Alleghany Children's Center	Sparta	Alleghany
Cape Fear Children's Center	Spring Lake	Cumberland, Harnett
Charlotte Children's Center	Charlotte	Mecklenburg
Summer Moore Children's Center	Greenville	Pitt, Beaufort
Charlie Gaddy Children's Center	Wake	Wake
Stepping Stones Children's Center	Lee	Lee, Harnett
Dorothy Spainhour Children's Center	Fayetteville	Cumberland, Harnett
Wilmington Children's Center	New Hanover	New Hanover, Brunswick Pender
Woodlawn	N. Wilkesboro	Wilkes
Craven-Cherry Point	Havelock	Craven, Carteret

Of 3-5 year olds with or at risk for disabilities:

- 60 children transitioned from developmental day to kindergarten at the end of the FY12.
- 44% of graduating special needs children transitioned to fully inclusive or mainstream educational settings to participate in kindergarten with typically developing peers.

Results from third-party evaluation surveys for Easter Seals UCP's Early Child Development service line demonstrate high levels of parent satisfaction with service and supports.



Budget & Positions

This Purchase of Service contract was for $1,083,478. Expenditures are broken out by service area. No administrative costs were charged to the contract. The per person cost of services was $1,468.10. No positions were funded by the contract. The total allowable funding was pulled down by March 31, 2012. Easter Seals UCP continued to provide supports and accrue unfunded service units beyond this contract amount.

	Budget 7/1/2011-6/30/2012				Actual 7/1/11-3/31/2012	
	Est. Units	Rate	Type	Amount	Units	Expended
Group Living Low	5,475.00	29.68	day	$189,170.00	2,495.00	$74,051.60
Group Living Moderate	8,395.00	45.79	day	$384,407.00	3,334.00	$152,758.07
Group Living Moderate - Unique	1,460.00	114.72	day	$164,491.00	1,035.00	$118,735.20
Non-licensed Group Living	730.00	38.24	1/3 day	$27,915.00	265.00	$10,133.60
Supported Living	2,078.00	17.84	hour	$37,072.00	676.00	$12,059.84
Supported Employment	10,208.00	44.84	hour	$457,727.00	1,915.50	$82,615.22
Developmental Day	26,880.00	18.96	unit (4units/hr)	$509,645.00	41,398.95	$784,919.35
	55,226.00			$1,770,427.00	51,119.45	$1,235,272.88
Contract Purchase of Service				$1,083,458.00	Received*	$1,083,458.00
					*Amount drawn down by March 31, 2012	

Easter Seals UCP FY 12 Contract Autism Early Intervention Services

The Centers for Disease Control estimates that 1 in 88 children born will be diagnosed with Autism Spectrum Disorder. Although the average age that a child may be diagnosed with Autism Spectrum Disorder is between 4.5 and 5.5 years of age studies show that 51– 91% of children's records show developmental concerns before age 3. The number of children diagnosed with Autism Spectrum Disorder is continuously rising. Research supports the critical importance of early intervention in young children diagnosed with Autism Spectrum Disorders as a means of insuring positive outcomes for the individual. Several effective interventions have been identified by the National Research Council to include:

- Entry into intervention as soon as autism spectrum disorder is seriously considered.
- Prompt educational intervention and routine screenings.
- Active engagement in intensive instructional programming for at least 25 hours per week
- Sufficient amount of adult attention in one-to-one and very small group instruction
- Low student/teacher ratios
- Inclusion of a family component, including parent training.
- Mechanism for on-going program evaluation and assessment of individual children's progress.

The primary goal of the contract project is to implement effective early intervention strategies with young children diagnosed with Autism Spectrum Disorder. The project provides scholarships to children on the Autism spectrum to attend a five-star licensed inclusive children's center with high quality early intervention, instruction, social skills training and family support. The project uniquely offers children on Autism spectrum to receive direct intensive early intervention supports, parent trainings and home visits. The inclusive children's center environment exposes children on Autism spectrum to peer modeled behaviors that can increase their socialization skills, which is critical for those with autism. In addition to the inclusive environment additional therapeutic services are offered to include: Speech Therapy, Occupational Therapy, Physical Therapy, and Community Based Rehabilitative Services.

Services are provided in three Easter Seals UCP inclusive children's centers:

Cape Fear Children's Center	Spring Lake, NC	Cumberland County
Spainhour Children's Center	Fayetteville, NC	Cumberland County
Charlie Gaddy Children's Center	Raleigh	Wake County

<u>Activities & Outcomes</u>

Twenty-five (25) children with autism were supported with early intervention within inclusive, early child development settings. Early childcare teachers, autism instructions and therapists provided an array of early intervention services. These services included evaluative assessments, educational services, individualized one-to-one special instruction, peer-to-peer

play facilitation, occupational and speech therapy, transportation assistance and family support services. Collaboration with Autism Society of NC and other consultative autism and early intervention experts for onsite integrated training to program instructional staff.

All children were documented as diagnosed or at-risk for diagnosis for Autism Spectrum Disorder. Children ranged in age from 2 years 1 month to 5 years 7 months. The average age was 4 years 6 months. Children receiving services reside in Cumberland, Harnett and Wake Counties.

- Twenty-five (25) children received services and financial assistance to participate within inclusive centers. This exceeded the target of 10-15 children.
- Sixteen (16) children received intensive early intervention within Cape Fear Children's Center. This level of service includes 6 hours of services per day, in which 4 hours are direct instructional and skills support provided by a one-to-one instructor.
- Nine (9) children attending the two sister children's centers received technical support, teacher consultation and other strategies to support their inclusive participation in early intervention and educational activities.
- Children received scholarships to participate with inclusive centers.
- Six (6) parent trainings and support events were offered.
- Six (6) staff trainings.

For the sixteen children (16) receiving intensive levels of autism early intervention services:

- 100% demonstrated improvement on at least 1-2 measures of the Early Social Communication Skills assessment.
- 100% demonstrated improvement on at least 1-2 levels of Symbolic Play Assessments.
- 100% mastered at least 60% of all initial Individualized Family Service Plan/Individualized Educational Plan goals.
- 100% showed progress in at least 3 areas of development measured by portfolio based assessment.
- 100% of children in two sister children's centers demonstrated improvement to succeed in their classrooms and meet the target goals on their IFSP/IEP with technical support.
- 100% of parents responding to surveys reported satisfaction with the program and communication with their child's autism instructor.

Budget & Positions

	Budget	Actual Expenditures
Personnel Costs	329,196	329,196
Supplies & Materials	7,375	6,978
Operational	22,741	22,741
Fixed Charges	7,391	7,391
Capital Outlay	-	
Grants/Contracts	-	
Purchase of Service	-	-
Indirect	-	-
Total	366,703	366,306

The contract supports the 10.7 FTE positions, as follows:

Position	# Positions	Total FTEs
Autism Coordinator	1	1.0
Educational Coordinator	1	0.25
Individual Instructors	5	5.0
Specialized Instructor	1	1.0
Infant Toddler Specialist	1	0.75
Lead Teachers	4	1.0
Assistant Teachers	5	1.25
Center Director	1	0.20
Administrative assistant	1	0.25
	20	10.7

PREVENT BLINDNESS NORTH CAROLINA

4011 WestChase Blvd. Suite 225 Raleigh, NC 27607 919-755-5044

The Kenneth Royall Children's Vision Screening Improvement Program

And

The North Carolina Preschool Vision Screening Program

Report for Contract Year 2011-2012
and Planned Year 2012-2013

August 30, 2012

Part I: The Kenneth Royall Children's Vision Screening Improvement Program

A. Description of program activities of Prevent Blindness North Carolina.

The Kenneth Royall Children's Vision Screening Improvement Program is a public-private program of training and certification for school vision screeners offered to all of the state's 100 counties, led by Prevent Blindness North Carolina [PBNC] and the School Health Unit of the Children and Youth Branch of DHHS. School screenings are North Carolina's principle means of performing pediatric vision screenings.

B. Activities funded by 2011-2012 State contracts, contract amounts, and program narrative.

The program is funded by a $419,000 State contract through DHHS. It offers training and certification for volunteer school vision screeners, as well as follow-up services.

Each three-hour training and certification workshop for local volunteer vision screeners includes instruction in the components of vision; the conditions that put children at risk for vision deficiencies; proper screening procedure, including standards, preparation, and techniques; resources available for low-income families and best practices in record-keeping, referral, and follow-up. Each includes a supervised practice session and a required demonstration of mastery of screening techniques by all participants. Certification is for two years.

PBNC's primary screening target is the state's 2022 elementary, middle, and charter schools.

C. Output data demonstrating the effects of the organization's activities.

The 2011-2012 training and certification workshops for vision screeners commenced on June 2, 2011 in Granville County and concluded on May 16, 2012 in Iredell County. During the 2011-2012 contract year, PBNC completed a total of 191 workshops and trained 3,341 vision screeners from 89 counties.

Combined with the 3,484 vision screeners PBNC trained from June 2010-May 2011, North Carolina had 6,825 total certified vision screeners during the two-year period, representing all 100 counties. (Because of constant turnover in the state's vision screening volunteers, certification is for a two-year period only. PBNC maintains a rolling two-year accounting of the total number of trained screeners. As of contract year 2011-2012, PBNC no longer includes the 3,285 screeners it trained in 2009-2010 in its total of current vision screeners.)

2011-2012 contract guidelines call for one certified screener for every 135 students in the target grades, or some 6,000 trained screeners for the state's K-6 population. These guidelines were exceeded with the state's 6,825 certified screeners at the close of the contract year.

In the period encompassing contract years 2010-2011 and 2011-2012, PBNC held 379 vision-screening workshops with participants from all 100 North Carolina counties.

Table 1 shows participation in the 191 workshops PBNC conducted in contract year 2011-2012, by county.

County	# Screeners Trained
Alamance	8
Alexander	39
Alleghany	4
Anson	11
Ashe	17
Avery	2
Beaufort	25
Bertie	0
Bladen	0
Brunswick	25
Buncombe	201
Burke	12
Cabarrus	43
Caldwell	9
Camden	9
Carteret	18
Caswell	8
Catawba	37
Chatham	5
Cherokee	36
Chowan	0
Clay	27
Cleveland	42
Columbus	76
Craven	24
Cumberland	138
Currituck	53
Dare	8

County	# Screeners Trained
Jones	6
Lee	7
Lenoir	14
Lincoln	7
Macon	10
Madison	20
Martin	27
McDowell	22
Mecklenburg	60
Mitchell	15
Montgomery	44
Moore	0
Nash	20
New Hanover	21
Northampton	0
Onslow	66
Orange	14
Pamlico	16
Pasquotank	19
Pender	22
Perquimans	3
Person	7
Pitt	33
Polk	35
Randolph	84
Richmond	36
Robeson	3
Rockingham	26

Davidson	54	Rowan	11
Davie	1	Rutherford	38
Duplin	0	Sampson	14
Durham	80	Scotland	0
Edgecombe	9	Stanly	48
Forsyth	166	Stokes	89
Franklin	9	Surry	2
Gaston	63	Swain	13
Gates	14	Transylvania	39
Graham	0	Tyrell	0
Granville	5	Union	86
Greene	21	Vance	7
Guilford	209	Wake	595
Halifax	18	Warren	15
Harnett	2	Washington	14
Haywood	1	Watauga	11
Henderson	40	Wayne	26
Hertford	2	Wilkes	10
Hoke	0	Wilson	0
Hyde	10	Yadkin	5
Iredell	48	Yancey	5
Jackson	32		
Johnston	15	All Counties	3341

TABLE 1: VISION SCREENERS CERTIFIED IN CONTRACT YEAR 2011-2012, BY COUNTY

The 3,339 participants in the training and certification workshops in 2011-2012 fell into occupational categories as shown in Table 2.

Teachers, TAs, Nurses, other school personnel	Volunteers and Students	Total
39%	61%	100%

TABLE 2: CERTIFIED VISION SCREENERS BY OCCUPATION, CONTRACT YEAR 2011-2012

513,884 children were screened in North Carolina during the 2011-2012 school year, representing a number equivalent to 65% of the target population of 792,833 K-6th graders. Of those 513,884 screened, 39,999 were referred to eye care professionals, an 8% referral rate.

Table 3 displays the 2011-2012 screening and referral data that counties have reported to PBNC to date.

Counties	# Screened	# Referred	% Referred	Counties	# Screened	# Referred	% Referred
Alamance	9,898	1,034	10%	Jackson	810	50	6%
Alexander	1,801	103	6%	Johnston	10,289	981	10%
Alleghany	1,049	34	3%	Jones	297	55	19%
Anson	2,838	161	6%	Lee	8,455	449	5%
Ashe	1,032	51	5%	Lenoir	3,147	212	7%
Avery	1,387	71	5%	Lincoln	4,858	350	7%
Beaufort	1,877	275	15%	Macon	2,975	238	8%
Bertie	203	20	10%	Madison	1,760	53	3%
Bladen	1,730	231	13%	Martin	1,381	108	8%
Brunswick	3,923	285	7%	McDowell	2,475	218	9%
Buncombe	9,383	759	8%	Mecklenburg	64,760	5,285	8%
Asheville City	1,551	116	7%	Mitchell	337	10	3%
Burke	5,009	371	7%	Montgomery	1,167	190	16%
Cabarrus	8,890	753	8%	Moore	4,857	222	5%
Kannapolis City	1,690	154	9%	Nash	5,145	708	14%
Caldwell	1,465	193	13%	New Hanover	7,550	644	9%
Camden	1,058	86	8%	Northampton	920	91	10%
Carteret	4,823	100	2%	Onslow	8,763	667	8%
Caswell	1,234	117	9%	Camp Lejeune	0	0	0%
Catawba	10,427	710	7%	Orange	2,872	172	6%
Hickory City	1,700	136	8%	Chapel Hill-Carrboro	4,095	236	6%
Newton-Conover	1,286	124	10%	Pamlico	802	47	6%
Chatham	3,436	398	12%	Pasquotank	1,877	74	4%
Cherokee	1,698	100	6%	Pender	2,920	105	4%
Chowan	797	106	13%	Perquimans	705	46	7%
Clay	958	50	5%	Person	2,369	238	10%
Cleveland	6,755	293	4%	Pitt	6,047	662	11%
Columbus	2,474	219	9%	Polk	660	50	8%

Whiteville City	919	82	9%
Craven	5,848	467	8%
Cumberland	19,805	1,300	7%
Ft. Bragg	2,841	0	0%
Currituck	938	51	5%
Dare	1,999	230	12%
Davidson	2,424	273	11%
Lexington City	1,115	148	13%
Thomasville City	1,143	64	6%
Davie	2,325	254	11%
Duplin	3,461	244	7%
Durham	2,792	344	12%
Edgecombe	2,314	189	8%
Forsyth	22,925	1,534	7%
Franklin	2,937	260	9%
Gaston	9,063	912	10%
Gates	866	38	4%
Graham	393	6	2%
Granville	1,999	78	4%
Greene	290	33	11%
Guilford	20,579	1,717	8%
Halifax	1,211	91	8%
Roanoke Rapids	1,939	75	4%
Weldon City	500	36	7%
Harnett	1,484	222	15%
Haywood	3,217	151	5%
Henderson	5,099	374	7%
Hertford	384	54	14%
Hoke	1,874	157	8%
Hyde	190	15	8%
Iredell	7,606	472	6%
Mooresville City	2,298	277	12%

Randolph	3,527	329	9%
Asheboro City	1,572	163	10%
Richmond	4,058	572	14%
Robeson	9,189	1,052	11%
Rockingham	7,519	430	6%
Rowan	7,207	355	5%
Rutherford	3,778	258	7%
Sampson	990	144	15%
Clinton City	571	78	14%
Scotland	1,924	84	4%
Stanly	4,156	293	7%
Stokes	2,615	155	6%
Surry	6,524	349	5%
Elkin City	800	32	4%
Mt. Airy City	918	53	6%
Swain	634	46	7%
Transylvania	2,344	122	5%
Tyrell	215	29	13%
Union	21,112	1,231	6%
Vance	1,658	159	10%
Wake	35,499	2,701	8%
Warren	654	77	12%
Washington	659	116	18%
Watauga	2,678	67	3%
Wayne	6,734	700	10%
Wilkes	5,584	457	8%
Wilson	1,774	325	18%
Yadkin	2,507	212	8%
Yancey	1,041	51	5%
All Counties	513,884	39,999	8%

TABLE 3: 2011-2012 SCREENING AND REFERRAL DATA REPORTED BY COUNTIES THROUGH MAY 31, 2012

School nurses, parents, and students across the state have expressed positive opinions of the program and have shared numerous success stories. Representative comments include the following:

Kayla, age 7, a 1st grader from Carl Furr Elementary was referred for a screening by her teacher. Kayla had glasses but lost them and could not receive another pair of glasses from Medicaid until June. She was reported as having trouble seeing in class which affected her performance. Funding for her new pair of glasses was received from the Healthy Eyes Eyeglass program through PBNC. Now that she is wearing glasses again, she is doing much better in class. Her teacher states that he has not seen her squinting and struggling to see the board.

Kay C., RN,Cabarrus Co. Schools

This is a wonderful resource to those children that do not have Medicaid. From most of my experience these children are the ones who would fall through the cracks and never get glasses without the funding through Prevent Blindness.
All the school nurses are very grateful to PBNC for the wonderful training and resources made available to our students. The trainings are excellent. Vision screenings are more accurate. It increases awareness about how accurate vision impacts academic success. Support from PBNC staff is excellent. Thank You!

Lucy K., RN, Alamance Co. Schools

We found a child in second grade with an undiagnosed lazy eye. She has been to Asheville to a specialist and hopefully will not require surgery.

Tammy C., RN, Ashe Co Schools

Jah'nila, age 7, is a third grader who was recommended to have a screening by her teacher. There was no family history of vision problems, yet she was prescribed glasses. She received her glasses through the help of a VSP voucher. Her teacher was very grateful to have her receive glasses and she has improved her work in class. Jah'nila was so excited to be able to see better and her teacher stated that the expression on her face when she came to school with her new glasses was priceless!

Denise N., RN, Bertie Co. Schools

As always, Prevent Blindness affords the opportunity to break down financial barriers to access vision services for children. Children who cannot see may not be able to learn at their best potential. This program is very valuable and has been a lifesaver for some of our families. It is such a pleasure to work with all the staff at Prevent Blindness North Carolina. Thank you for everything.

Shannon P., RN, Person Co. Schools

A first grade teacher reports improvement in academic work and more enthusiasm about learning in regards to students we have served. Another first grade teacher reports improvement academically and behavior wise. She is receiving positive comments from parents and Special Ed. teachers. Parent thanked me for checking vision due to change in prescription that parents were not aware of until vision screening.
Lisa K., RN, MSN, Burke Co. Schools

Emily, a 5th grader, was screened and found to need glasses. Her parents took her for an eye exam and received a pair of glasses. Now Emily reports, "The smart board was really blurry before and I could hardly see it. Now I can see it great."
Flo B., RN, Cabarrus Co. Schools

PBNC has a huge impact on our school system. Our HOSA students were trained and helped with the screening process. Without their help, we would have only screened 1st and 6th grades. The voucher program also helps our students get the glasses they need and it is a tremendous help. We are very thankful to have the PBNC training. It has helped us significantly to screen accurately and provide certified screeners.
Terri W., RN, Gates Co. Schools

PBNC is a great asset to the school health program because they are able to provide many needy children with eye exams and glasses that would not otherwise be able to get them. Many students do not have insurance or Medicaid to pay for these services. PBNC has convenient, friendly services for the families we serve. The PBNC training provides up-to-date screening guidelines, additional resources and supplies to school nurses.
Carol E., RN, Nash-Rocky Mount Schools

D. Additional activities in 2011-2012 merit mention.

Vision Resource Guide
Each year PBNC develops and distributes a Vision Resource Guide. The resource guide provides individuals, health departments, departments of social services and school system staff with a better understanding of the resources available for securing eye care for those in financial need throughout our state. PBNC mailed one vision resource guide to each North Carolina Health Department.

School Nurse Consultation
PBNC serves as the primary vision screening resource for school nurses and administrators across North Carolina. During the 2011-12 contract year, PBNC certification program staff conducted strategy meetings to assess and enhance existing school vision screening programs

in each North Carolina school district. PBNC additionally conducted 29 in-service vision screening certification workshops tailored for school nurses. The in-service certifications are designed to be more interactive and include discussion about vision screening processes as well as issues specific to administering successful school vision screening programs.

Vision Service Plan. Vision Service Plan (VSP) distributes vouchers redeemable for eye exams, glasses, and other products and services to Prevent Blindness America affiliates and other non-profit organizations. PBNC has integrated the extensive use of VSP vouchers into its system for providing follow-up services to families whose children have been diagnosed as needing professional eye care but cannot afford such care. During the 2011-2012 school year, PBNC issued 993 VSP vouchers to North Carolina children. The average value of each voucher was $147, making the program value to North Carolina total almost $146,000.

Donor Docs Program
Prevent Blindness North Carolina, with the support of the Early Childhood Vision Care Commission, introduced the Donor Docs Program in 2008 to mirror the eye care services previously funded through the state ECVC Program. Eye care professionals have the opportunity to provide their donated services to a large group of individuals to include children in preschool through 12th grade, as well as adults, referred through vision screenings. During the 2011-2012 year, 179 doctors volunteered to donate a total of 532 eye exams and 367 pairs of glasses. Vouchers were issued to 380 children and adults across the state.

Healthy Eyes Program
In 2010, Prevent Blindness launched the Healthy Eyes Eyeglass Program in collaboration with Luxottica. This program provides eye glasses for children and adults. During the 2011-2012 school year, 404 children and 148 adults were served through this program at an estimated value of $59,000.

E. Planned objectives and activities for the 2012-2013 contract year.

PBNC's objective for 2012-2013 is to train more than 3,000 screeners using revised training manuals and materials. PBNC will invite volunteer screeners to attend local workshops throughout North Carolina. PBNC will provide participants with all of the charts and screening materials they will need to conduct screenings and record their results. PBNC will certify the trained screeners for two years when they have completed their workshops and demonstrated their mastery of the subject matter.

PBNC's objective for the 2012-2013 contract year is to provide sufficient recruitment services, training, coordination, support, and follow-up to produce a screening infrastructure in North Carolina that will screen a minimum of 504,869 children as well as maintain a statewide referral rate of approximately 7% (±3%).

Part II: The North Carolina Preschool Vision Screening Program

A. Description of program activities of Prevent Blindness North Carolina.

The North Carolina Preschool Vision Screening Program screens children using paid PBNC personnel and local healthcare professionals. The Preschool program serves children ages 2-5, including learning disabled children and children with language delays. The program uses photo-refractive screening technology.

The Preschool Program conducted screenings in 486 child care centers during the 2011-2012 contract year. Participating centers included Head Start centers, NC PreK sites, Title 1 PreK programs, and private childcare centers.

B. Activities funded by 2011-2012 State contracts, contract amounts, and program narrative.

The program is funded by a $450,000 state contract through the School Health Unit of the Children and Youth Branch of DHHS. Like the Kenneth Royall Program, the Preschool Program is coordinated through the Division of Public Health of DHHS.

During the photo-refractive screening in childcare centers, a non-invasive photograph is taken of the child's eyes and is analyzed for possible vision problems, to include refractive errors such as nearsightedness and farsightedness, misalignment, astigmatism, and opacities such as cataracts. The primary purpose of the PBNC preschool vision screenings is to detect vision problems that can to amblyopia, a condition that will lead to permanent vision loss if not treated at an early age, preferably during the preschool years.

C. Output data demonstrating the effects of the organization's activities.

During the 2011-2012 contract year, which ended May 31, 2012, the Preschool Program operated in 29 counties and assisted the health department in one other. The program screened 24,184 children and referred 2,149 (9%) to eye care professionals. PBNC also distributed educational materials regarding the signs of possible vision problems to the parents/guardians of 27,522 children, as well as the center directors and teachers.

Table 4 displays the screening totals for all counties served during 2011-2012.

County	# Centers	# Offered	# Screened	# Referred
Alamance	15	350	311	43
Brunswick	2	153	129	5
Buncombe	31	1559	1337	85
Burke	14	696	591	46
Caldwell	6	384	365	32
Chatham	10	355	320	36
Cumberland	59	3425	2888	254
Down East	10	84	615	74
Durham	22	1098	955	86
Forsyth	54	2786	2479	250
Franklin	4	84	84	14
Guilford	21	809	683	66
Harnett	4	112	106	14
Henderson	6	343	308	18
Johnston	42	1821	1500	127
Lee	2	119	103	10
Lenoir-Greene	3	237	228	28
Mecklenburg	36	3110	2588	253
New Hanover	38	2631	2263	190
Orange	15	405	332	47
Pender	4	192	168	9
Robeson	1	60	53	7
Rowan	1	64	55	11
Sampson	3	202	186	13
Stokes	1	62	47	9
Wake	75	5890	5052	382
Wilson	7	491	438	40
Total	**486**	**27522**	**24184**	**2149**
Total Centers	**486**			
Total Offered	**27522**			
Total Screened	**24184**			
Utilization Rate	**88%**			
Total Referred	**2149**			
Referral Rate	**9.00%**			

Table 4: 2011-2012 screening totals

PBNC utilized a portion of the program's funding to serve NC PreK, Head Start and Title 1 PreK students. 10,830 children were screened in 216 of these sites across the state. Many of these sites depend on PBNC to help fulfill the state's requirement for their students to receive vision screenings each year.

As of July 31, 2012 PBNC had completed follow-up with 70% of all referred children to determine confirmed care and necessary glasses or other treatment. Follow-up is ongoing and it is anticipated to reach 75% confirmed care by September 30, 2012. PBNC offers every child whom is screened and referred to an eye care professional, and whose family cannot afford to pay for professional services, free eye examinations, glasses, and other treatment.

Throughout the screening year PBNC distributed follow-up questionnaires to the participating childcare centers. Success story information was also requested from the parents of the referred children who were seen by eye care professionals and diagnosed as having vision problems. Below is just a small sample of the overwhelming support shown each year for the preschool program.

Words cannot express how grateful I am to your organization for the eye screening that you recently conducted at my daughter Vivian's daycare. Vivian is two years old and was diagnosed with far-sighted vision that is so poor, she is legally blind. However, I never suspected that she had a vision problem as there were no obvious indicators. Because of your screening and the recommendation you provided suggesting that she see an eye doctor, my daughter's vision problem will more than likely be corrected with glasses. I am beyond grateful for your organization's pro-active mission. The service you provide is not only necessary but is critical for young children. Therefore I am spreading the word about Prevent Blindness NC and the value of the free screenings you offer across the state.
Melissa, Vivian's mom, Forsyth County

Another good screening find. Keep up the good work!
Dr. Brian Jackson, Eye Care Associates

I am really grateful for this program because being able to see clearly is critical to learning and so many of our parents may not think to take their children to the eye doctor for an exam.
Center Director, Durham County

Talon has moderate astigmatism – he needed glasses; he loves them!! Thank you so much for what you all do!!!
Talon's mom, Pender County

A number of years ago a very serious tumor was discovered by your screening. The little girl was in danger of losing her sight. We thank the program and thank the screeners for their good work. We can't say enough about this wonderful program!
Center Director, New Hanover County

I am thankful for this test for the children's sake. I wish it could have been done when my sons were in daycare, for I did not know one son had eye problems until he began public school.
Center Director, Johnston County

Naomi was seen by an ophthalmologist in December and was prescribed glasses. She was diagnosed with amblyopia. She will begin patching as well. Thank you so much for providing such a wonderful service! I never would have guessed that she had a need for glasses because she only needs the prescription for one eye. Thank you!
Naomi's mom, Wake County

We have done this for several years. Each year we have had a wonderful experience. The staff is very efficient. The results have allowed parents to provide glasses and medical care early on for our Pre-K students."
Pre-K teacher, Sampson County

"Great experience! So glad you were able to provide these screenings. What a great resource for these young students!"
Jessica M., Preschool Director, Mecklenburg County

"The screening is wonderful!! Our children love it! Our parents are so grateful that you provide such a needed service to our center. Thank you so much!"
Renee S., Center Director, Guilford County

D. Planned objectives and activities for the 2012-2013 contract year.

PBNC's objective for 2012-2013 is to screen 24,000 children ages 2-5 in preschool settings to include NC PreK (formerly More @ Four), Head Start and Title 1 PreK classes as well as private childcare centers. Paid PBNC personnel and local healthcare professionals will complete the screenings. PBNC will maintain a referral rate between 6% and 9%.

Part III: The Combined Programs

In 2011-2012, PBNC secured $538,342 in foundation support, corporate and professional in-kind contributions, and PBNC cash matching grants to help fund the Kenneth Royall and Preschool programs. That amount boosted the combined state funding of $869,000 by more than 62%.

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

2-21-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Cethen	NC. Division Services for Blind
Care Prevette	Services for the Blind
Eddie Weaver	Services for the Blind
D Orr	NCRMA
Peyton Maynard	[illegible]
[illegible]	[illegible]
Andy Chase	KMA
Chris McClure	Brooks Pierce
[illegible]	NCALTIF
Julia Adams	The Arc of NC
[illegible]	The Policy Group
John Metcalf	Policy Group
Fred Weedale	Easter Seals UCP
C L Cochran	" " "
Mar [illegible]	The Mariposa School
Jessica Harwell	The Mariposa School
Marcia Brantley	Prevent Blindness
Jennif Yalbot	Prevent Blindness

09-21-201

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

2/21/13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lindsay Welsh	DSOHF
Lisa Moon	DSOHF
Adam Shelar	DHHS
Sherry Bradley	DHHS
Sarah Wolfe	MWC LLC
George Smith	Nexsen Pruet
Helen Tack	DHHS, DAAS
Alicia Blater	DHHS, DAAS
Suzanne Merrill	DHHS, DAAS
India Heckstall	intern Legislative
Matt Gray	NCPC
Tracey Sheriff	NSNC
Alexander Myers	ASNC
Jimmy Broughton	Womble
Judy Mahan	ASNC
Mary Bell	AARP. NC
Ken Melton	K.M.A.

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

2/21/13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TRACY COLVARD	AHEC
John Hardin	NCHCS
Lauren Absher	NASW-NC
Kay Paksoy	NASW-NC
Tara Moore	The Arc of NC
[illegible]	Benchmarks
Annaliese Dolph	BRNO
[illegible]	SEBHC
Valarie A Gaskins	Nurse of Day. Vidant Health System
Corye Barnes	DRNC
Benton Albritton	ABC of the Carolinas

09-21-201

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

2-21-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Holly Hunnicutt	The Arc of NC 5041 Newcentre Dr. St 100 Wilm, NC 28409
[illegible]	TC [illegible]
PAUL WENDLER	AUTISM SOCIETY OF NC
Kerri Erb	Autism Society of NC
Janice White	Div. of MH/DD/SAS
JOEL HAMNARD	GPM & ASSOC
John McMillan	MFDS
Susan Rothacker	Brubaker & Assoc
Jonathan Brubaker	Brubaker & Assoc.
Paul Mott	Rep Avila's office
Kepe Harrison	The Arc of Wake County
CAROL ORNITZ	NC Brain Injury Advisory Council
JAY PETERS	CSS
[illegible]	CSS
[illegible]	GSK
John DelGiorno	Brubaker & Assoc.

09-21-201

JOINT APPROPRIATIONS SUBCOMMITTEE HEALTH AND HUMAN SERVICES

AGENDA

February 26, 2013
Legislative Office Building - Room 643
8:30 a.m.

Senator Ralph Hise, Presiding

Prevent Blindness	Jennifer Talbot, Chief Executive Officer
Overview: Division of Mental Health/Developmental Disabilities/Substance Abuse Services Division of State Operated Health Facilities	Denise Thomas Committee Staff Fiscal Research Division
Adjourn	
Next Meeting:	Wednesday, February 27, 8:30 a.m.

Joint House Committee on Appropriations Subcommittee on Health and Human Services
Tuesday,February 26, 2013 at 8:30 a.m
Room 643

MINUTES

The Joint Committee on Appropriations Subcommittee on Health and Human Services met at 8:30 a.m.on February 26, 2013 in Room 643. Representatives Avila, Brisso,Farmer-Butterfield, Ford, Fulghum, Hollo, Insko, Lambeth, Martin attended. Senators Hise, Pate, Barringer, McKissick were in attendance.

Senator Hise called the meeting to order but due to a conflicting committee meeting he turned the gavel over to Sen. Pate.

Pages were introduced. They were: Danielle Jones from the Senate,James Hennessy, Elizabeth Higdon, Melinda Kaufmann from the House.

Fred Hines, Marvin Lee, Charles Godwin, Leslie Wright, and Steve Wilson were the Sergeants of Arms.

Jennifer Talbot, Chief Executive Officer of Prevent Blindness made a presentation. (see attached).

Denise Thomas, Fiscal Research, gave an overview report of the Division of Mental Health, Developmental Disabilities and Substance Abuse and on the Divison of State Operated Health facitities. (see attached)

The meeting adjourned at 9:50 a.m.

Senator Louis Pate
Presiding

Susan Lewis, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 21, 2013 12:17 PM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Tuesday, February 26, 2013 at 8:30 AM

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Tuesday	February 26, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Table 15B: 2015 Projections of Psychiatric Bed Need
By Local Management Entity-Management Care Organization (LME-MCO)
Part 1. Projection of Child/Adolescent Psychiatric Bed Need for 2015

A	B	C	D	E	F	G	H	I	J
Local Management Entity-Managed Care Organization	2011 <18 Days of Care	2011 <18 Population Projected	2015 <18 Population Projected	2015 <18 Projected Days of Care (B x D)/C	2015 Adjusted Days of Care (E-20%E)	<18 Number of Beds Needed (F/365)	<18 Total Beds Needed (G/75%)	Child/Adol Inventory	Child/Adol Need (Surplus or Deficit) (I-H) Deficits are "-"
Cardinal Innovations 1: Cabarrus, Davidson, Rowan, Stanley, Union	3,629	196,611	194,129	3,583	2,867	8	10	0	-10
Cardinal Innovations 2: Alamance, Caswell, Chatham, Franklin, Granville, Halifax, Orange, Person, Vance, Warren	4,190	148,194	148,111	4,188	3,350	9	12	26	14
CenterPoint Human Services: Davie, Forsyth, Rockingham, Stokes	2,966	126,638	126,442	2,961	2,369	6	9	38	29
Coastal Care System: Brunswick, Carteret, New Hanover, Onslow, Pender	5,375	134,847	144,960	5,778	4,622	13	17	62	45
Cumberland (Alliance Behavioral Healthcare)	1,351	89,052	91,192	1,383	1,107	3	4	0	-4
Durham (Alliance Behavioral Healthcare)	889	61,636	66,851	964	771	2	3	5	2
East Carolina Behavioral Health: Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington	2,507	134,757	134,423	2,501	2,001	5	7	0	-7
Eastpointe: Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, Wilson	4,406	203,826	201,636	4,359	3,487	10	13	0	-13
Johnston (Alliance Behavioral Healthcare)	982	48,249	49,303	1,003	803	2	3	0	-3
MeckLINK Behavioral Healthcare: Mecklenburg	8,571	236,262	250,301	9,080	7,264	20	27	42	15
Partners Behavioral Health Management: Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, Yadkin,	3,831	213,533	207,743	3,727	2,982	8	11	27	16
Sandhills Center/Guilford: Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond	5,006	255,968	261,229	5,109	4,087	11	15	30	15
Smoky Mountain Center 1: Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain	919	37,651	38,087	930	744	2	3	0	-3
Smoky Mountain Center 2: Alleghany, Alexander, Ashe, Avery, Caldwell, McDowell, Watauga, Wilkes	782	69,671	67,528	758	606	2	2	0	-2
Wake (Alliance Behavioral Healthcare)	9,090	240,870	253,205	9,556	7,644	21	28	82	54
Western Highlands Network: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey	2,851	106,749	108,942	2,910	2,328	6	9	17	8
Child/Adolescent Grand Totals	57,345	2,304,514	2,344,082	58,790	47,032	129	172	329	

Table 15B: 2015 Projections of Psychiatric Bed Need
By Local Management Entity-Management Care Organization (LME-MCO)
Part 2. Projection of Adult Psychiatric Bed Need for 2015

J	K	L	M	N	O	P	Q	S
Local Management Entity-Managed Care Organization	**2011 18+ Days of Care**	**2011 18+ Population**	**2015 18+ Population Projected**	**2015 18+ Projected Days of Care (K x M)/L**	**Number of Beds Adults (N/365)**	**Total Beds Needed (O/75%)**	**Adult Inventory**	**Adult Bed (Surplus/Deficit) (Q-P) Deficits are "-"**
Cardinal Innovations 1: Cabarrus, Davidson, Rowan, Stanley, Union	17,841	560,042	585,400	18,649	51	68	107	39
Cardinal Innovations 2: Alamance, Caswell, Chatham, Franklin, Granville, Halifax, Orange, Person, Vance, Warren	23,738	516,270	537,246	24,702	68	90	127	37
CenterPoint Human Services: Davie, Forsyth, Rockingham, Stokes	17,546	413,573	425,171	18,038	49	66	190	124
Coastal Care System: Brunswick, Carteret, New Hanover, Onslow, Pender	19,986	495,313	521,882	21,058	58	77	74	-3
Cumberland (Alliance Behavioral Healthcare)	6,465	244,540	245,186	6,482	18	24	28	4
Durham (Alliance Behavioral Healthcare)	6,155	212,743	219,990	6,365	17	23	42	19
East Carolina Behavioral Health: Beaufort, Bertie, Camden, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, Northampton, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington	24,669	474,861	486,483	25,273	69	92	125	33
Eastpointe: Bladen, Columbus, Duplin, Edgecombe, Greene, Lenoir, Nash, Robeson, Sampson, Scotland, Wayne, Wilson	29,307	626,532	633,221	29,620	81	108	186	78
Johnston (Alliance Behavioral Healthcare)	4,246	126,945	134,855	4,511	12	16	20	4
MeckLINK Behavioral Healthcare: Mecklenburg	29,717	704,997	759,357	32,008	88	117	165	48
Partners Behavioral Health Management: Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry, Yadkin,	35,543	560,042	715,364	45,400	124	166	222	56
Sandhills Center/Guilford: Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, Richmond	32,258	804,230	791,043	31,729	87	116	146	30
Smoky Mountain Center 1: Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain	3,901	159,026	165,852	4,068	11	15	16	1
Smoky Mountain Center 2: Alleghany, Alexander, Ashe, Avery, Caldwell, McDowell, Watauga, Wilkes	11,459	275,339	283,462	11,797	32	43	16	-27
Wake (Alliance Behavioral Healthcare)	28,294	691,795	749,819	30,667	84	112	115	3
Western Highlands Network: Buncombe, Henderson, Madison, Mitchell, Polk, Rutherford, Transylvania, Yancey	25,586	422,181	446,503	27,060	74	99	131	32
Adult Grand Totals	316,711	7,288,429	7,700,834	337,428	924	1,233	1,710	

Department of Health and Human Services

Unfunded Liabilities as of January 5, 2013

Jim Slate, Director, Budget & Analysis, DHHS
Jim.Slate@dhhs.nc.gov; 919-855-4850

- **Total Unfunded Liabilities** **$49,927,369**

  - Permanent Reduction to Non-profit Contracts $5,000,000
    Per HB 950, Section 10.18
    - This reduction was required by legislation in 2011, but was addressed with one-time funding.
    - This reduction was re-emphasized in the 2012 session, but was not addressed prior to January, 2013.
    - To comply with the legislative mandate, contract reductions have been identified and will be implemented with an effective date of March 1.

  - Division of Mental Health Unpaid Bills $35,629,079
    - Beginning in SFY 08-09, Broughton and Cherry both temporarily lost their ability to bring in patient receipts from Medicare and Medicaid to support hospital operations.
    - More recently the closure of the Dorothea Dix hospital and the opening of the new Central Regional Hospital also had a negative impact on revenue collection.
    - The Division Mental Health carried forward $35M in unpaid invoices into the current state fiscal year.

  - Recurring Mental Health Facility Revenue Shortfall $4,998,290
    - Steps have been taken to reduce the ongoing revenue shortfall through administrative efficiencies and revenue enhancement initiatives.
    - However, even with these efforts, the SFY 12-13 shortfall amount is expected to be $5M.

  - Intellectual\Developmental Disabilities Community Services Funding $4,300,000
    - Due to an error in communication between the Department and the legislature in developing the Social Services Block Grant, funding for ongoing services were not included in budget.

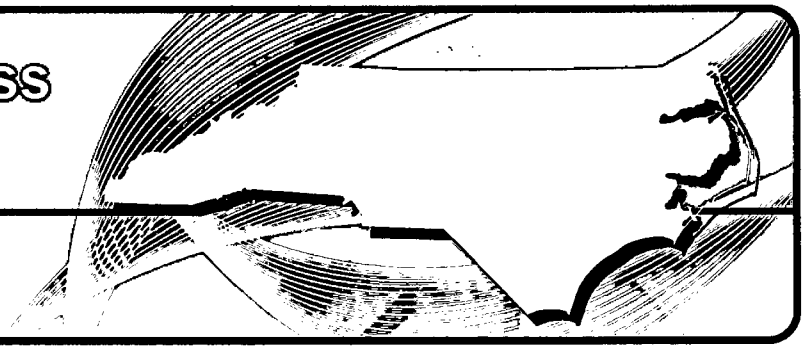
Authorized State Operated Psychiatric Facilities

Facility	Location	# Beds	# Positions	$ FY11-12 Cost per Bed
Psychiatric Hospitals				
Broughton	Morganton	278	1,236	332,194
Central Regional	Butner	398	2,138	431,559
Cherry	Goldsboro	190	1,403	422,580
	Total Beds	866		
Developmental Center				
Caswell	Kinston	405	1,528	223,028
J. Iverson Riddle	Morganton	327	945	180,025
Murdoch	Butner	548	1,701	192,827
	Total Beds	1,280		
Alcohol and Drug Treatment Centers				
Julian F. Keith	Black Mountain	80	217	237,084
R.J. Blackley	Butner	80	163	244,376
Walter B. Jones	Greenville	80	172	208,254
	Total Beds	240		
Neuro-Medical Treatment Centers				
Black Mountain	Black Mountain	156	435	166,551
Longleaf	Wilson	231	487	138,077
O'Berry	Goldsboro	270	950	210,546
	Total Beds	657		
Residential Programs for Children				
Whitaker Psychiatric Residential Treatment Facility*	Butner	18	74	233,206
Wright School	Durham	24	39	232,598
	Total Beds	42		

*Whitaker School is completely receipt-supported.

Prevent Blindness
North Carolina

A State with Vision



PREVENT BLINDNESS NC IS THE ONLY ORGANIZATION OPERATING A STATEWIDE CHILDREN'S VISION SCREENING AND EYECARE PROGRAM.

IN 2011-2012 PBNC:

- ***Saved sight* with annual screenings for over 535,000 children for only $1.61 per child.**
  - Assists low-income preschool programs in meeting vision screening requirements using quality state of the art photo-refractive technology.
  - Administers the largest school vision screening program in the country and is the only statewide provider of vision screening certification training.

- ***Provided access* to over $232,000 in free eyecare. The cost to NC... $0.00.**
  - Matches medically indigent children referred from screening to comprehensive donated eye care (eye exam, glasses and aftercare) through the VSP "Sight for Students Program," PBNC Donor Docs Program, and Healthy Eyes Eyeglass Program.

***Leveraged* over $538,000 in cash and in-kind contributions, boosting state funding by 60%.**

- ***Partnered* with federal agencies to build state infrastructure & develop a national model.**
  - ***In partnership with Duke University & the American Board of Pediatrics***, PBNC:
    - Promoted the Preschool Vision Screening Performance Improvement Module for pediatric Maintenance of Certification as a model for improving other preventive care services including newborn screening for critical congenital heart disease, childhood obesity management, and adolescent depression screening.
  - ***With $25,000 of MCHB funding***, PBNC:
    - Is 1 of only 3 affiliates selected by the MCHB National Center for Children's Vision and Eye Health to pilot a national framework for vision screening by leading in developing statewide vision screening and eye health programs for young children prior to school entry.
    - Participated in a National Expert Panel Recommendations for vision screening which will be published in 3 peer reviewed journals.

- ***Validated* that 89% of children referred through a PBNC school screening research collaborative received corrective lenses.**

- ***Saved* North Carolina $528,870 in skilled workforce labor by utilizing 3,339 certified volunteer vision screeners.**

- ***Generated additional savings* in deterred medical costs to NC. Costs of overreferral due to lack of training exceed total funding for PBNC children's vision screening programs.**

PREVENT BLINDNESS NORTH CAROLINA

4011 WestChase Blvd. Suite 225 Raleigh, NC 27607 919-755-5044

The Kenneth Royall Children's Vision Screening Improvement Program

And

The North Carolina Preschool Vision Screening Program

Report for Contract Year 2011-2012 and Planned Year 2012-2013

August 30, 2012

Part I: The Kenneth Royall Children's Vision Screening Improvement Program

A. Description of program activities of Prevent Blindness North Carolina.

The Kenneth Royall Children's Vision Screening Improvement Program is a public-private program of training and certification for school vision screeners offered to all of the state's 100 counties, led by Prevent Blindness North Carolina [PBNC] and the School Health Unit of the Children and Youth Branch of DHHS. School screenings are North Carolina's principle means of performing pediatric vision screenings.

B. Activities funded by 2011-2012 State contracts, contract amounts, and program narrative.

The program is funded by a $419,000 State contract through DHHS. It offers training and certification for volunteer school vision screeners, as well as follow-up services.

Each three-hour training and certification workshop for local volunteer vision screeners includes instruction in the components of vision; the conditions that put children at risk for vision deficiencies; proper screening procedure, including standards, preparation, and techniques; resources available for low-income families and best practices in record-keeping, referral, and follow-up. Each includes a supervised practice session and a required demonstration of mastery of screening techniques by all participants. Certification is for two years.

PBNC's primary screening target is the state's 2022 elementary, middle, and charter schools.

C. Output data demonstrating the effects of the organization's activities.

The 2011-2012 training and certification workshops for vision screeners commenced on June 2, 2011 in Granville County and concluded on May 16, 2012 in Iredell County. During the 2011-2012 contract year, PBNC completed a total of 191 workshops and trained 3,341 vision screeners from 89 counties.

Combined with the 3,484 vision screeners PBNC trained from June 2010-May 2011, North Carolina had 6,825 total certified vision screeners during the two-year period, representing all 100 counties. (Because of constant turnover in the state's vision screening volunteers, certification is for a two-year period only. PBNC maintains a rolling two-year accounting of the total number of trained screeners. As of contract year 2011-2012, PBNC no longer includes the 3,285 screeners it trained in 2009-2010 in its total of current vision screeners.)

2011-2012 contract guidelines call for one certified screener for every 135 students in the target grades, or some 6,000 trained screeners for the state's K-6 population. These guidelines were exceeded with the state's 6,825 certified screeners at the close of the contract year.

In the period encompassing contract years 2010-2011 and 2011-2012, PBNC held 379 vision-screening workshops with participants from all 100 North Carolina counties.

Table 1 shows participation in the 191 workshops PBNC conducted in contract year 2011-2012, by county.

County	# Screeners Trained
Alamance	8
Alexander	39
Alleghany	4
Anson	11
Ashe	17
Avery	2
Beaufort	25
Bertie	0
Bladen	0
Brunswick	25
Buncombe	201
Burke	12
Cabarrus	43
Caldwell	9
Camden	9
Carteret	18
Caswell	8
Catawba	37
Chatham	5
Cherokee	36
Chowan	0
Clay	27
Cleveland	42
Columbus	76
Craven	24
Cumberland	138
Currituck	53
Dare	8

County	# Screeners Trained
Jones	6
Lee	7
Lenoir	14
Lincoln	7
Macon	10
Madison	20
Martin	27
McDowell	22
Mecklenburg	60
Mitchell	15
Montgomery	44
Moore	0
Nash	20
New Hanover	21
Northampton	0
Onslow	66
Orange	14
Pamlico	16
Pasquotank	19
Pender	22
Perquimans	3
Person	7
Pitt	33
Polk	35
Randolph	84
Richmond	36
Robeson	3
Rockingham	26

Davidson	54	Rowan	11
Davie	1	Rutherford	38
Duplin	0	Sampson	14
Durham	80	Scotland	0
Edgecombe	9	Stanly	48
Forsyth	166	Stokes	89
Franklin	9	Surry	2
Gaston	63	Swain	13
Gates	14	Transylvania	39
Graham	0	Tyrell	0
Granville	5	Union	86
Greene	21	Vance	7
Guilford	209	Wake	595
Halifax	18	Warren	15
Harnett	2	Washington	14
Haywood	1	Watauga	11
Henderson	40	Wayne	26
Hertford	2	Wilkes	10
Hoke	0	Wilson	0
Hyde	10	Yadkin	5
Iredell	48	Yancey	5
Jackson	32		
Johnston	15	All Counties	3341

TABLE 1: VISION SCREENERS CERTIFIED IN CONTRACT YEAR 2011-2012, BY COUNTY

The 3,339 participants in the training and certification workshops in 2011-2012 fell into occupational categories as shown in Table 2.

Teachers, TAs, Nurses, other school personnel	Volunteers and Students	Total
39%	61%	100%

TABLE 2: CERTIFIED VISION SCREENERS BY OCCUPATION, CONTRACT YEAR 2011-2012

513,884 children were screened in North Carolina during the 2011-2012 school year, representing a number equivalent to 65% of the target population of 792,833 K-6th graders. Of those 513,884 screened, 39,999 were referred to eye care professionals, an 8% referral rate.

Table 3 displays the 2011-2012 screening and referral data that counties have reported to PBNC to date.

Counties	# Screened	# Referred	% Referred	Counties	# Screened	# Referred	% Referred
Alamance	9,898	1,034	10%	Jackson	810	50	6%
Alexander	1,801	103	6%	Johnston	10,289	981	10%
Alleghany	1,049	34	3%	Jones	297	55	19%
Anson	2,838	161	6%	Lee	8,455	449	5%
Ashe	1,032	51	5%	Lenoir	3,147	212	7%
Avery	1,387	71	5%	Lincoln	4,858	350	7%
Beaufort	1,877	275	15%	Macon	2,975	238	8%
Bertie	203	20	10%	Madison	1,760	53	3%
Bladen	1,730	231	13%	Martin	1,381	108	8%
Brunswick	3,923	285	7%	McDowell	2,475	218	9%
Buncombe	9,383	759	8%	Mecklenburg	64,760	5,285	8%
Asheville City	1,551	116	7%	Mitchell	337	10	3%
Burke	5,009	371	7%	Montgomery	1,167	190	16%
Cabarrus	8,890	753	8%	Moore	4,857	222	5%
Kannapolis City	1,690	154	9%	Nash	5,145	708	14%
Caldwell	1,465	193	13%	New Hanover	7,550	644	9%
Camden	1,058	86	8%	Northampton	920	91	10%
Carteret	4,823	100	2%	Onslow	8,763	667	8%
Caswell	1,234	117	9%	Camp Lejeune	0	0	0%
Catawba	10,427	710	7%	Orange	2,872	172	6%
Hickory City	1,700	136	8%	Chapel Hill-Carrboro	4,095	236	6%
Newton-Conover	1,286	124	10%	Pamlico	802	47	6%
Chatham	3,436	398	12%	Pasquotank	1,877	74	4%
Cherokee	1,698	100	6%	Pender	2,920	105	4%
Chowan	797	106	13%	Perquimans	705	46	7%
Clay	958	50	5%	Person	2,369	238	10%
Cleveland	6,755	293	4%	Pitt	6,047	662	11%
Columbus	2,474	219	9%	Polk	660	50	8%

Whiteville City	919	82	9%
Craven	5,848	467	8%
Cumberland	19,805	1,300	7%
Ft. Bragg	2,841	0	0%
Currituck	938	51	5%
Dare	1,999	230	12%
Davidson	2,424	273	11%
Lexington City	1,115	148	13%
Thomasville City	1,143	64	6%
Davie	2,325	254	11%
Duplin	3,461	244	7%
Durham	2,792	344	12%
Edgecombe	2,314	189	8%
Forsyth	22,925	1,534	7%
Franklin	2,937	260	9%
Gaston	9,063	912	10%
Gates	866	38	4%
Graham	393	6	2%
Granville	1,999	78	4%
Greene	290	33	11%
Guilford	20,579	1,717	8%
Halifax	1,211	91	8%
Roanoke Rapids	1,939	75	4%
Weldon City	500	36	7%
Harnett	1,484	222	15%
Haywood	3,217	151	5%
Henderson	5,099	374	7%
Hertford	384	54	14%
Hoke	1,874	157	8%
Hyde	190	15	8%
Iredell	7,606	472	6%
Mooresville City	2,298	277	12%

Randolph	3,527	329	9%
Asheboro City	1,572	163	10%
Richmond	4,058	572	14%
Robeson	9,189	1,052	11%
Rockingham	7,519	430	6%
Rowan	7,207	355	5%
Rutherford	3,778	258	7%
Sampson	990	144	15%
Clinton City	571	78	14%
Scotland	1,924	84	4%
Stanly	4,156	293	7%
Stokes	2,615	155	6%
Surry	6,524	349	5%
Elkin City	800	32	4%
Mt. Airy City	918	53	6%
Swain	634	46	7%
Transylvania	2,344	122	5%
Tyrell	215	29	13%
Union	21,112	1,231	6%
Vance	1,658	159	10%
Wake	35,499	2,701	8%
Warren	654	77	12%
Washington	659	116	18%
Watauga	2,678	67	3%
Wayne	6,734	700	10%
Wilkes	5,584	457	8%
Wilson	1,774	325	18%
Yadkin	2,507	212	8%
Yancey	1,041	51	5%
All Counties	513,884	39,999	8%

TABLE 3: 2011-2012 SCREENING AND REFERRAL DATA REPORTED BY COUNTIES THROUGH MAY 31, 2012

School nurses, parents, and students across the state have expressed positive opinions of the program and have shared numerous success stories. Representative comments include the following:

Kayla, age 7, a 1st grader from Carl Furr Elementary was referred for a screening by her teacher. Kayla had glasses but lost them and could not receive another pair of glasses from Medicaid until June. She was reported as having trouble seeing in class which affected her performance. Funding for her new pair of glasses was received from the Healthy Eyes Eyeglass program through PBNC. Now that she is wearing glasses again, she is doing much better in class. Her teacher states that he has not seen her squinting and struggling to see the board.

Kay C., RN,Cabarrus Co. Schools

This is a wonderful resource to those children that do not have Medicaid. From most of my experience these children are the ones who would fall through the cracks and never get glasses without the funding through Prevent Blindness.
All the school nurses are very grateful to PBNC for the wonderful training and resources made available to our students. The trainings are excellent. Vision screenings are more accurate. It increases awareness about how accurate vision impacts academic success. Support from PBNC staff is excellent. Thank You!

Lucy K., RN, Alamance Co. Schools

We found a child in second grade with an undiagnosed lazy eye. She has been to Asheville to a specialist and hopefully will not require surgery.

Tammy C., RN, Ashe Co Schools

Jah'nila, age 7, is a third grader who was recommended to have a screening by her teacher. There was no family history of vision problems, yet she was prescribed glasses. She received her glasses through the help of a VSP voucher. Her teacher was very grateful to have her receive glasses and she has improved her work in class. Jah'nila was so excited to be able to see better and her teacher stated that the expression on her face when she came to school with her new glasses was priceless!

Denise N., RN, Bertie Co. Schools

As always, Prevent Blindness affords the opportunity to break down financial barriers to access vision services for children. Children who cannot see may not be able to learn at their best potential. This program is very valuable and has been a lifesaver for some of our families. It is such a pleasure to work with all the staff at Prevent Blindness North Carolina. Thank you for everything.

Shannon P., RN, Person Co. Schools

A first grade teacher reports improvement in academic work and more enthusiasm about learning in regards to students we have served. Another first grade teacher reports improvement academically and behavior wise. She is receiving positive comments from parents and Special Ed. teachers. Parent thanked me for checking vision due to change in prescription that parents were not aware of until vision screening.
Lisa K., RN, MSN, Burke Co. Schools

Emily, a 5th grader, was screened and found to need glasses. Her parents took her for an eye exam and received a pair of glasses. Now Emily reports, "The smart board was really blurry before and I could hardly see it. Now I can see it great."
Flo B., RN, Cabarrus Co. Schools

PBNC has a huge impact on our school system. Our HOSA students were trained and helped with the screening process. Without their help, we would have only screened 1st and 6th grades. The voucher program also helps our students get the glasses they need and it is a tremendous help. We are very thankful to have the PBNC training. It has helped us significantly to screen accurately and provide certified screeners.
Terri W., RN, Gates Co. Schools

PBNC is a great asset to the school health program because they are able to provide many needy children with eye exams and glasses that would not otherwise be able to get them. Many students do not have insurance or Medicaid to pay for these services. PBNC has convenient, friendly services for the families we serve. The PBNC training provides up-to-date screening guidelines, additional resources and supplies to school nurses.
Carol E., RN, Nash-Rocky Mount Schools

D. Additional activities in 2011-2012 merit mention.

Vision Resource Guide
Each year PBNC develops and distributes a Vision Resource Guide. The resource guide provides individuals, health departments, departments of social services and school system staff with a better understanding of the resources available for securing eye care for those in financial need throughout our state. PBNC mailed one vision resource guide to each North Carolina Health Department.

School Nurse Consultation
PBNC serves as the primary vision screening resource for school nurses and administrators across North Carolina. During the 2011-12 contract year, PBNC certification program staff conducted strategy meetings to assess and enhance existing school vision screening programs

in each North Carolina school district. PBNC additionally conducted 29 in-service vision screening certification workshops tailored for school nurses. The in-service certifications are designed to be more interactive and include discussion about vision screening processes as well as issues specific to administering successful school vision screening programs.

Vision Service Plan. Vision Service Plan (VSP) distributes vouchers redeemable for eye exams, glasses, and other products and services to Prevent Blindness America affiliates and other non-profit organizations. PBNC has integrated the extensive use of VSP vouchers into its system for providing follow-up services to families whose children have been diagnosed as needing professional eye care but cannot afford such care. During the 2011-2012 school year, PBNC issued 993 VSP vouchers to North Carolina children. The average value of each voucher was $147, making the program value to North Carolina total almost $146,000.

Donor Docs Program
Prevent Blindness North Carolina, with the support of the Early Childhood Vision Care Commission, introduced the Donor Docs Program in 2008 to mirror the eye care services previously funded through the state ECVC Program. Eye care professionals have the opportunity to provide their donated services to a large group of individuals to include children in preschool through 12th grade, as well as adults, referred through vision screenings. During the 2011-2012 year, 179 doctors volunteered to donate a total of 532 eye exams and 367 pairs of glasses. Vouchers were issued to 380 children and adults across the state.

Healthy Eyes Program
In 2010, Prevent Blindness launched the Healthy Eyes Eyeglass Program in collaboration with Luxottica. This program provides eye glasses for children and adults. During the 2011-2012 school year, 404 children and 148 adults were served through this program at an estimated value of $59,000.

E. Planned objectives and activities for the 2012-2013 contract year.

PBNC's objective for 2012-2013 is to train more than 3,000 screeners using revised training manuals and materials. PBNC will invite volunteer screeners to attend local workshops throughout North Carolina. PBNC will provide participants with all of the charts and screening materials they will need to conduct screenings and record their results. PBNC will certify the trained screeners for two years when they have completed their workshops and demonstrated their mastery of the subject matter.

PBNC's objective for the 2012-2013 contract year is to provide sufficient recruitment services, training, coordination, support, and follow-up to produce a screening infrastructure in North Carolina that will screen a minimum of 504,869 children as well as maintain a statewide referral rate of approximately 7% (±3%).

Part II: The North Carolina Preschool Vision Screening Program

A. Description of program activities of Prevent Blindness North Carolina.

The North Carolina Preschool Vision Screening Program screens children using paid PBNC personnel and local healthcare professionals. The Preschool program serves children ages 2-5, including learning disabled children and children with language delays. The program uses photo-refractive screening technology.

The Preschool Program conducted screenings in 486 child care centers during the 2011-2012 contract year. Participating centers included Head Start centers, NC PreK sites, Title 1 PreK programs, and private childcare centers.

B. Activities funded by 2011-2012 State contracts, contract amounts, and program narrative.

The program is funded by a $450,000 state contract through the School Health Unit of the Children and Youth Branch of DHHS. Like the Kenneth Royall Program, the Preschool Program is coordinated through the Division of Public Health of DHHS.

During the photo-refractive screening in childcare centers, a non-invasive photograph is taken of the child's eyes and is analyzed for possible vision problems, to include refractive errors such as nearsightedness and farsightedness, misalignment, astigmatism, and opacities such as cataracts. The primary purpose of the PBNC preschool vision screenings is to detect vision problems that can to amblyopia, a condition that will lead to permanent vision loss if not treated at an early age, preferably during the preschool years.

C. Output data demonstrating the effects of the organization's activities.

During the 2011-2012 contract year, which ended May 31, 2012, the Preschool Program operated in 29 counties and assisted the health department in one other. The program screened 24,184 children and referred 2,149 (9%) to eye care professionals. PBNC also distributed educational materials regarding the signs of possible vision problems to the parents/guardians of 27,522 children, as well as the center directors and teachers.

Table 4 displays the screening totals for all counties served during 2011-2012.

County	# Centers	# Offered	# Screened	# Referred
Alamance	15	350	311	43
Brunswick	2	153	129	5
Buncombe	31	1559	1337	85
Burke	14	696	591	46
Caldwell	6	384	365	32
Chatham	10	355	320	36
Cumberland	59	3425	2888	254
Down East	10	84	615	74
Durham	22	1098	955	86
Forsyth	54	2786	2479	250
Franklin	4	84	84	14
Guilford	21	809	683	66
Harnett	4	112	106	14
Henderson	6	343	308	18
Johnston	42	1821	1500	127
Lee	2	119	103	10
Lenoir-Greene	3	237	228	28
Mecklenburg	36	3110	2588	253
New Hanover	38	2631	2263	190
Orange	15	405	332	47
Pender	4	192	168	9
Robeson	1	60	53	7
Rowan	1	64	55	11
Sampson	3	202	186	13
Stokes	1	62	47	9
Wake	75	5890	5052	382
Wilson	7	491	438	40
Total	**486**	**27522**	**24184**	**2149**
Total Centers	**486**			
Total Offered	**27522**			
Total Screened	**24184**			
Utilization Rate	**88%**			
Total Referred	**2149**			
Referral Rate	**9.00%**			

Table 4: 2011-2012 screening totals

PBNC utilized a portion of the program's funding to serve NC PreK, Head Start and Title 1 PreK students. 10,830 children were screened in 216 of these sites across the state. Many of these sites depend on PBNC to help fulfill the state's requirement for their students to receive vision screenings each year.

As of July 31, 2012 PBNC had completed follow-up with 70% of all referred children to determine confirmed care and necessary glasses or other treatment. Follow-up is ongoing and it is anticipated to reach 75% confirmed care by September 30, 2012. PBNC offers every child whom is screened and referred to an eye care professional, and whose family cannot afford to pay for professional services, free eye examinations, glasses, and other treatment.

Throughout the screening year PBNC distributed follow-up questionnaires to the participating childcare centers. Success story information was also requested from the parents of the referred children who were seen by eye care professionals and diagnosed as having vision problems. Below is just a small sample of the overwhelming support shown each year for the preschool program.

Words cannot express how grateful I am to your organization for the eye screening that you recently conducted at my daughter Vivian's daycare. Vivian is two years old and was diagnosed with far-sighted vision that is so poor, she is legally blind. However, I never suspected that she had a vision problem as there were no obvious indicators. Because of your screening and the recommendation you provided suggesting that she see an eye doctor, my daughter's vision problem will more than likely be corrected with glasses. I am beyond grateful for your organization's pro-active mission. The service you provide is not only necessary but is critical for young children. Therefore I am spreading the word about Prevent Blindness NC and the value of the free screenings you offer across the state.
Melissa, Vivian's mom, Forsyth County

Another good screening find. Keep up the good work!
Dr. Brian Jackson, Eye Care Associates

I am really grateful for this program because being able to see clearly is critical to learning and so many of our parents may not think to take their children to the eye doctor for an exam.
Center Director, Durham County

Talon has moderate astigmatism – he needed glasses; he loves them!! Thank you so much for what you all do!!!
Talon's mom, Pender County

A number of years ago a very serious tumor was discovered by your screening. The little girl was in danger of losing her sight. We thank the program and thank the screeners for their good work. We can't say enough about this wonderful program!
Center Director, New Hanover County

I am thankful for this test for the children's sake. I wish it could have been done when my sons were in daycare, for I did not know one son had eye problems until he began public school.
Center Director, Johnston County

Naomi was seen by an ophthalmologist in December and was prescribed glasses. She was diagnosed with amblyopia. She will begin patching as well. Thank you so much for providing such a wonderful service! I never would have guessed that she had a need for glasses because she only needs the prescription for one eye. Thank you!
Naomi's mom, Wake County

We have done this for several years. Each year we have had a wonderful experience. The staff is very efficient. The results have allowed parents to provide glasses and medical care early on for our Pre-K students."
Pre-K teacher, Sampson County

"Great experience! So glad you were able to provide these screenings. What a great resource for these young students!"
Jessica M., Preschool Director, Mecklenburg County

"The screening is wonderful!! Our children love it! Our parents are so grateful that you provide such a needed service to our center. Thank you so much!"
Renee S., Center Director, Guilford County

D. Planned objectives and activities for the 2012-2013 contract year.

PBNC's objective for 2012-2013 is to screen 24,000 children ages 2-5 in preschool settings to include NC PreK (formerly More @ Four), Head Start and Title 1 PreK classes as well as private childcare centers. Paid PBNC personnel and local healthcare professionals will complete the screenings. PBNC will maintain a referral rate between 6% and 9%.

Part III: The Combined Programs

In 2011-2012, PBNC secured $538,342 in foundation support, corporate and professional in-kind contributions, and PBNC cash matching grants to help fund the Kenneth Royall and Preschool programs. That amount boosted the combined state funding of $869,000 by more than 62%.

Department of Health and Human Services

Division of Mental Health/Developmental Disabilities/Substance Abuse Services
and
Division of State Operated Health Facilities

[Click to Add Committee Name or Team Name]
Joint Appropriations House and Senate
Subcommittee on Health and Human Services

March 26, 2013

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Presentation Outline

Overview of DHHS Mental Health Divisions, Programs, and Services

Review 2011 and 2012 Legislative Actions

Budget Overview

Review Budget and Policy Issues

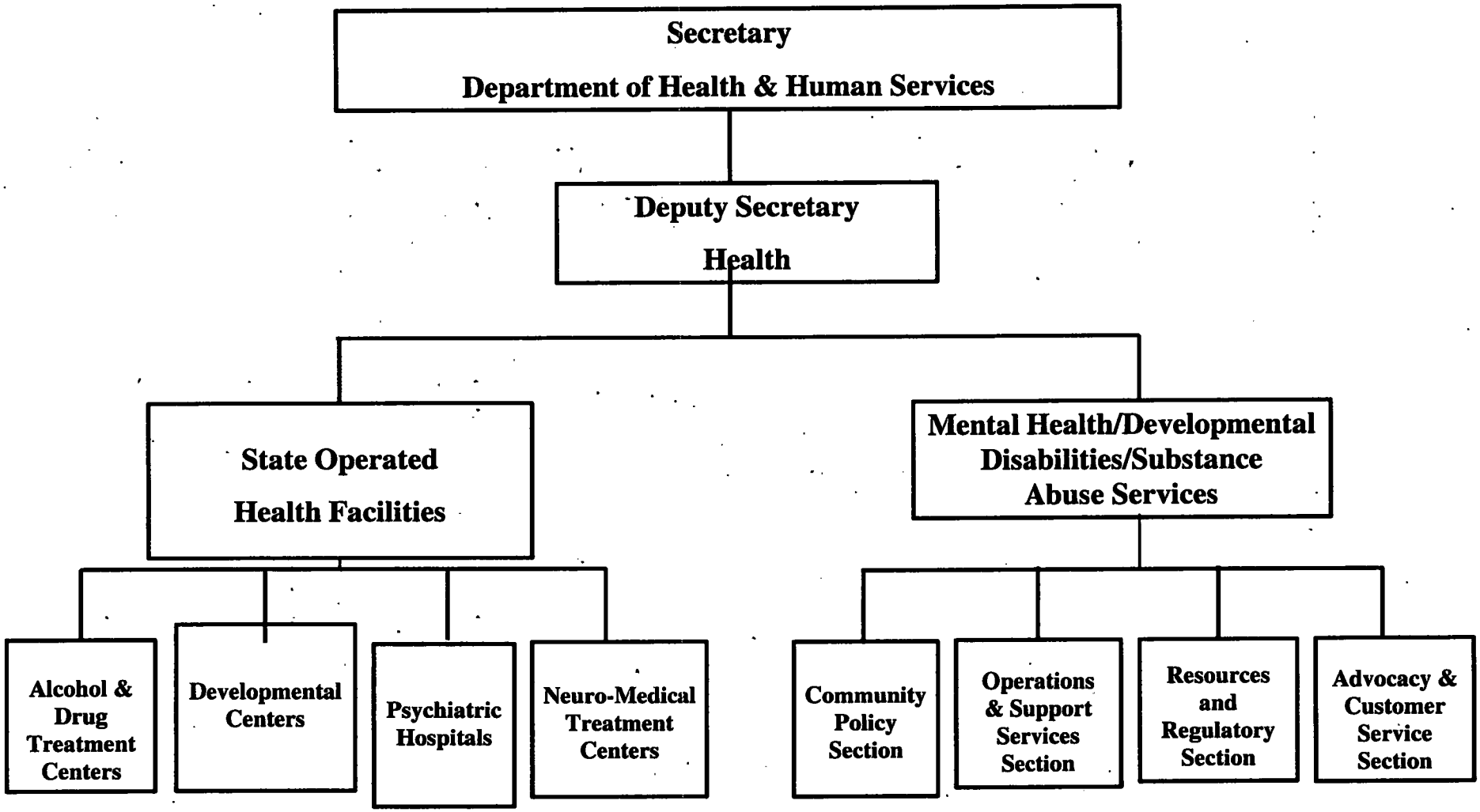
OVERVIEW
MENTAL HEALTH DIVISIONS, PROGRAMS, AND SERVICES

G.S. 122C-2: Mental Health Policy

The policy of the State is to assist individuals with needs for mental health, developmental disabilities, and substance abuse services in ways consistent with the dignity, rights, and responsibilities of all North Carolina citizens.

Within available resources it is the obligation of State and local government to provide mental health, developmental disabilities, and substance abuse services through a delivery system designed to meet the needs of clients in the least restrictive, therapeutically most appropriate setting available and to maximize their quality of life.

It is further the obligation of State and local government to provide community-based services when such services are appropriate, unopposed by the affected individuals, and can be reasonably accommodated within available resources and taking into account the needs of other persons for mental health, developmental disabilities, and substance abuse services.


Secretary
Department of Health & Human Services
Deputy Secretary
Health
State Operated
Health Facilities
Mental Health/Developmental
Disabilities/Substance
Abuse Services
Alcohol &
Drug
Treatment
Centers
Developmental
Centers
Psychiatric
Hospitals
Neuro-Medical
Treatment
Centers
Community
Policy
Section
Operations
& Support
Services
Section
Resources
and
Regulatory
Section
Advocacy &
Customer
Service
Section

G.S. 122 C-2: Community Services Policy

The public service system will strive to provide a continuum of services for clients while considering the availability of services in the private sector. Within available resources, State and local government shall ensure that the following core services are available:

(1) Screening, assessment, and referral.

(2) Emergency services.

(3) Service coordination.

(4) Consultation, prevention, and education.

Within available resources, the State shall provide funding to support services to targeted populations, except that the State and counties shall provide matching funds for entitlement program services as required by law.

Behavioral Health Services Delivery

- Multiple entities have a role in the delivery of mental health, developmental disabilities, and substance abuse services
  - DMHDDSAS
  - DSOHF
  - Local Management Entities (LMEs)
  - Private service providers
  - Division of Medical Assistance

- Funding provided by State, federal, and local sources

- State-wide system is built upon on partnerships and cooperation
  - No one entity is completely in charge

Mental Health System Stakeholders

- Consumers and their families
- Providers
- State agencies
- Consumer advocacy groups
- LMEs/MCOs
- Public and private hospitals
- Local governments
- Federal government

Community MH/DD/SA Services

- The State budgets around $340 million in General Fund, federal block grants, and other receipts for community services
- LMEs manage and have oversight for the delivery of mental health, developmental disabilities, and substance abuse services to residents, adults and children, living in their catchment areas
- Most community services delivered using a network of private providers
- Community services include but are not limited to:
  - Assessment
  - Psychiatric therapy
  - Rehabilitation services
  - Medication management
  - Crisis Intervention
  - Outpatient substance abuse treatment
  - Intensive in-home treatment
  - Case Management
  - CAP/Innovations

Critical Access Behavioral Health Agency (CABHA)

- In 2009, DHHS approved CABHAs as a new provider category for community-based mental health and substance abuse services
  - CABHAs' may be for profit, not for profit, public, or private entities.
  - Must be certified by both DMH/DD/SAS and DMA
  - 187 certified CABHAs
- Purpose is to provide a comprehensive clinical assessment and an appropriate array of services.
  - The services will vary depending upon the age and needs of the consumers to be served by the agency but all must offer three core services: medication management, comprehensive clinical assessment, and outpatient therapy and at least two other types of services
- S.L. 2012-171 mandated that only CABHAs may provide certain services to Medicaid recipients: community support team, intensive in-home therapy, child/adolescent day treatment

Local Management Entities (LMEs)

- LMEs are in transition
  - In the past, there were as many as 40 LMEs and most provided direct services

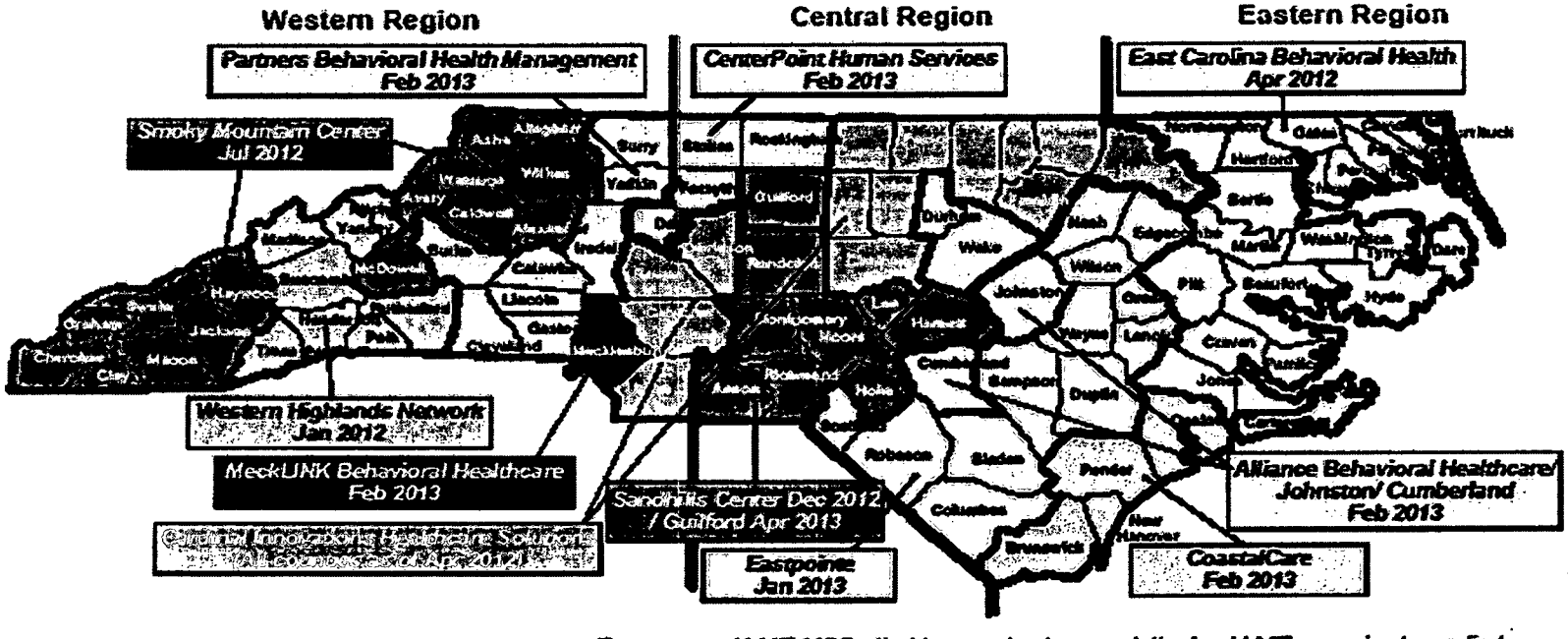
- In 2005, DHHS piloted a Medicaid 1915 (b) (c) waiver operated by Piedmont Behavioral Health (PBH) to provide behavioral health services in Cabarrus, Davidson, Rowan, Stanly and Union Counties

- S.L. 2011-264 mandated the state wide expansion of the 1915 (b) (c) waiver to be fully implemented by June 30, 2013
  - 11 LME/MCOs will administer all behavioral health services

DHHS Funding for LME/MCO's

- LMEs/MCOs manage State, federal, Medicaid, and local/county funds
  - Responsible for authorizing services, maintaining provider network, monitoring service quality, customer service, etc.
- FY12-13 Funding for LMEs/MCOs:
  - Medicaid: $2.1 billion
  - Community Service Funds: $340 million
    - Includes federal block grant funds
    - Funding has decreased by $78 million, almost 20%, since 2000
  - Administrative Funding: $98 million
    - Includes funds provided to support MCO mergers

Local Management Entity - Managed Care Organizations (LME-MCOs) and their Member Counties (Current and Proposed on February 1, 2013)



- *For proposed LME-MCOs that have not yet merged, the lead LME name is shown first.*
- *Sandhills Center and Guilford are scheduled to merge on January 1, 2013.*
- *Dates shown through December 2012 are actual Waiver start dates.*
- *Dates after December 2012 are the planned Waiver start dates.*
- *Reflects plans and accomplishments as of December 6, 2012.*

Three-Way Contracts

- Contractual agreement between DHHS, LMEs/MCOs, and community hospitals to purchase inpatient psychiatric services
  - Use local community hospital beds to provide short-term, acute inpatient services allowing patients to be served close to home while reserving state hospitals for those needing more long-term inpatient treatment

- S.L. 2008-107, the 2008 appropriations act, authorized and appropriated funds to be used for three-way contracts to purchase local inpatient psychiatric services.
  - Three-way contract beds days shall be distributed across the State according to need as determined by the Department.
  - Directed DHHS to enter into contracts with the LMEs and community hospitals for the management of these beds or bed days.
  - Authorized LMEs to manage and control the local inpatient psychiatric beds, including selecting the hospital that an individual should be admitted to pursuant to an involuntary commitment order.

Three-Way Contracts

- Funds may be used only to increase the number of community hospital psychiatric beds available to LMEs and shall not be used to supplant other funds available for this purpose

- 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 10 working days of receipt of payment from the Division.

Three-Way Contracts Funding

- 22 hospitals currently have 141 beds available for the contract rate of $750/day
  - Rate includes room, physician charges, and pharmacy
  - Hospitals indicate that the rate is insufficient for high acuity patients who require more specialized services, and more staff
- 2012-142 appropriated $9 million R expansion funding to increase number of beds from 141 to 186
  - Directed that funds could not be spent prior to December 31, 2012 and could only be used if not needed to address Medicaid funding shortfall
- Hospitals have reported billing issues and delays in receiving payment

Community Psychiatric Bed Needs: Adults

- DHHS Division of Health Services Regulation's annual inventory of community hospital psychiatric beds
  - 2015 projected # adult beds needed: 1,233
  - 2015 projected # adult beds available: 1,710

- While overall the projected 2015 inventory of adult beds exceeds need by nearly 500 beds, shortfalls are anticipated for two MCOs
  - Coastal Care: -3
  - Smoky Mountain: -27

Community Psychiatric Bed Needs: Child/Adolescent

- DHHS Division of Health Services Regulation's annual inventory of community hospital psychiatric beds
  - 2015 projected # child/adolescent beds needed: 172
  - 2015 projected # child/adolescent beds available: 329

- While overall the projected 2015 inventory of child/adolescent beds exceeds need by over 150 beds, shortfalls are anticipated for some MCOs
  - Cardinal I (Cabarrus, Davidson, Rowan, Stanley, and Union): -10
  - Alliance – Cumberland: -4
  - Alliance – Johnston: -3
  - Eastpointe: -13
  - Smoky Mountain: -5

G.S.122C-181: State Facilities

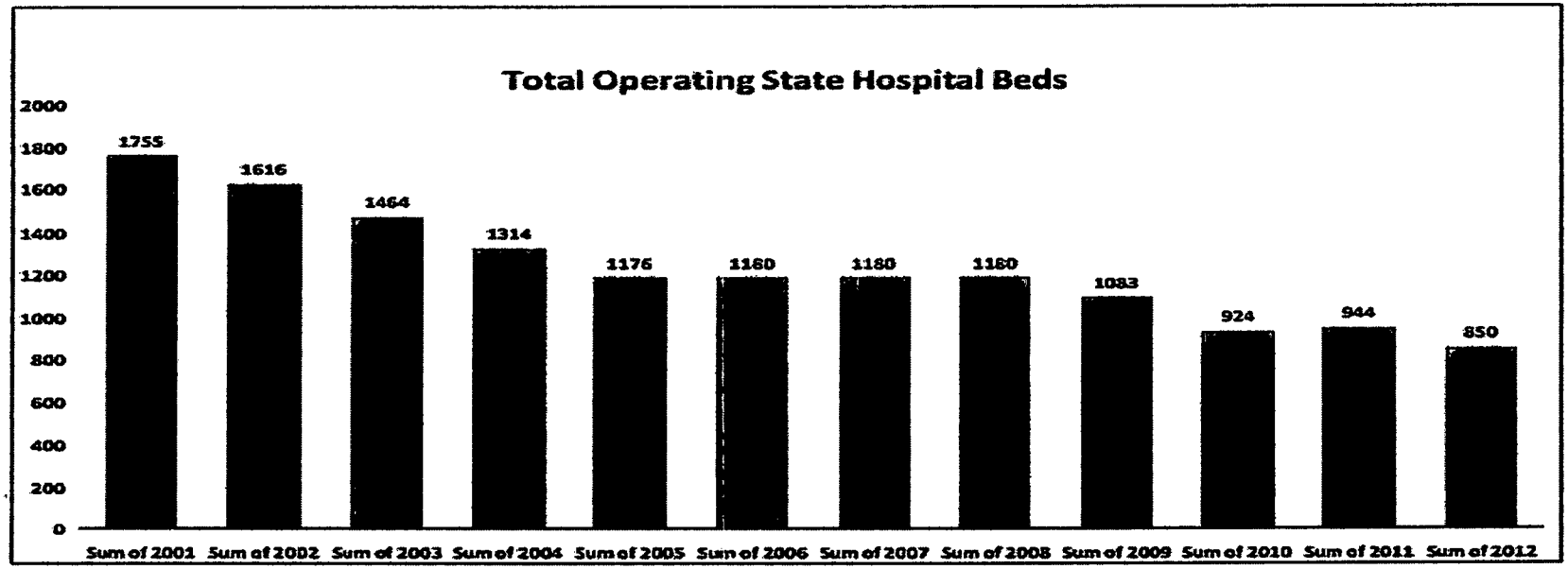
- Authorizes the DHHS Secretary to operate State Facilities
  - Psychiatric Hospitals
  - Developmental Facilities
  - Alcohol and Drug Treatment Centers
  - Neuro-Medical Treatment Centers
  - Residential Programs for Children
- Secretary, with the approval of the Governor and Council of State, may close any State facility

State Operated Facilities

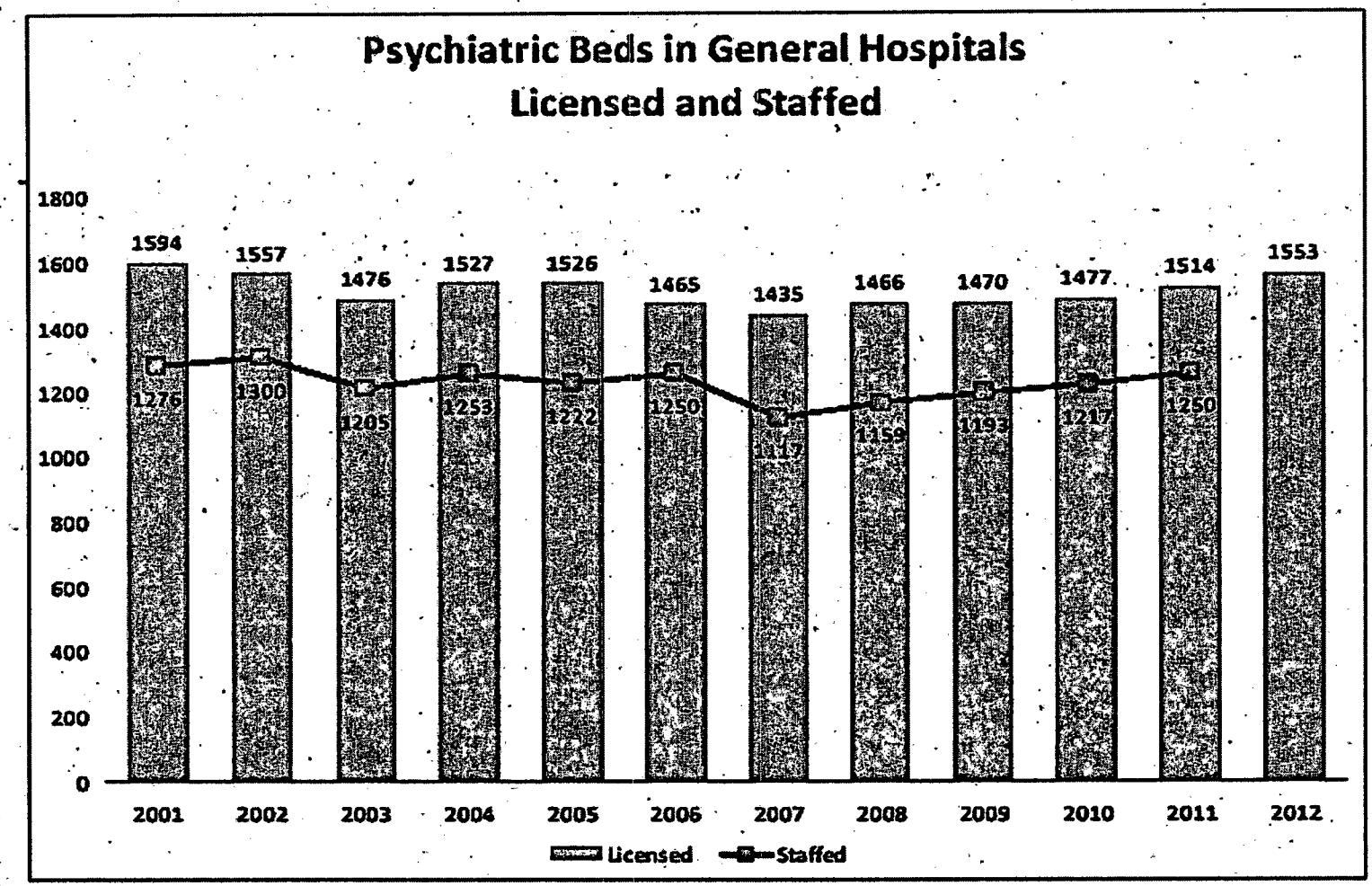
- Hospitals provide inpatient psychiatric services for persons who cannot be served in community-based settings
- Alcohol and drug treatment centers provide treatment to adults with addition and related disorders
- Neuro-medical treatment centers serve adults with neurological disorders and complex medical conditions
- Developmental disability centers serve persons with intellectual and developmental disabilities whose treatment needs exceed the level available in the community
- Residential schools
  - Wright School serves children, ages 6 to 12, with emotional, behavioral, education, intellectual, social, and neurological conditions
  - Whitaker School provides inpatient psychiatric services to adolescents, ages 13 to 18

Change in State Hospital Bed Capacity

(Source: Division of State Operated Facilities, September 2012)

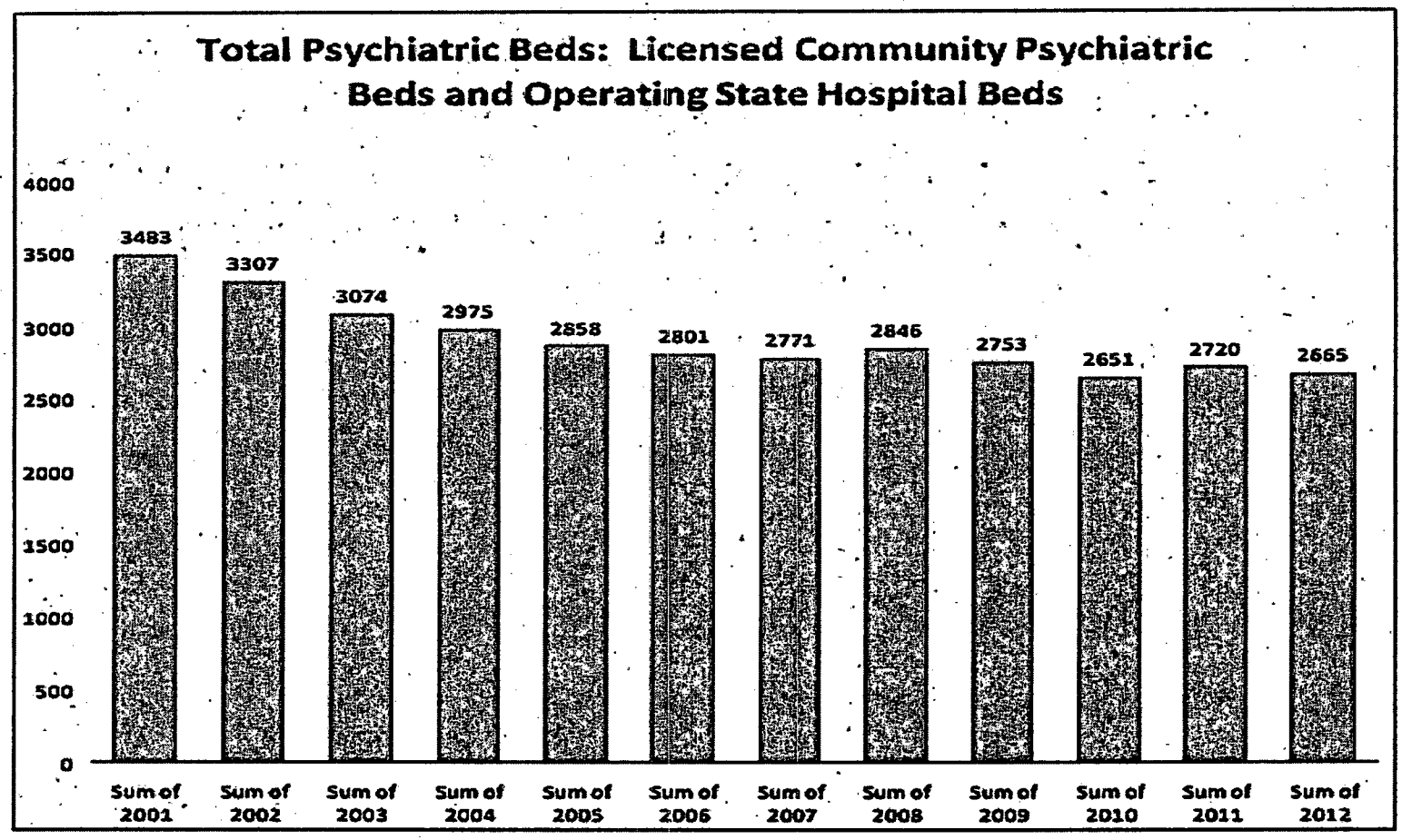


10



Source: DHSR Annual Applications

11



Source: DHSR Annual Applications

12

State Psychiatric Hospital Capacity

- Mental Health Subcommittee of the Joint HHS House and Senate Legislative Oversight studied issues related to State psychiatric hospital bed capacity.
  - The Subcommittee heard about impact on community hospitals when individuals with a behavioral health crisis are brought to emergency rooms.
    - Reportedly, the average length of stay for these individuals was 15 hours, 52 minutes and over half (53%) were discharged to home or self-care.

- Subcommittee found that even though the State's total population continues to grow, the number of psychiatric hospital beds have decreased.
  - Increasing the capacity of the State psychiatric facilities can help decrease the length of stay in community hospital emergency rooms.

HHS LOC Recommendation

- Direct the Department of Health and Human Services to
  - (i) determine the cost of increasing the number of beds in State psychiatric hospitals,
  - (ii) explore the possibility of creating a south central mental health region to include at least Anson, Cabarrus, Davidson, Mecklenburg, Montgomery, Moore, Randolph, Richmond, Rowan, Scotland, Stanly, and Union counties, and
  - (iii) investigate the possibility of placing a new psychiatric facility in this region of the State.

- Department shall provide a written report to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2013.

Significant Legislative Actions
2011-2012 Sessions

2011 Significant Legislative Actions

- HB 916 – mandated statewide expansion of Medicaid 1915 (b)(c) Behavioral Health waiver by June 30, 2013
- Community service funds swap ($25 million) NR
- Community services reduction ($20 million) NR
- Mandated co-pay effective January 1, 2012 for mental health/developmental disabilities/substance abuse services
- Directed DHHS to issue RFP for consolidation of all forensic hospital care at Dix Hospital
- Eliminated funding for facility IT system upgrades ($5.1 million) R

2012 Significant Legislative Actions

- Community services reduction ($20 million) NR
- Expansion funding to increase the number of community hospital beds from 141 to 185 ($9,000,000) R*
- Reduced LME administrative funding in anticipation of savings from MCO conversions ($8,497,935) R
- 373 additional Cherry Hospital positions - $3,472,94R
- Funds for 19 additional beds at Broughton Hospital - $3,513,000 R*
- Eliminated funding for drug treatment court services – (2,258,000) R

2012 Significant Legislative Actions

- In 2011, the NC Disabilities Rights submitted a complaint to the U.S. Department of Justice (US DOJ) alleging that North Carolina had been institutionalizing persons with intellectual and developmental disabilities (I/DD) in violation of the federal American with Disabilities Act (ADA) and Olmstead ruling.
  - US DOJ conducted an investigation and determined that North Carolina was in violation
  - NC DHHS and US DOJ negotiated a settlement setting forth the actions that NC must take to transition affected persons from group or adult care homes to home and community-based settings

2012 Significant Legislative Actions

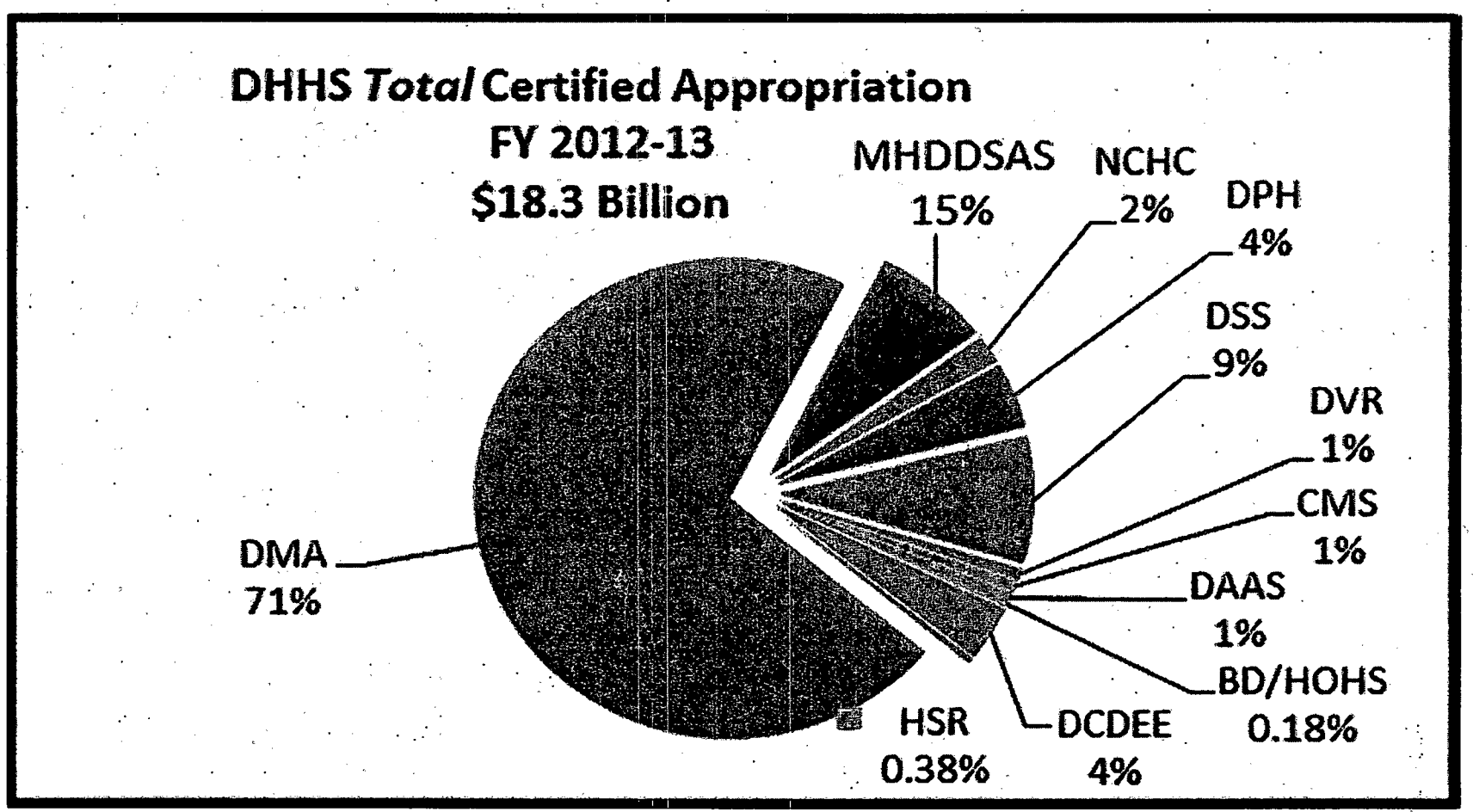
- S.L. 2012-142, Sec. 10.23A appropriated $10.3 million to establish the Transitions to Community Living Fund to begin implementing a plan to transition individuals to community living arrangements, including housing assistance and any wrap-around services they may need
- Sec. 10.23A also established the Blue Ribbon Commission on Transitions to Community Living to i) examine the State's system of community housing and supports for people with severe mental illness and I/DD and ii) develop a plan to address the issues identified by US DOJ
  - The Commission's final report, issued in January 2013, includes 17 recommendations, several having a direct impact on the mental health divisions and the LME/MCOs.

Budget Overview

Mental Health/Developmental Disabilities/Substance Abuse Services

State Operated Health Facilities

Department of Health and Human Services
2012-13 Total Budget



FY 2012-13 Budget

- FY 2012-13 Certified Budget:

Requirements:	$1,366,532,639
Revenues:	$ 671,017,388
Net G.F. Appropriation	$ 695,515,251

- Positions: 11,719

- Approximately 50% budget is supported by Medicaid, federal block grant funds and other revenue
  - Federal block grant funding: $52.8 million

FY11-12 Division Expenditures

- Facilities $863 million
- Community Services $365 million
- LME Administration $104 million
- Division Administration $24 million

FY 2012-13 Budgeted Expenditures

Purpose	$ Amount	% Total
Salaries & Benefits	630,090,230	45.4%
Purchased Services	48,477,515	3.5%
Supplies; Property; Equipment	56,364,535	4.1%
Aid & Public Assistance	487,888,977	35.1%
Reserves & Other Expenditures	21,269,961	1.5%
Intergovernmental Transfers	145,153,701	10.4%
Total	1,389,244,919	100%

State Psychiatric Hospitals Requirements

Hospital	FY11-12 Actual Expenditures ($)	FY12-13 Certified Budget ($)	FY13-14 Continuation Budget ($)
Broughton	125,945,271	131,484,007	131,972,504
Central Regional	229,047,155	193,213,302	187,640,526
Cherry	106,264,385	128,325,296	145,910,650
Total	**461,256,811**	**453,022,605**	**465,523,680**

General Fund Budget Comparisons

	$ Amount	% Change
FY 2011– 12 Actual Expenditures	669,003,343	
FY 2012 – 13 Certified Budget	703,670,925	+5.2%
FY 2013 – 14 Continuation Budget	706,978,374	+0.5%

Mental Health Budget and Policy Issues

- Cost to implement the State's settlement agreement with U.S. DOJ to transfer and divert persons from institutions/facilities to home and community-based settings

- Adequacy of community services funding
  - Especially for non-Medicaid eligible persons

- Continue special appropriations for select nonprofit agencies ($6.2 million)

- Impact of federal/Congressional decisions regarding block grant funding
  - S.L. 2012-142 appropriated $57 million in federal block grant funds for mental health/developmental disabilities/substance abuse services

  - DHHS I waiver proposal

Mental Health Budget and Policy Issues

- Impact of State Medicaid policy changes
  - Approximately 1,500 group home residents and 3,600 adult care home residents with mental illness or developmental disabilities lost eligibility for personal care services on January 1, 2013
- LME/MCO financial solvency
  - Which entity is financially liable for LME/MCO cost overruns that exceed available risk reserve and fund balance?
    - HB 916 exempts county governments from financial liability
- Ongoing staff shortages at State operated facilities
- State operated facilities capacity
  - More community and state facility beds needed

Questions

Denise Thomas, Principal Fiscal Analyst

Fiscal Research Division

(919) 733-4910

Committee Sergeants at Arms

NAME OF COMMITTEE J+Appon Health & Human Services

DATE: 2/26/13 **Room:** 643

House Sgt-At Arms:

1. **Name:** Fred HINES
2. **Name:** MARVIN LEE
3. **Name:** Charles Godwin
4. **Name:**
5. **Name:**

Senate Sgt-At Arms:

1. **Name:** Leslie Wright
2. **Name:** Steve WILSON
3. **Name:**
4. **Name:**
5. **Name:**

PAGES ATTENDING

COMMITTEE: Joint: Health & Hum. Serv ROOM: 643

DATE: 2-26 ~~25~~ TIME: 8:30am

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!

Page Name	Hometown	Sponsoring Senator
1 Danielle Jones	Clinton, NC	Berger
2		
3		
4		
5		
6		
7		
8		
9		
10		

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

PAGES

Tuesday, February 26	**Room**	**Time**
JOINT APPROPRIATIONS HEALTH & HUMAN SERVICES	643	8:30 am

Name	County	Sponsor
James Hennessy	Dare	Tillis
Elizabeth Higdon	Union	Horn
Melinda Kauffman	Wake	Stam

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — Name of Committee

Feb 26, 2013 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Abby Emanuelson	NMSS
Colleen Kahanek	NCCEP
Butch Gunnells	NC Bev A
Debbie Whitford	CTE
Alan Rideout	NCASA
Chip Killian	Nelson Mullins
Kaitlyn Kregg	UNC Chapel Hill School of Journalism
DARLA GOLDFUSS	NORTH CAROLINA ASSOCIATION OF CAREER & TECHNICAL EDUCATORS NCACTE

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — Name of Committee

Feb 26, 2013 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Winslow Carter	North Carolina Association of ~~National~~ Career & Technical Education
Fletcher Kneebusch	NCACTE

VISITOR REGISTRATION SHEET

Jt Appr. on Health & Human Svc. 2/26/13

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fred Wadell	Eastern Seals UCP
Alice Watkins	Alzheimer's North Carolina
Maraa Brantley	Prevent Blindness NC
Anya Helfrich	Prevent Blindness NC
Alex Mullineaux	Constant Health
Andy Willard	UNC-CH
Matthew McConnell	Carolinas HealthCare Sys
George Smith	Nexsen Pruet
Daniel VanLiere	Vidant Health
Cody Hand	NCHA
Marci Wilder	Novant
Daniel Andrews	NCEMA

VISITOR REGISTRATION SHEET

H. Apps on HHS — 2/26/13

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JAY PETERS	CSS
[illegible]	NCHCA
[illegible]	CSS
[illegible]	DRNC
[illegible]	[illegible]
[illegible]	NCSA
[illegible]	NAMI NC
[illegible]	[illegible]
[illegible]	[illegible]
Johanna Reese	NCACC
[illegible]	NASW-NC

VISITOR REGISTRATION SHEET

Joint Appr on HHS — 2/26/13

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rebecca Troutman	NCACC
Yolanda Stith	Capital Access
[illegible]	Donate Life NC
Harry Ballard	Surgical Hospitalists of New Bern
[illegible] Mayer	Junior League of Charlotte
Jane [illegible]	Junior League of Charlotte
[illegible]	North Raleigh Ministries
[illegible]	EWC[illegible]
[illegible]	MF$S
[illegible]	MP
Christine Weason	ACS CAN
Shelley [illegible]	citizen - spectator

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS
Name of Committee

Feb 26 2013
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wendy Kelly	Policy Group
Terry Haworth	NCPCF NCCM
John Mercer	Policy Grp
John Thompson	CCNC
David Barnes	Electricities
Ellen McDonell	Troutman Sanders
Brenda Williams	Sanford Housing Authority
Paula H. Hopper	Children's Hsp
Van Denton	NC Education Lobby
Gene Causby	NCSBA
Jeff Moss	HCS

VISITOR REGISTRATION SHEET

Jt Approp on Health + Human SVCs 2/26/13

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Metcalf	The Policy Group
Caroline Cobb	The Policy Group.
Mary Bethea	AARP-NC
Sarah Wolfe	MWC LLC
Kerra Bolton	LCA
Matt Gross	NCR
[illegible]	MWC
[illegible]	NC Health News
JOE LANIER	NELSON MULLINS
Allison Waller	Nelson Mullins
JOEL MAYNARD	GPM: ASSOC

VISITOR REGISTRATION SHEET

2/26/13

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Penny Magnum	
Alex Badger	CSS
JESSICA HERRMANN	GOVERNOR'S INSTITUTE
TRACY COLVARD	AHHC
Ken Melton	KMA
ALAN BRIGGS	NC Food Banks
Jennifer Mahan	ASNC
Julia Adams	The Arc of NC/NCARF
BRUCE THOMPSON	PARKER POE
Pam Shipman	Carolina Innovations

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

February 27, 2013
Legislative Office Building - Room 643
8:30 a.m.

House
Rep. Marilyn Avila, Co-Chair
Rep. William Brisson, Co-Chair
Rep. Mark Hollo, Co-Chair
Rep. Donnie Lambeth, Vice Chair
Rep. Susan Martin, Vice Chair
Rep. Tom Murry, Vice Chair
Rep. Beverly Earle
Rep. Jean Farmer-Butterfield
Rep. Carl Ford
Rep. Jim Fulghum
Rep. Verla Insko

Senate
Sen. Ralph Hise, Co-Chair
Sen. Louis Pate, Co-Chair
Sen. Austin Allran
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Martin Nesbitt.
Sen. Gladys Robinson

Overview: Statewide Expansion of the Medicaid 1915(b)(c) Behavioral Health Waiver; S.L. 2011-64	Denise Thomas Committee Staff Fiscal Research Division
Overview: Waiver Implementation Status and Performance	Ann Rodriguez, Policy Analyst NC Council of Community Programs
Perspectives on the LME/MCO Conversion Process and Operations	Brian Ingraham, CEO Smoky Mountain Center MCO Ken Jones, CEO Eastpointe MCO
Adjourn	
Next Meeting:	February 28, 2013- 8:30 a.m.

Joint House Committee on Appropriations Subcommittee on Health and Human Services
Wednesday, February 27, 2013 at 8:30
Room 643

MINUTES

The Joint House Committee on Appropriations Subcommittee on Health and Human Services met at 8:30 am on February 27, 2012 in Room 643. Representatives Avila, Brisson, Earle, Farmer-Butterfield, Ford, Fulghum, Hollo,Lambeth, Martin, and Murry attended. Senators Barringer, Hise, Pate, Robinson and McKissick also attended.

Rep. Marilyn Avila presided.She gaveled the meeting to order at 8:30 am. Pages introduced were Thomas Bryd,Abby Sparrow, Andre Tyson. Sergeants at Arms were Leslie Wright, Steve Wilson, Marvin Lee, Charles Godwin.

Denise Thomas, Fiscal Research Division was introduced to present an overview of the state expansion of the Medicaid 1915 (b) (c) Behavioral Health Waiver. (attached)

Ann Rodriguez, Policy Analyst for the NC Council of Community Programs, gave an overview of the waiver implementation status.

Brian Ingraham, CEO Smoky Mountian Center MCO gave a perspective on LME/MCO conversions and operations.

Ken Jones, CEO Eastpoints MCO, was scheduled to present but due to time was asked to do so on February 28.

The meeting adjourned at 9:50 am.

Representative Marilyn Avila
Presiding

Susan Lewis, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

n: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 21, 2013 12:20 PM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Wednesday, February 27, 2013 at 8:30 AM

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	February 27, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Overview: 1915 b/c Medicaid Waivers

Joint Appropriations House and Senate Subcommittee On Health and Human Services

February 27, 2013

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

1915 (b)(c) Medicaid Waiver: Legislative Action

- Under the 1915 (b)(c) Medicaid waiver, NC can enroll Medicaid participants into managed care plans and limit the number of providers who can serve them. In addition, the waiver allows Medicaid funds to provide home and community-based services to persons who might otherwise be placed in an institution.
  - In 2005, DHHS piloted a Medicaid 1915 (b) (c) waiver operated by Piedmont Behavioral Health (PBH) to provide behavioral health, e.g. mental health, developmental disabilities, or substance abuse treatment, services to persons living in Cabarrus, Davidson, Rowan, Stanly, or Union Counties.
  - The pilot demonstrated that quality behavioral health services could be effectively provided in a cost-efficient manner, resulting in Medicaid cost savings
- During the 2011 Session, the Legislature passed HB 916, S.L. 2011-264, which mandated the state wide expansion of the 1915 (b) (c) waiver to be fully implemented by June 30, 2013

1915 (b)(c) Medicaid Waiver

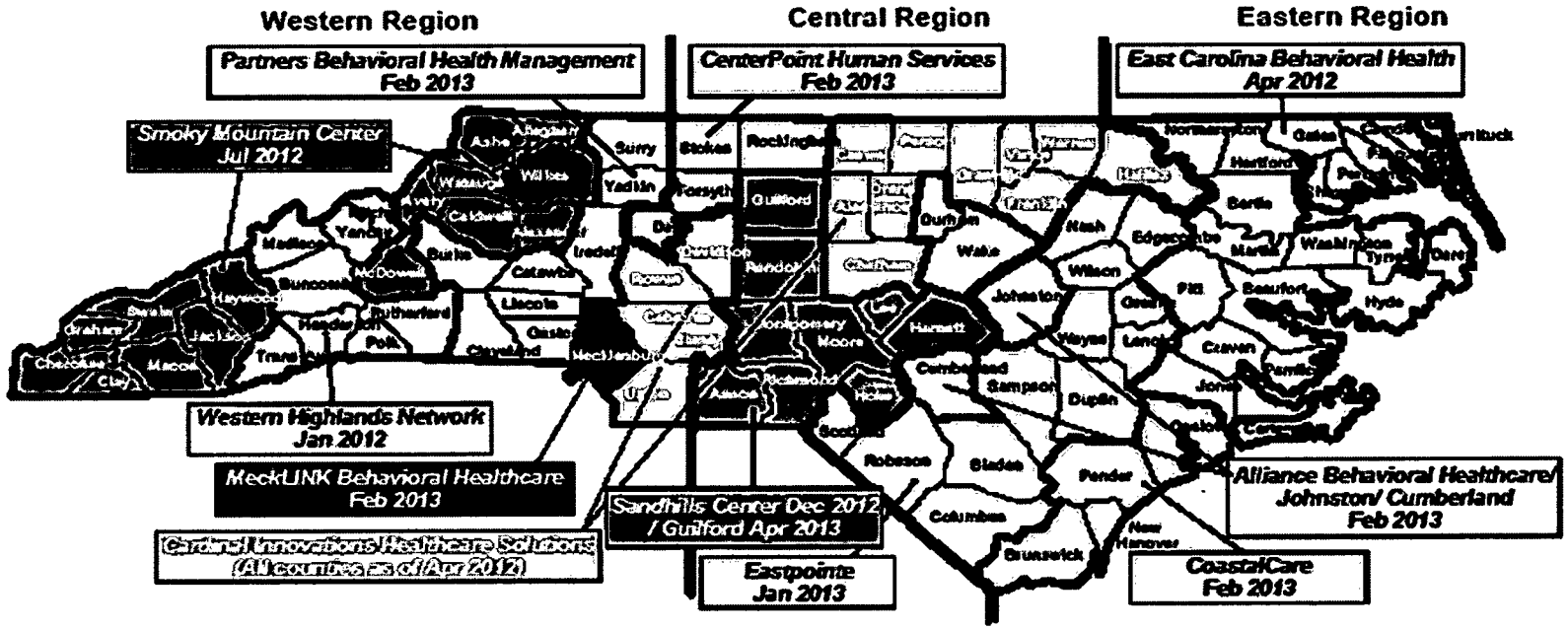
- Based upon population size, 23 LMEs have consolidated since 2011 to form 11 managed care organizations (MCO)
  - Catchment area minimum population size: 500,000

- MCOs receive their Medicaid funds in the form a capitated allocation. In addition, they receive a separate, combined allocation of State, federal block grant and other funding to be used to provide behavioral health services that are not covered by Medicaid, including services to individuals who are not eligible for Medicaid
  - MCOs are responsible for managing their funds within capitation budget and must cover any cost overruns with their own resources, e.g. mandated risk reserve, fund balances
    - HB 916 specifies that county governments are not financially liable for MCO cost overruns
  - Any operating budget surpluses are retained by the MCO

Division of **Medical Assistance**

north carolina medicaid

Local Management Entity - Managed Care Organizations (LME-MCOs) and their Member Counties (Current and Proposed on February 1, 2013)



- *For proposed LME-MCOs that have not yet merged, the lead LME name is shown first.*
- *Sandhills Center and Guilford are scheduled to merge on January 1, 2013.*
- *Dates shown through December 2012 are actual Waiver start dates.*
- *Dates after December 2012 are the planned Waiver start dates.*
- *Reflects plans and accomplishments as of December 6, 2012.*

6

DMA

Managed Care Organizations (MCOs)

Authority and Responsibilities

- establish a provider network
  - May limit the number of service providers
- Contract with providers for services, including hospitals and state operated facilities
- Set rates for services
- Impose prior authorization or other utilization management approaches which may restrict the type and amount of services to be provided
- Coordinate care
- Pay provider claims
- Establish and maintain an IT system
- Monitoring and quality assurance
- Maintain a website to provide consumer information

DHHS Funding for LME/MCO's

- LMEs/MCOs manage State, federal, Medicaid, and local/county funds
  - Responsible for authorizing services, maintaining provider network, monitoring service quality, customer service, etc.
- FY12-13 Funding for LMEs/MCOs:
  - Medicaid: $2.1 billion
  - Community Service Funds: $340 million
    - Includes federal block grant funds
    - Funding has decreased by $78 million, almost 20%, since 2000
  - Administrative Funding: $98 million
    - Includes funds provided to support MCO mergers

Budget Impact

- S.L. 2011-145, the 2011 Appropriations Act, reduced the Medicaid budget in both years of the biennium in anticipation of savings due to implementation of the 1915 (b)(c) waiver:

FY11-12	FY12-13
($10,537,931) R	($52,551,082)

- S.L. 2012-142, the 2012 Appropriation Act, adjusted the FY12-13 reduction by $1,700,000 NR to reflect the impact of delays in the LME/MCO conversion process
  - Estimated impact of current year conversion schedule delays will decrease anticipated savings by an additional $11.7 million

- S.L. 2012-142 also reduced the DMH/DD/SAS budget for LME administrative expenses in anticipation of savings from the transition to MCOs ($8,497,935) R

Questions

Denise Thomas, Principal Fiscal Analyst

Fiscal Research Division

(919) 733-4910

• MENTAL HEALTH
• DEVELOPMENTAL DISABILITIES
• SUBSTANCE ABUSE

NORTH CAROLINA
COUNCIL OF COMMUNITY PROGRAMS

MEDICAID WAIVER IMPLEMENTATION STATUS AND PERFORMANCE

January 2013

77 NC Counties Are Now Under the Medicaid 1915 (b)(c) Waiver

Status:

LME-MCO	Status	# Medicaid Eligibles
Cardinal Innovations Healthcare Solutions (CIHS)	Implemented 4/1/05, expanded to manage Alamance County 10/1/11, Five County 1/1/12, OPC 4/1/12 (and merged with all counties involved)	183,708
Western Highlands Network (WHN)	Implemented 1/3/12	67,693
East Carolina Behavioral Health (ECBH)	Implemented 4/1/12	86,907
Smoky Mountain Center (SMC)	Implemented 7/1/12	76,315
Sandhills Center (SC)	Implemented 12/1/12 (Guilford County will join waiver 4/1/13, merger occurred 1/1/13)	83,827
Eastpointe (EP)	Implemented 1/1/13	178,680

*Excludes children under 3 years of age; also excludes retroactively eligible population.

Provider Network as of Implementation Date:

	CIHS #	WHN #	ECBH #	SMC#	Sandhills	EP
# in network before waiver/expansion	257	221	181	162	371	274
# in network after waiver/expansion	802	377	356	286	658	572
# denied access to waiver at time of implementation	34	2	5	0	1	11

*Total network, IPRS and MCD

**Based on before implementation/expansion. The numbers do not include those who did not apply in time for implementation.

Claims Adjudication:

	CI HS#	CI HS%	WHN #[3]	WHN %	ECBH #[4]	ECBH %	SMC #	SMC%	SC #	SC %	EP	EP%
Average Days to Process a Clean Claim (received date to processed date)	2.67[1]	N/A	15 Days	N/A	9.5	N/A	0.2 days	N/A	9.4	N/A	9.19	NA
Total Billed Claims For Month Indicated (Medicaid only)	270,869[2]		251,879	100%	74,025	100%	85,975	100%	64,261[5]	100%	67,726	100%
Total Approved Claims	210,800[2]	77.82%	220,488	87.5%	65,026	87.8%	72,462	84.3%	43,583	67.8%	55,447	81.87%
Claims not processed due to Provider Claims Processing Issues	60,069	22.18%	31,353	12.4%	8,545	11.5%	9462	11%	20,401	31.7%	7,513	11%
Claims not processed due to LME-MCO Systems Issues	0	0%	38	0.02%	434	0.6%	4051	4.7%	277	0.4%	4,766	7%

**Total billed claims include both paper and electronic; Medicaid fund sources only.

*** The contract between DHHS and the LME-MCO allows a 30-day turnaround time for clean claims.

1. CIHS Processing Days reflects only Medicaid Claims
2. CIHS Claims totals are all claims processed (Medicaid and State)
3. WHN reporting on claims 8/1/12 through 10/31/12
4. ECBH there are 20 pended claims (.1%) included in the total billed claims.
5. SC claim service lines processed 01/01/13 thru 01/31/13 and includes 428 pending claim service lines as of Jan 31, 2013

Service Authorizations:

	CIHS #	CIHS %	WHN #	WHN %	ECBH #[2]	ECBH %	SMC #[1]	SMC%	SC#	SC%	EP	EP%
Total Authorizations Requested	4,481	100%	7175	100%	2425	100%	2326	100%	2193	100%	5,244	100%
Total Authorizations Approved	3,803	84.9%	6529	91.0%	1457	60%	1568	68%	1701	78%	4,748	91%
Administrative Denials	632	14.1%	595	8.3%	580	24%	424	18%	438	20%	263	5%
Denied for Medical Necessity	46	1.0%	45	0.6%	227	9.4%	334	14%	54	2%	233	4%

1 SMC - Does not include those authorizations that are unable to process.

2 ECBH- There are 161 authorizations (6.6%) that are still being processed in the time allotted.

Consumer Grievances:

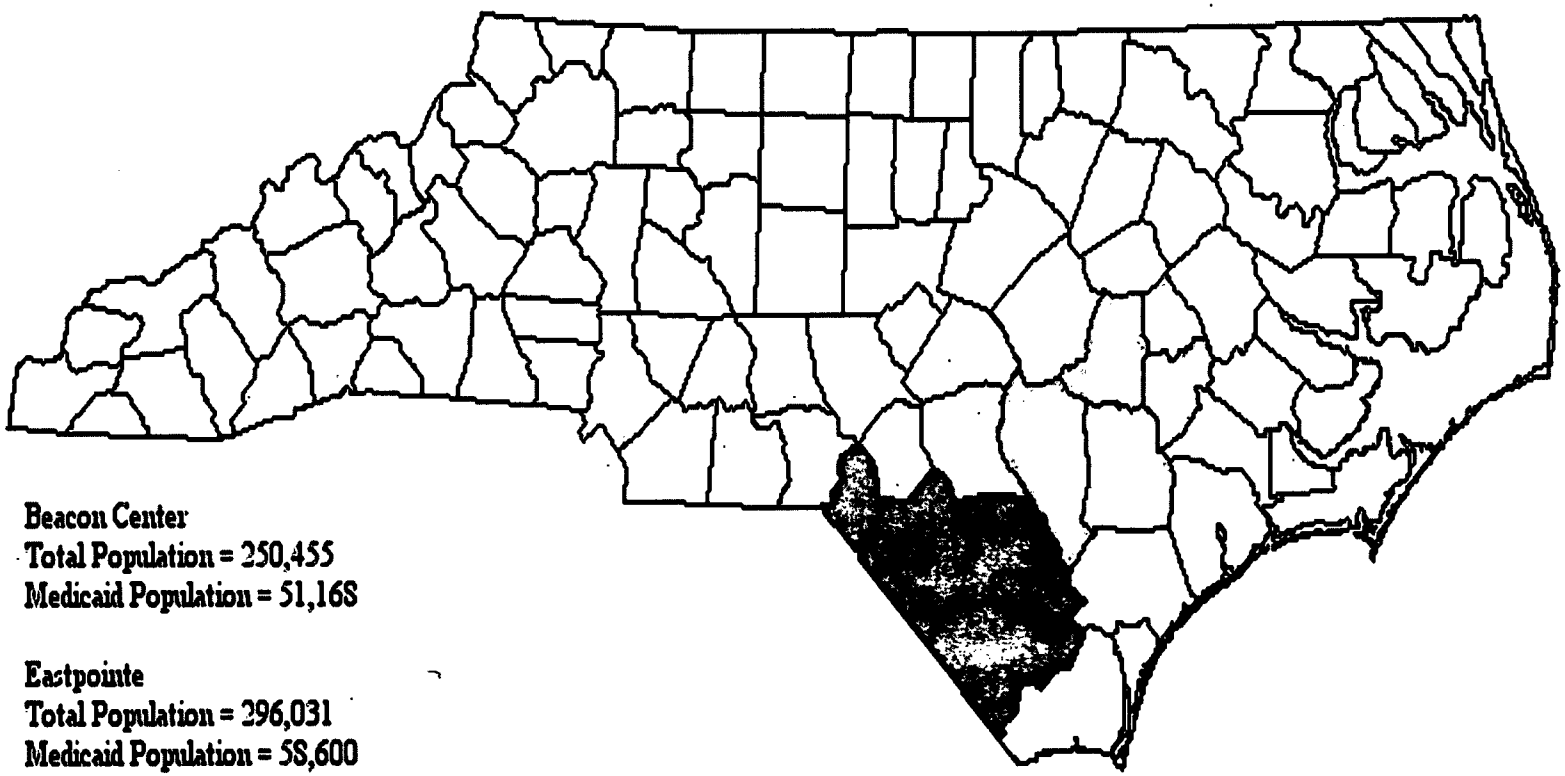
	CIHS	WHN	ECBH	SMC	SC	EP
# Per Month About the LME-MCO	12	4	5	4	1	5
# Per Month About the Provider	41	13	9	9	11	21

Statewide Issues Resolution:

Issue	Resolution
Need standardized application process for providers across all LME-MCOs	Central repository established for provider application used by 8 MCOs
Need standardized contracts for providers across all LME-MCOs	Contracts adopted for inpatient and State facilities, negotiating refinement of licensed practitioners and agencies contracts
Need standard program integrity measures	Council working with DHHS for all LME-MCOs to use same sampling methodology and fraud and abuse data systems as the State and federal government

Life as an MCO- The First Month

As presented by Ken Jones, CEO
February 27, 2013



The Beacon Center
Edgecombe, Greene,
Nash, Wilson

Eastpointe
Duplin, Lenoir,
Sampson, Wayne

Southeastern Regional
Bladen, Columbus,
Robeson, Scotland

Beacon Center
Total Population = 250,455
Medicaid Population = 51,168

Eastpointe
Total Population = 296,031
Medicaid Population = 58,600

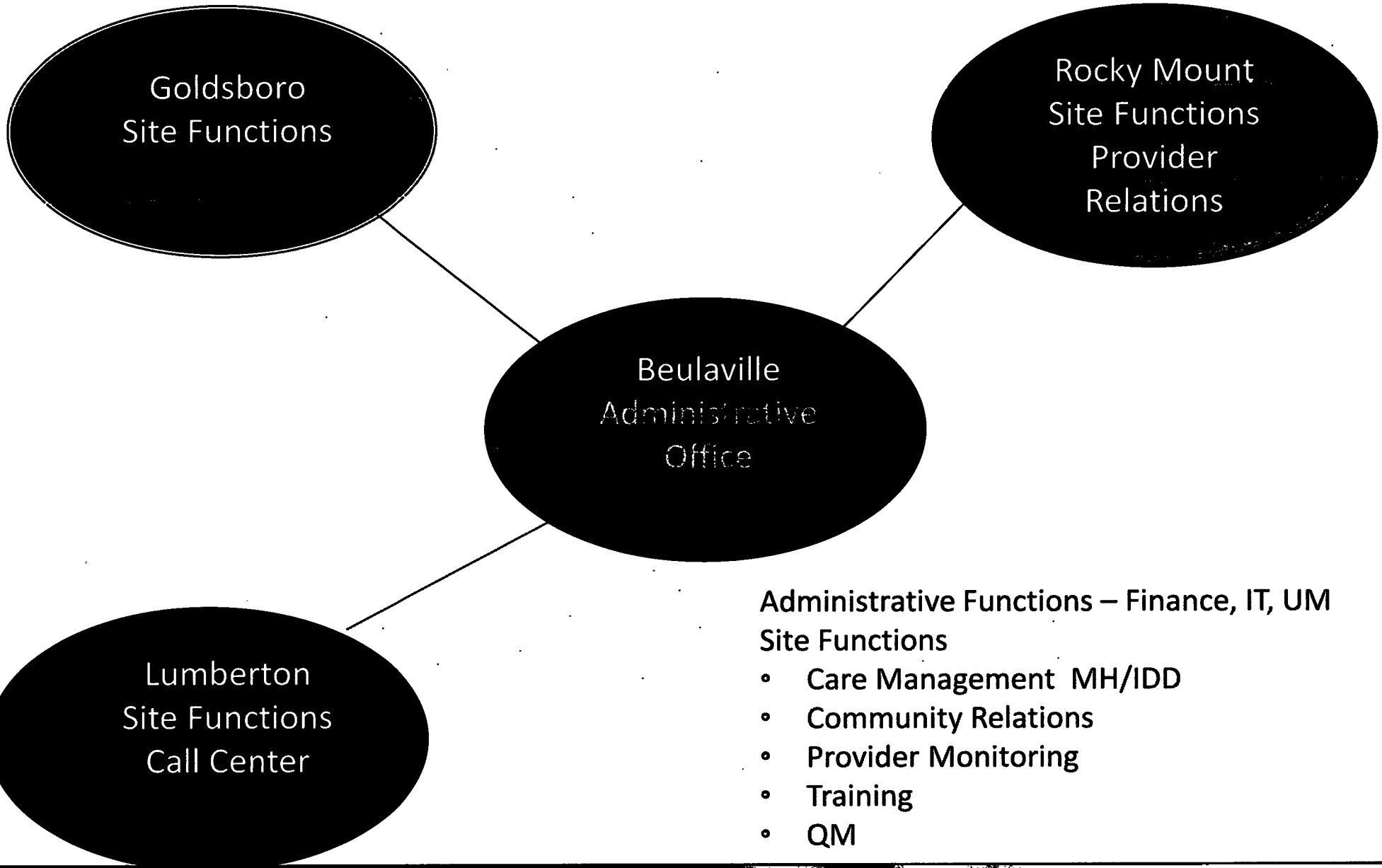
Southeastern Regional
Total Population = 257,541
Medicaid Population = 68,912

Total Population = 804,027
Total Medicaid Population =178,680
Total % of State Population = 8.45
Total % of State Medicaid Population = 13%

- Total expenditures projected ~$400 Million

Member Lives Covered-Medicaid

	LME	Medicaid
1	Alliance Behavioral Healthcare	186,485
2	Cardinal Innovations Healthcare Solutions	183,708
3	Eastpointe	178,775
4	Sandhills Center for MH/DD/SAS	147,872
5	Partners Behavioral Health Management	140,677
6	MeckLINK Behavioral Healthcare	115,344
7	East Carolina Behavioral Health	93,757
8	Smoky Mountain Center	83,089
9	CenterPoint Human Services	76,315
10	Western Highlands Network	67,693
11	CoastalCare	69,787



Administrative Functions – Finance, IT, UM

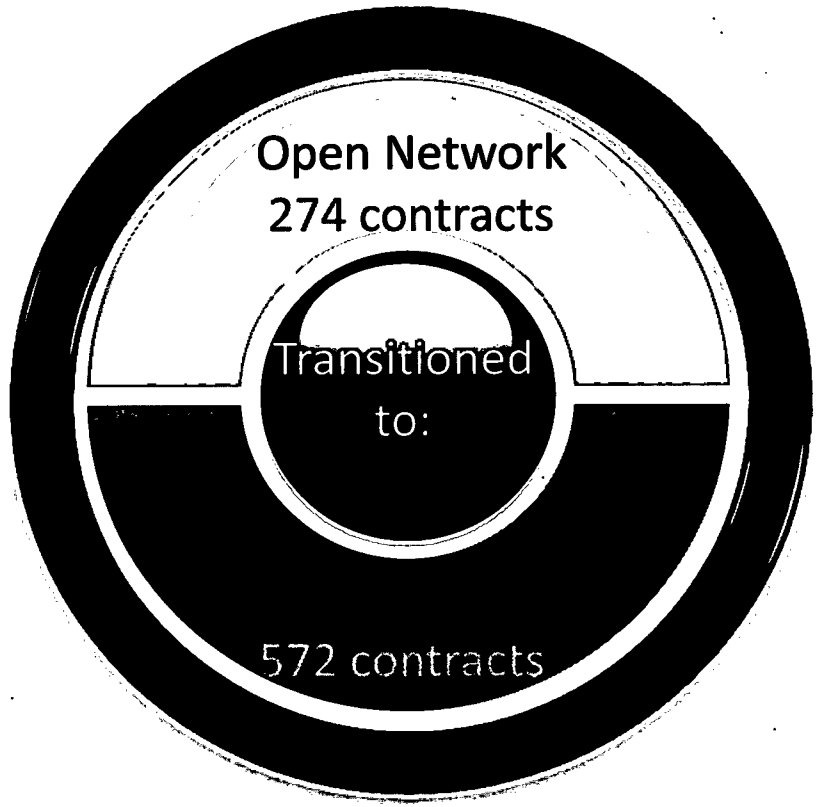
Site Functions

- **Care Management MH/IDD**
- **Community Relations**
- **Provider Monitoring**
- **Training**
- **QM**

Goals

- To manage care and ensure **cost effective** treatment
  - Medicaid $22M/per month
  - State Indigent IPRS $3M/per month
  - 3-way contract $250,000 per month
  - 12 Counties $212,000 per month
- Improved access to services and **Quality of Care**
- To have management of **State/Medicaid** Services occur at a **local community level**

Provider Network



Eastpointe started publicizing application process in May 2012

More than 1200 individuals attended multiple educational sessions thru December.

More than 520 email notifications sent via provider listserve.

Consumer and Provider Access to Eastpointe MCO

- Consumer Family Advisory Council (CFAC)
- Provider Council
- Client's Rights Committee
- Clinical Advisory Committee
- Credentialing Committee
- Cultural Competency Committee
- Global Quality Management Committee
- Community Relations Staff assigned to each county
- Monthly Provider meetings and Provider Council meetings
- Bi-Weekly Provider Trainings/Webinars
- Consumer Forums on Special topics
- Community Collaborative Group (Hospitals, Sheriffs' Department, Health Agency, DSS, Crisis Walk-In Centers)
- Suggestion Boxes
- Telephonic and Email availability for Grievances
- Call Center
- Website

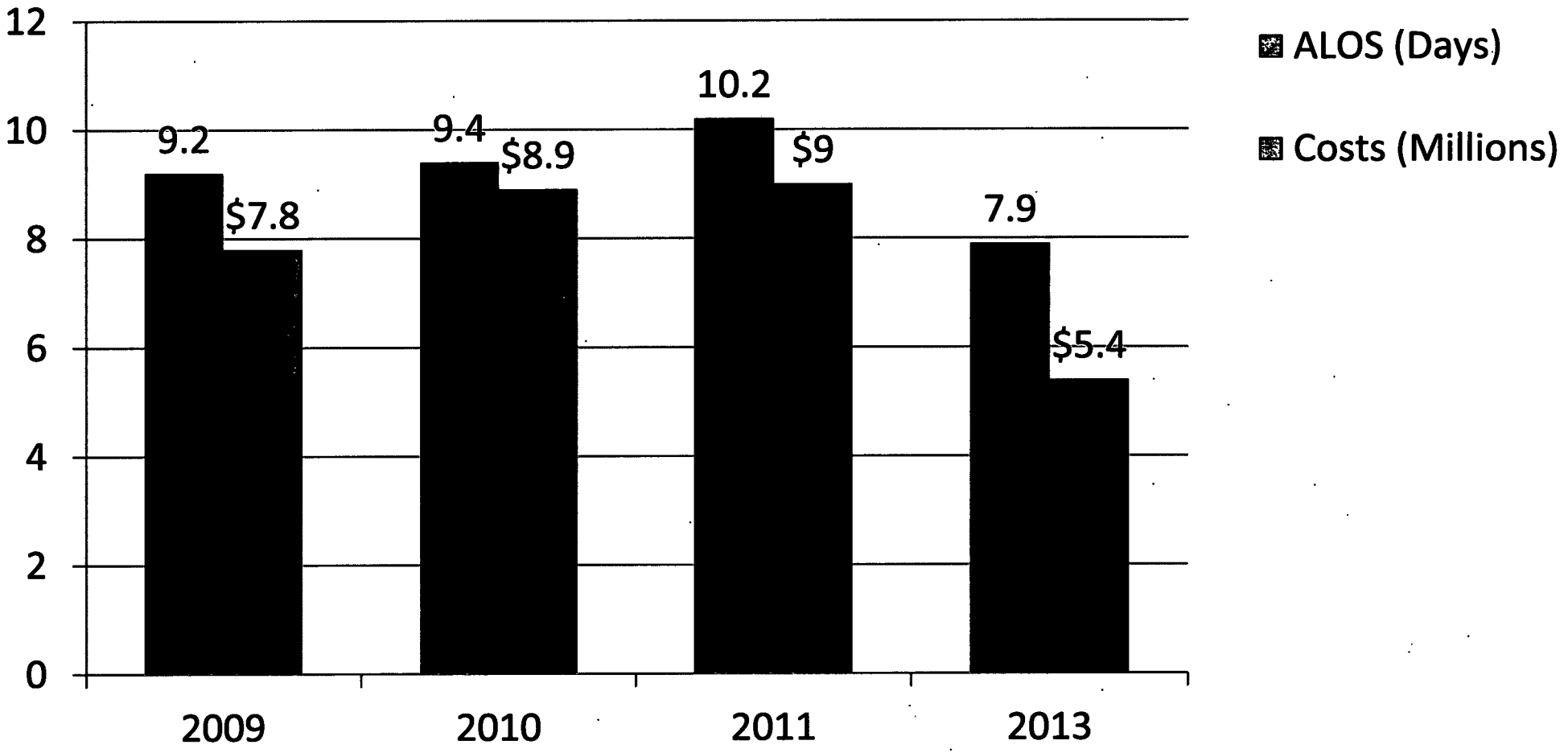
Information Technology System

- Eastpointe uses Netsmart Technologies, Inc. as their MCO software vendor
- Netsmart has been in business since 1968 and Eastpointe has utilized their products since 1999.
- They have 21,000 clients and 40 state systems
- Eastpointe successfully utilized the Netsmart system during our 2 years as a Medicaid UR vendor
- Netsmart is certified by the Certification Commission for Healthcare Information Technology (CCHIT)

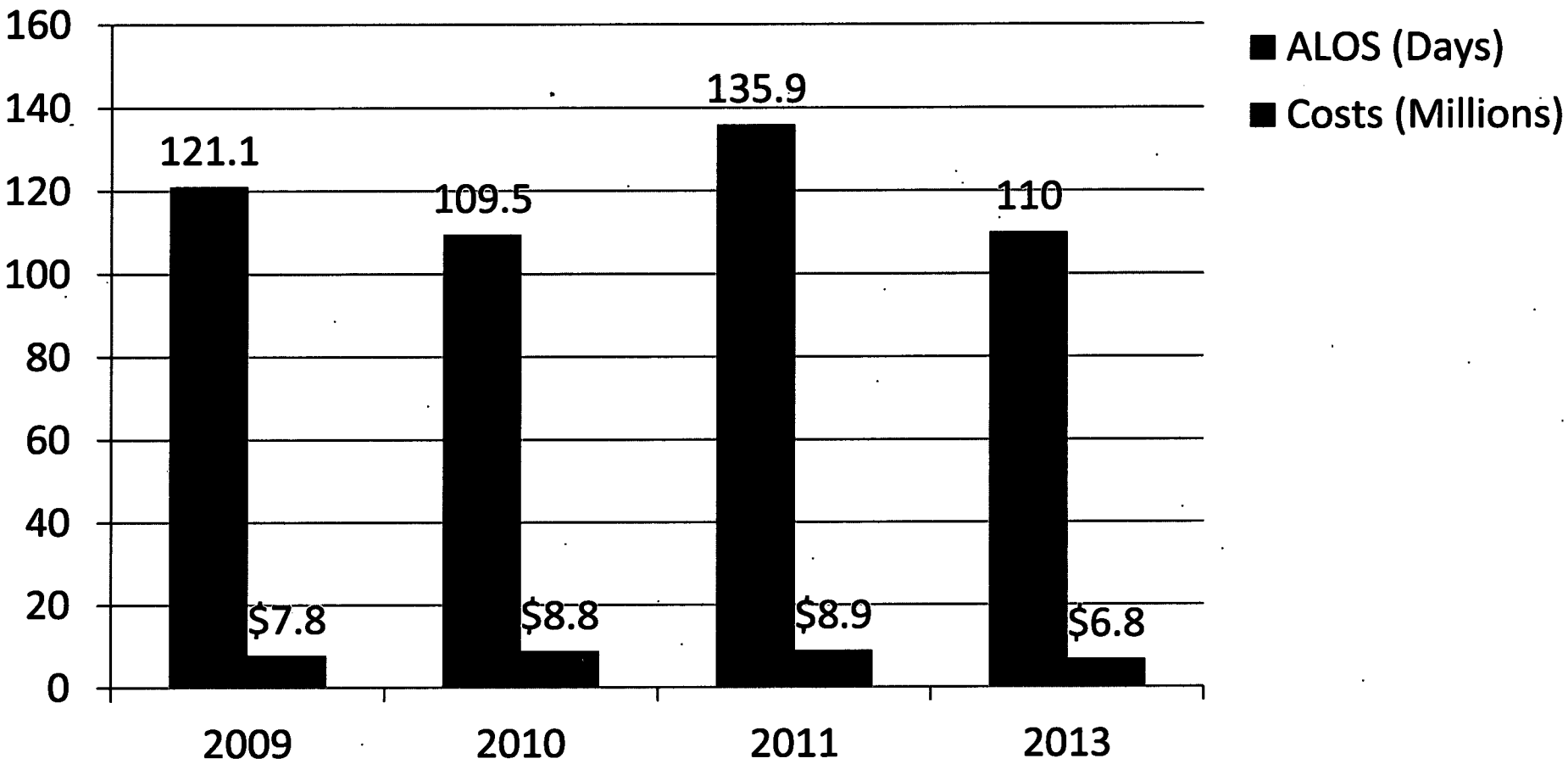
Eastpointe - Initial Budget Strategy

- Budget preparation included both clinical and finance staff; budget includes drill down to service level.
- In some cases, Eastpointe budgeted over the PMPM service rates for services underfunded. Other service areas Eastpointe showed savings to make budget.
- Eastpointe MCO is too new at this point in time to showcase results. Instead, here are some examples of the roadmap we plan to use.

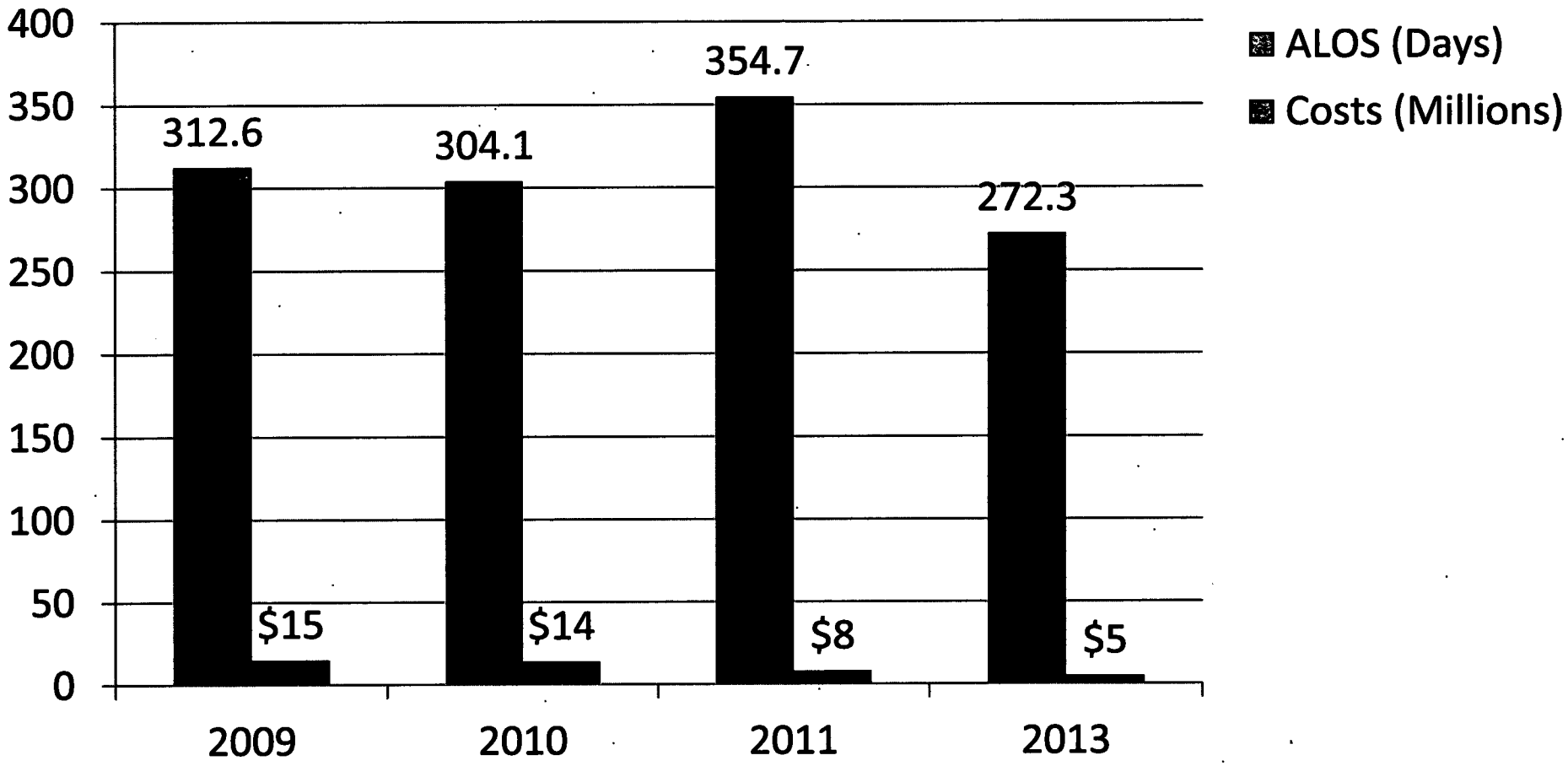
Inpatient Average Length of Stay (ALOS) and Costs of Care



PRTF Average ALOS and Cost of Care



Partial Hospital / Day Treatment ALOS and Cost of Care



Reshaping Service Delivery

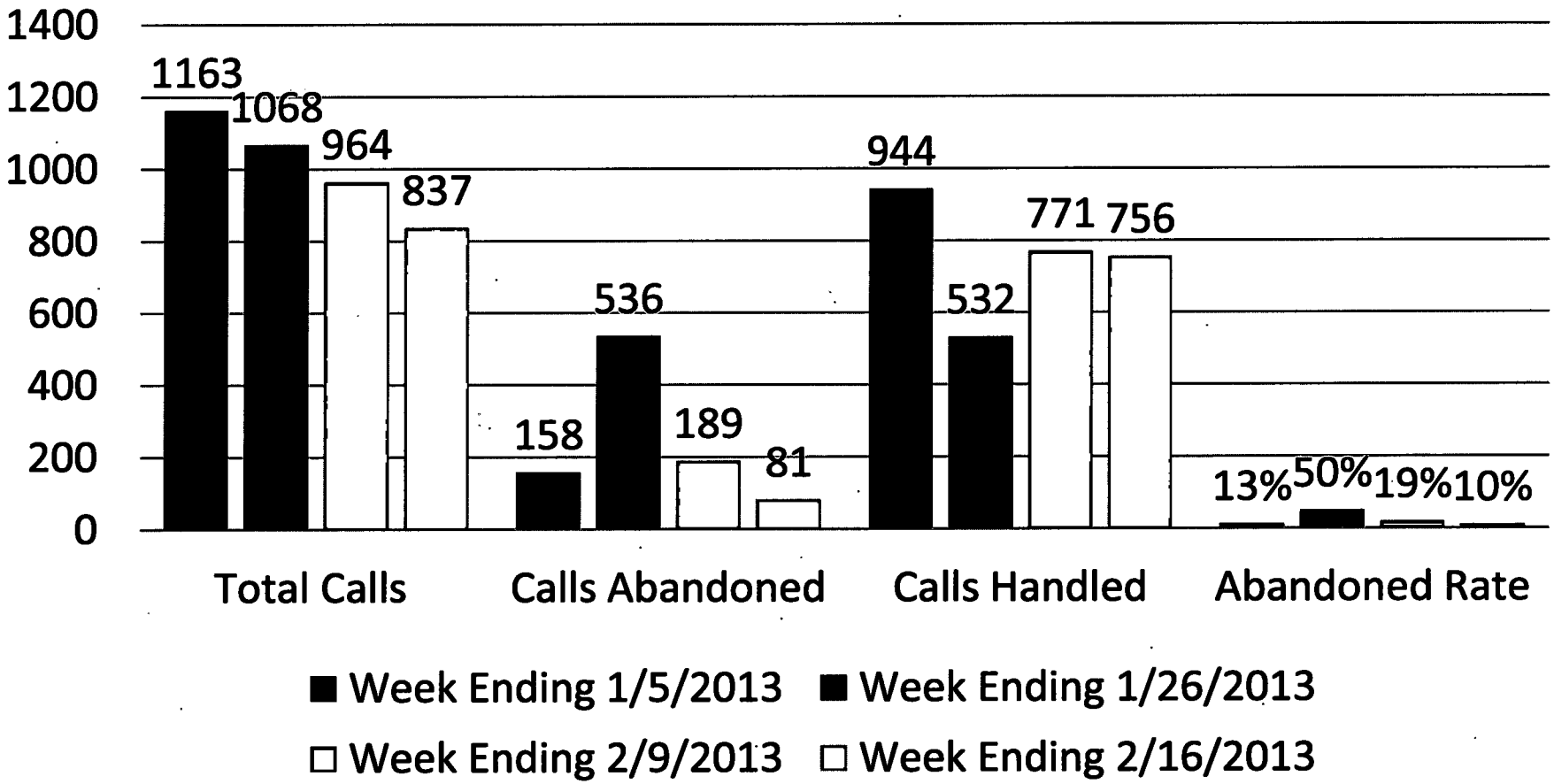
- ACTT – an additional 11.9% of what is saved in other areas will be redirected here
- Psych Rehab – an additional 7.1% of savings will be redirected in these supportive services

Life as an MCO

- **Member Call Statistics (January 2013)**
  - Out of 10,066 calls, only 23 calls went to voice mail

Life as an MCO

Provider Call Center Stats



Life as an MCO

(Initial issues and resolutions)

- Authorizations
  - Obtaining the former vendor's authorizations impacting our MCO was problematic and spilled into our go-live. We have resolved this issue but it was very visible to the provider community.
- Claims Processing
  - Training, Transition, and Setup Issues (resolved)
  - Eastpointe continues to look at denials and trends to determine training and/or payment issues.

Claims Processing

Transition Issues/Concerns

Claims Issue/Concern	Eastpointe Response/Resolution
Member not admitted into the system- thus provider could not submit requests and bill.	Eastpointe implemented "Team LCAD" to enter all admissions until software allows direct admission by the provider.
VO authorizations not loaded into the Eastpointe system.	Eastpointe continues to received an enter authorizations completed by VO that were not on the file received by Eastpointe.
Incorrect authorization number (VO number) entered on claim, causing a denial.	Eastpointe trained providers on issue, communicated via listserve, and had software vendor added temporary logic to correct provider error and search for appropriate auth.

Claims Processing

- Transition Issues/Concerns

Claims Issue/Concern	Eastpointe Response/Resolution
Provider agency billed $0.00 in claim. Eastpointe's logic paid the lesser of amount billed or contracted amount.	Eastpointe re-adjudicated all claims that were paid at the $0.00 amount and educated providers on the issue. Eastpointe has temporarily lifted this logic (edit).
837 system loop error	Eastpointe identified issue and software vendor resolved issue.
Third Party Payer denial for Innovations and Enhanced Service recipients.	Eastpointe corrected this internally- this was a set up issue easily resolved. All claims previously denied were re-adjudicated.

Life as an MCO

- **FACTS For January Claims:**
  - Total Claims Processed – 67,726
  - Total Claims Paid to Providers -$11.7 M

No Changes to HB 916 and the 1915(b)(c) Medicaid Waiver

- HB 916 is solution focused Legislation – Give it time to See the Results
  - The Delivery of Medically Necessary Services
  - Increased Quality of Care
  - Cost Savings
  - Predictability Cost
  - Sustainable Business Environment

Closing

- Website: www.eastpointe.net
- Phone: 919-587-0377
- Email: kjones@eastpointe.net

Smoky Mountain Center (SMC)
Operations at a Glance – January 2013

SMC is committed to being a transparent organization and keeping stakeholders informed. To support these efforts, SMC will create a brief, monthly summary of operations by functional area.

Individuals Eligible for Medicaid Services through SMC

SMC is responsible for the oversight of behavioral health and intellectual/developmental disability Medicaid services in our 15-county area. For January:

- Individuals on the NC Innovations waiver: **638**
- Other individuals who receive Medicaid: **75,677**

Explanation: Each month the North Carolina Division of Medical Assistance (DMA) pays SMC a capitated amount per Medicaid recipient (numbers above). From those funds, we must manage services for any individual in SMC's 15 counties who needs a Medicaid service for mental health, intellectual/developmental disabilities, or substance abuse.

Customer Services (Medicaid and State-funded)

- SMC customer service representatives answered: **2,826 calls during January** and **2,826 YTD***
- Average time to answer a call: **11 seconds during January** and **11 seconds YTD**

Explanation: Customer service representatives take calls related to accessing services, answering questions, and providing support. SMC is required to answer calls within 30 seconds.

Care Management/Utilization Management (Medicaid Only)

- SMC care managers processed **2,419** requests for the authorization of services **during January** and **2,419 YTD**
  - Average time for review and authorization of requests: **7.4 days during January** and **7.4 YTD**
  - Mental health or substance abuse service requests: **2,008 during January** and **2,008 YTD**
  - Intellectual/developmental disability service requests: **411 during January** and **411 YTD**
  - Requests not authorized: **851 during January** and **851 YTD**
    - Incomplete or inappropriate requests: **517 during January** and **517 YTD**
    - Requests without supporting evidence for "medical necessity": **334 during January** and **334 YTD**
- Reconsideration requests: **44 during January** and **44 YTD**
- Reconsideration decisions appealed: **1 during January** and **1 YTD**

Explanation: Many Medicaid services require prior authorization. In this process, a care manager reviews a request for services along with supporting documentation for "medical necessity." Services that meet "medical necessity" criteria are necessary and appropriate for prevention, diagnosis or treatment, and reasonably related to the diagnosis for which prescribed. SMC expects care managers to complete service request reviews within 14 calendar days of receipt. Days reported above are business days. Weekends and holidays are not calculated in the total. Incomplete requests do not contain all of the information necessary to properly identify the provider, the consumer or the service being requested. Inappropriate requests are those for services that do not require authorization from SMC. These two types of requests are returned to the provider as unable to process. When SMC denies a request for service due to lack of medical necessity ("adverse decision"), the consumer has the right to appeal the decision. There are three (3) steps in the appeal process. Those steps are local reconsideration, mediation and the State fair hearing.

***YTD** - Year to date. For the purpose of this report, it is everything that has occurred since January 1, 2013.

Care Coordination (Medicaid and State-funded)

- SMC I/DD-Innovations care coordinators worked with **660** individuals/families during January.
- At the end of January, SMC has **408** individuals on the waiting list for a NC Innovations waiver slot.
- SMC mental health or substance abuse care coordinators worked with **891** individuals/families identified with special healthcare needs or who are at high risk during January.

Explanation: The Medicaid 1915 (b)/(c) Waiver clearly defines criteria for people considered to have special health care needs. The LME-MCO must ensure that care coordination occurs for those individuals. Individuals who have high-risk conditions or those who use an amount of services considered high-cost (the top 20% of service dollars) also receive care coordination. The goal is to ensure that all individuals receiving care coordination have access to the right amount of clinically appropriate care.

Quality Management (Medicaid only)

- SMC staff handled **13** grievances **during January** and **13 YTD**
  - Grievances about SMC: **Four (4) during January** and **Four (4) YTD**
  - Grievances about providers: **Nine (9) during January** and **Nine (9) YTD**
- Of the 13 grievances received in January, **one (1)** is fully resolved.
- Average time to resolve a grievance: **eight (8) days during January** and **eight (8) YTD**

Explanation: SMC is required to track all grievances. The definition of grievance is "an expression of dissatisfaction by or on behalf of an Enrollee." A grievance is about any matter other than a service request that does not get prior authorization. SMC is required to resolve grievances within 30 days of their receipt.

Finance/Claims (Medicaid only)

- SMC Claims Specialists processed **85,965 claims during January** and **85,965 YTD.**
  - Claims approved and paid: **72,462 during January** and **72,462 YTD**
  - Average time to process a "clean claim": **0.2 days during January** and **0.2 days YTD**
  - Payments: **$6,724,695 paid to 232 providers in January** and **$6,724,695 paid to 232 providers YTD**

Explanation: SMC now processes Medicaid claims. SMC is required to process a claim within 18 days of receipt, and is required to pay 90% of clean claims within 30 days. A "clean claim" is one that can be processed without obtaining additional information from the provider. SMC pays providers on a weekly basis. This means that once a claim is processed and approved, the provider rarely has to wait longer than eight (8) days to receive payment.

Provider Network (Medicaid and State-funded)

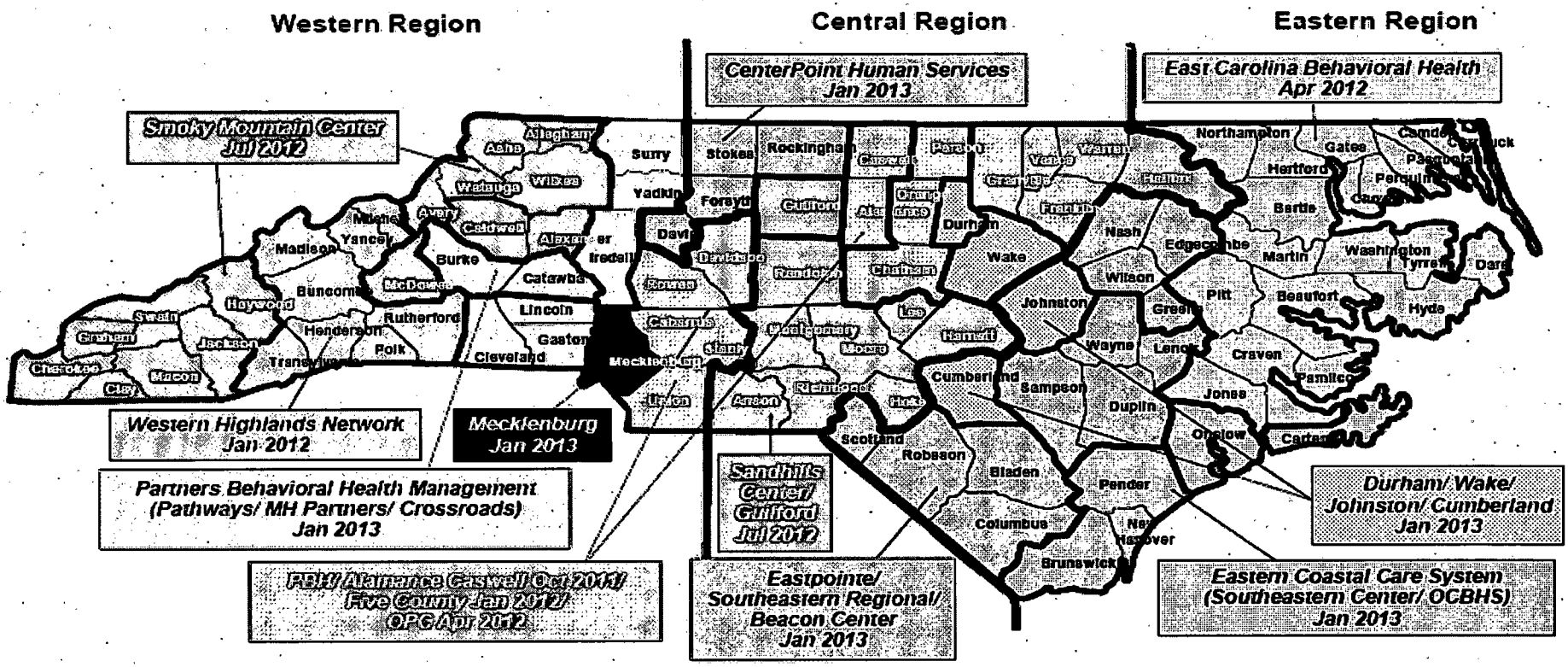
- There are **286** providers in SMC's network as of the end of January.
- As of the end of January, SMC has agreements with **six (6)** providers outside our network who provide services to individuals with Medicaid eligibility in one of SMC's 15 counties.

Explanation: Before "going live" on the Waiver, there were 162 providers in the SMC network. During Waiver implementation, SMC offered contracts to 263 providers. SMC now operates a closed provider network. That means SMC must determine a need or gap to introduce a new service to the network. When that happens, SMC may contract with a new provider, or request that a current network provider add the service to its array.

Smoky Mountain Center Report to the North Carolina General Assembly Joint Appropriations Subcommittee on Health and Human Services

Presented by
Brian Ingraham, CEO
February 27, 2013

Proposed Local Management Entity - Managed Care Organizations (LME-MCOs) and their Member Counties on January 1, 2013



Unless otherwise indicated, the LME name is the county name(s).
The lead LME name for the proposed LME-MCO is shown first.
Dates shown are the planned Waiver start dates.
Reflects plans as of February 9, 2012.

Information & Education

- Operations under the Waiver represent a different set of business practices, expectations and requirements
- These changes, which are showing better outcomes and cost control are challenging to adapt to
- Providing information and education to consumer members, providers and stakeholders on these changes, and explaining "what Smoky is doing" is an important part of our mission....

Monthly "Operations at a Glance" Report

Smoky Mountain Center (SMC)
Operations at a Glance – January 2013

SMC is committed to being a transparent organization and keeping stakeholders informed. To support these efforts, SMC will create a brief, monthly summary of operations by functional area.

Individuals Eligible for Medicaid Services through SMC

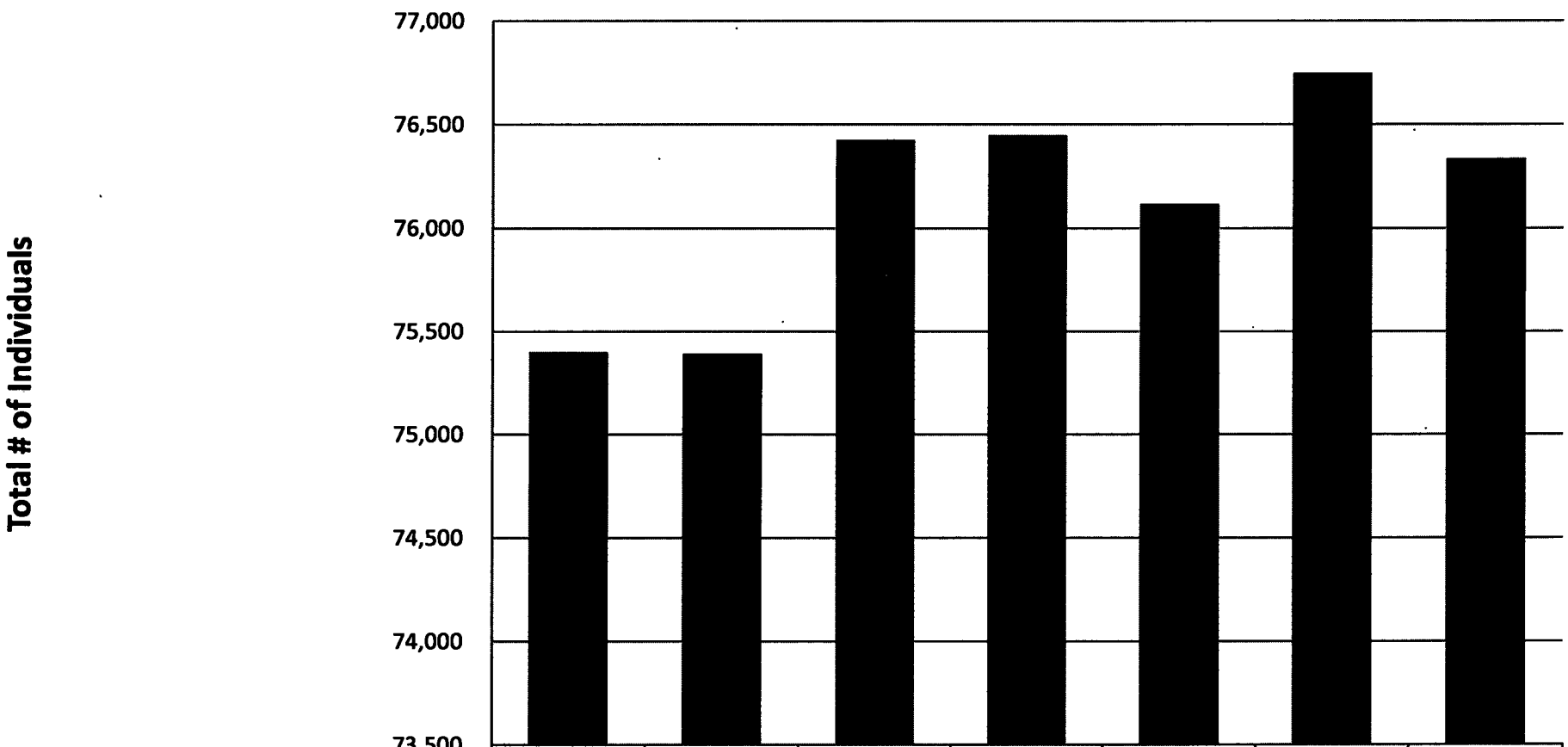
SMC is responsible for the oversight of behavioral health and intellectual/developmental disability Medicaid services in our 15-county area. For January:

- Individuals on the NC Innovations waiver: **638**
- Other individuals who receive Medicaid: **75,677**

Explanation: Each month the North Carolina Division of Medical Assistance (DMA) pays SMC a capitated amount per Medicaid recipient (numbers above). From those funds, we must manage services for any individual in SMC's 15 counties who needs a Medicaid service for mental health, intellectual/developmental disabilities, or substance abuse.

Customer Services (Medicaid and State-funded)

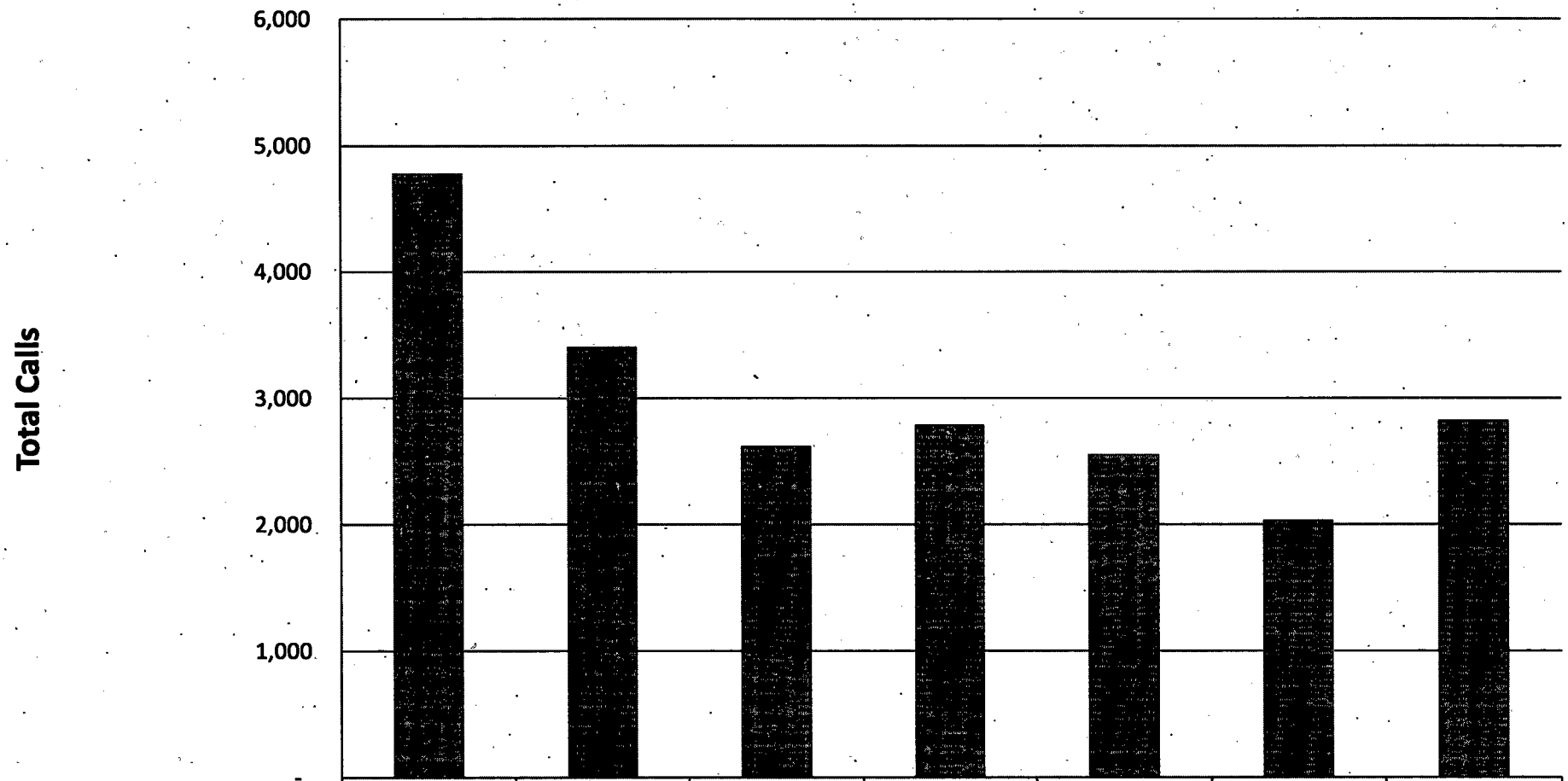
Individuals Eligible for Medicaid



	July	Aug	Sep	Oct	Nov	Dec	Jan
Individuals on the NC INNOVATIONS Waiver	649	640	648	646	643	643	638
Others Who Receive Medicaid	74,751	74,751	75,777	75,800	75,472	76,105	75,697

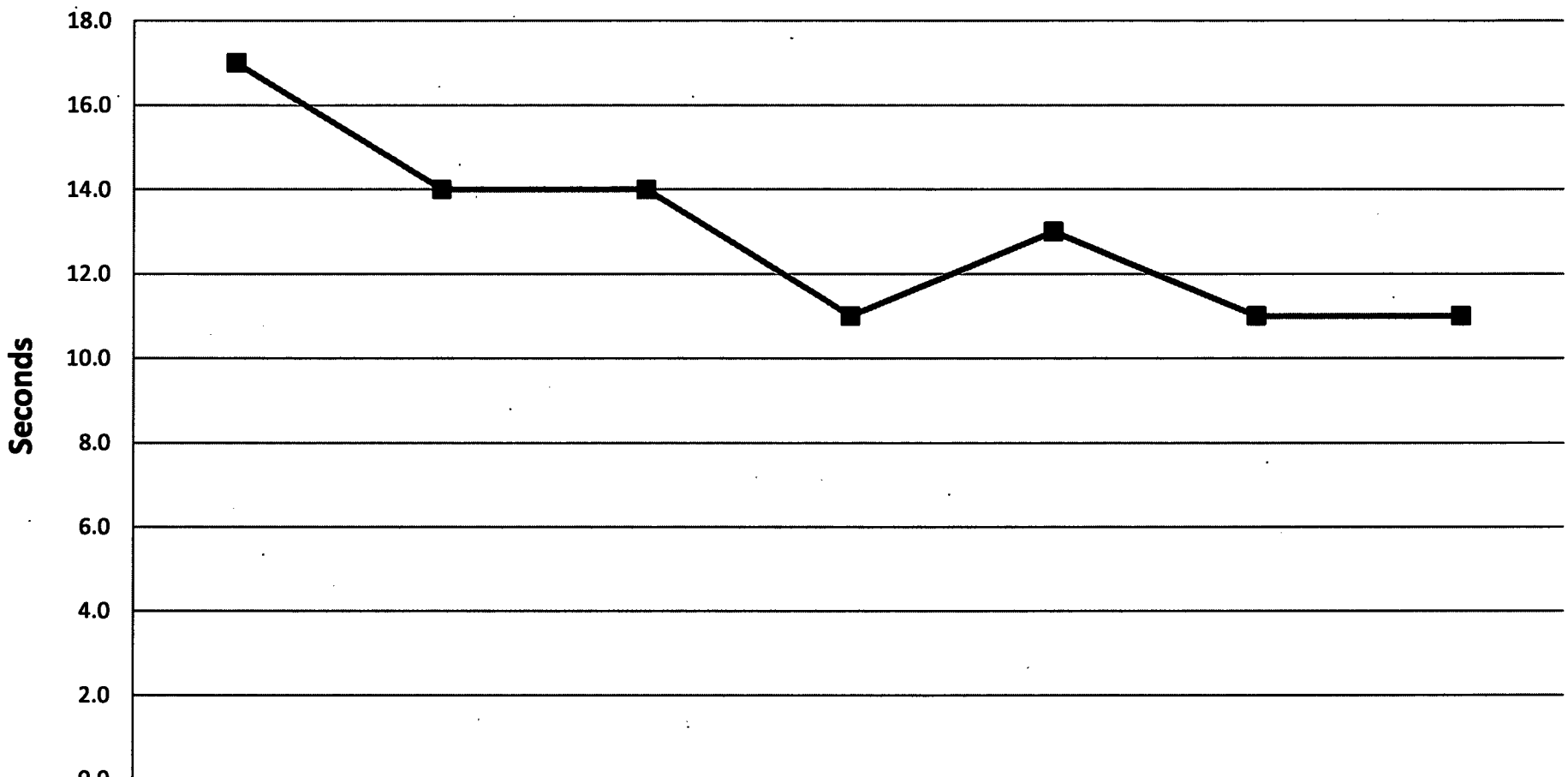
SMOKY MOUNTAIN CENTER

Calls Answered by SMC Customer Services



	July	Aug	Sep	Oct	Nov	Dec	Jan
Calls Answered by SMC CSRs	4,778	3,406	2,622	2,790	2,554	2,036	2,826

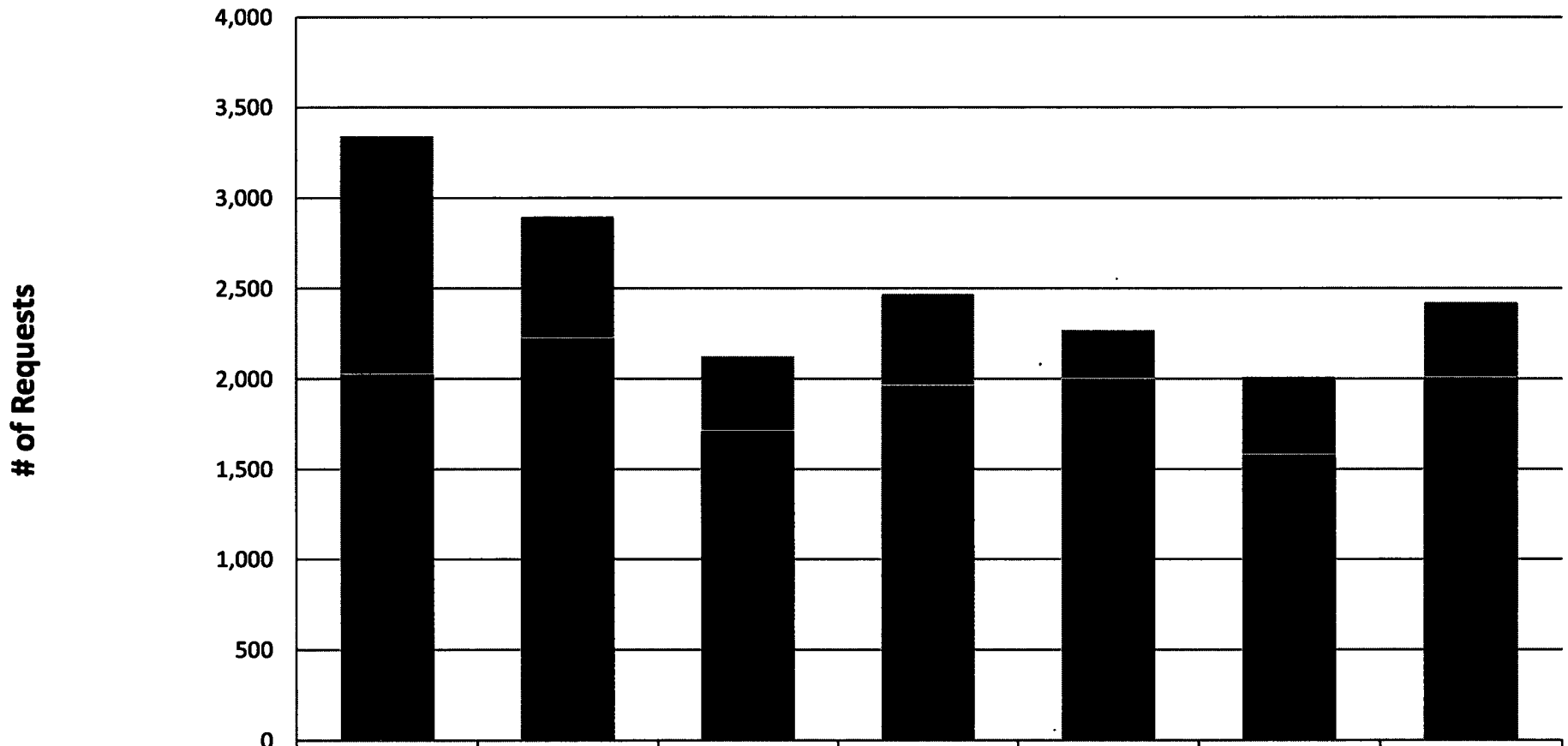
Average Time to Answer Calls (in seconds)



	July	Aug	Sep	Oct	Nov	Dec	Jan
Time	17.0	14.0	14.0	11.0	13.0	11.0	11.0

SMOKY MOUNTAIN CENTER

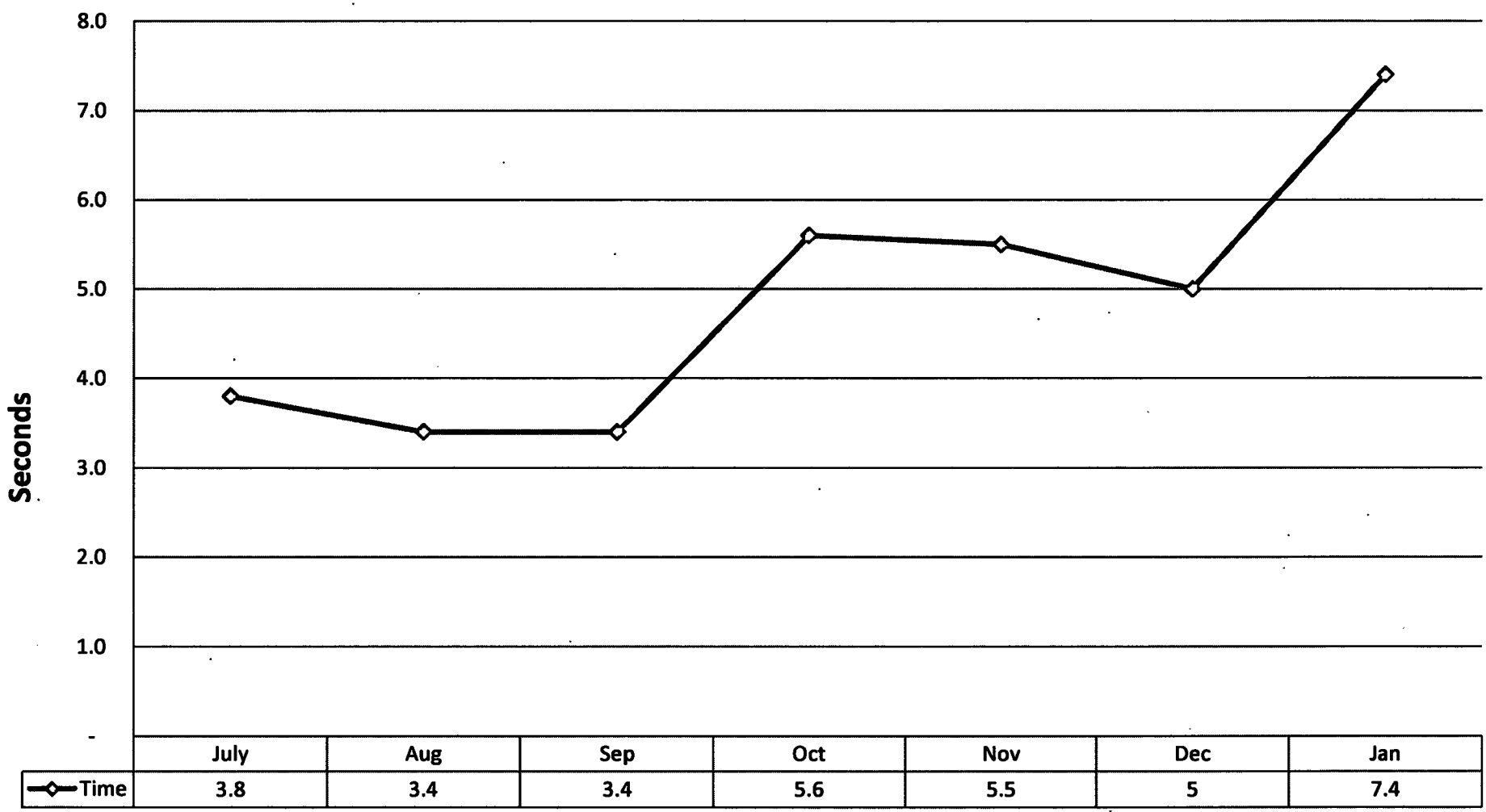
Approved Authorization Requests



	July	Aug	Sep	Oct	Nov	Dec	Jan
I/DD Service Requests	1,315	672	409	503	265	429	411
MH/SA Service Requests	2,026	2,224	1,713	1,963	2,001	1,580	2,008

SMOKY MOUNTAIN CENTER

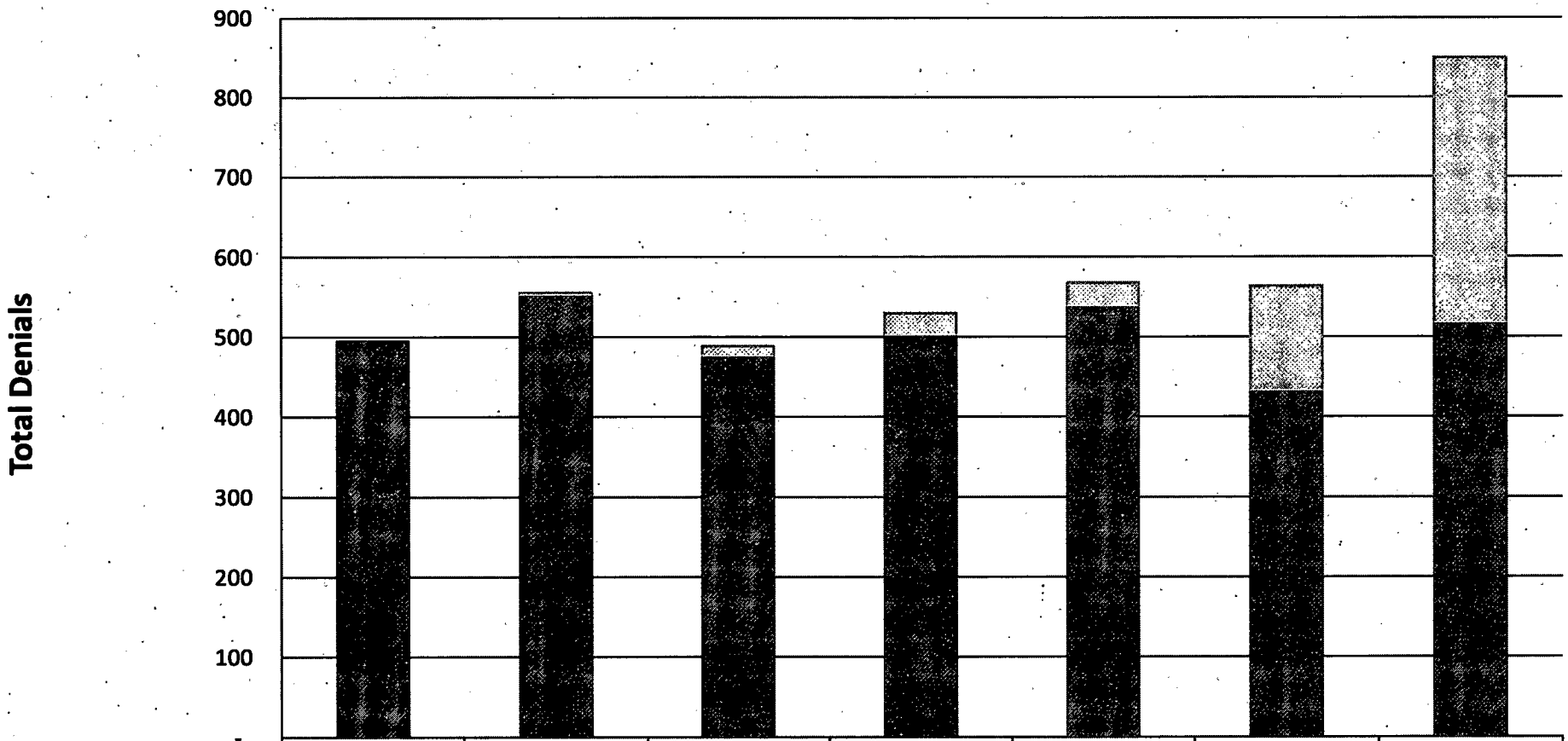
Average Time for Review of Authorizations for Care Management



	July	Aug	Sep	Oct	Nov	Dec	Jan
Time	3.8	3.4	3.4	5.6	5.5	5	7.4

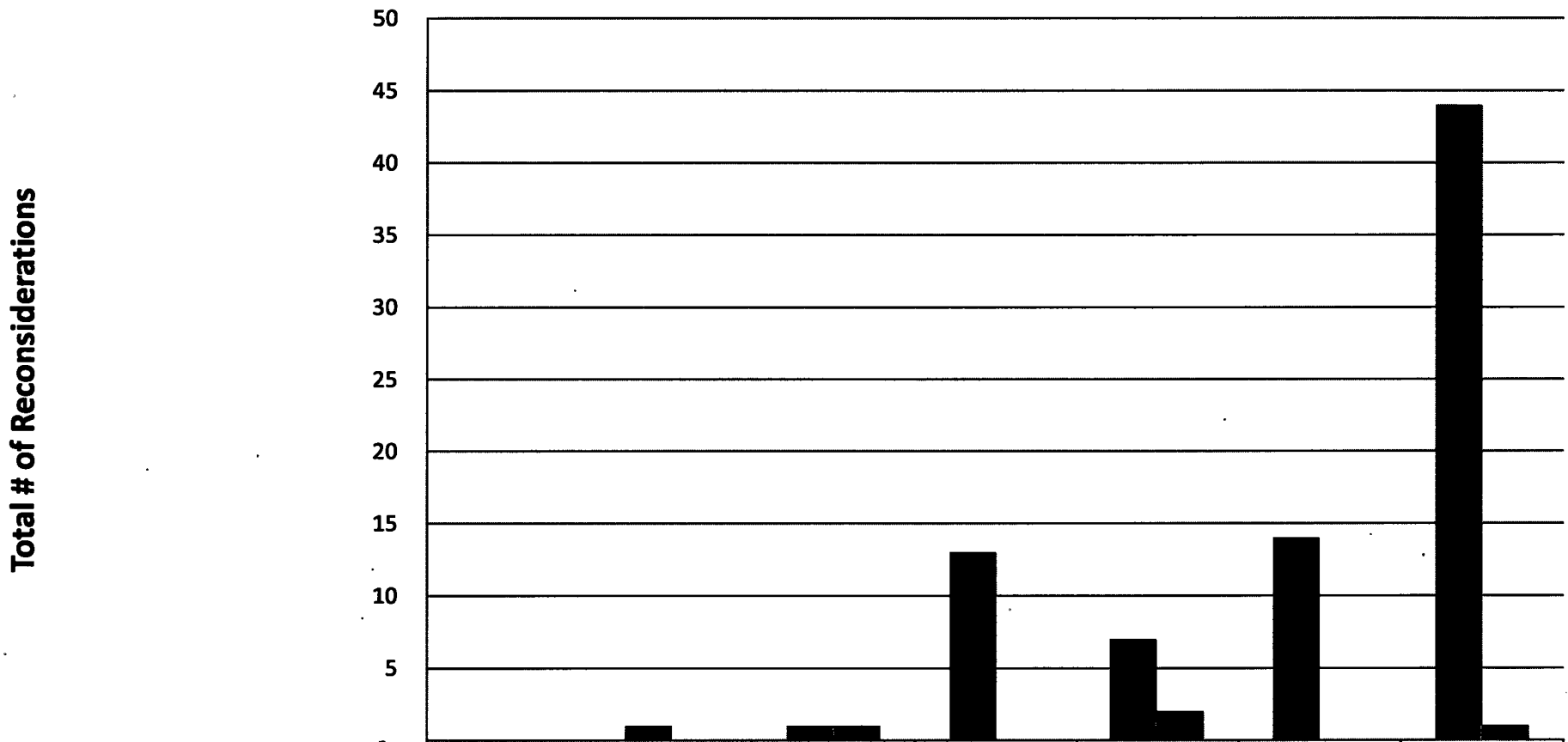
SMOKY MOUNTAIN CENTER

Requests Not Authorized
(Administrative and Non-Administrative Denials)



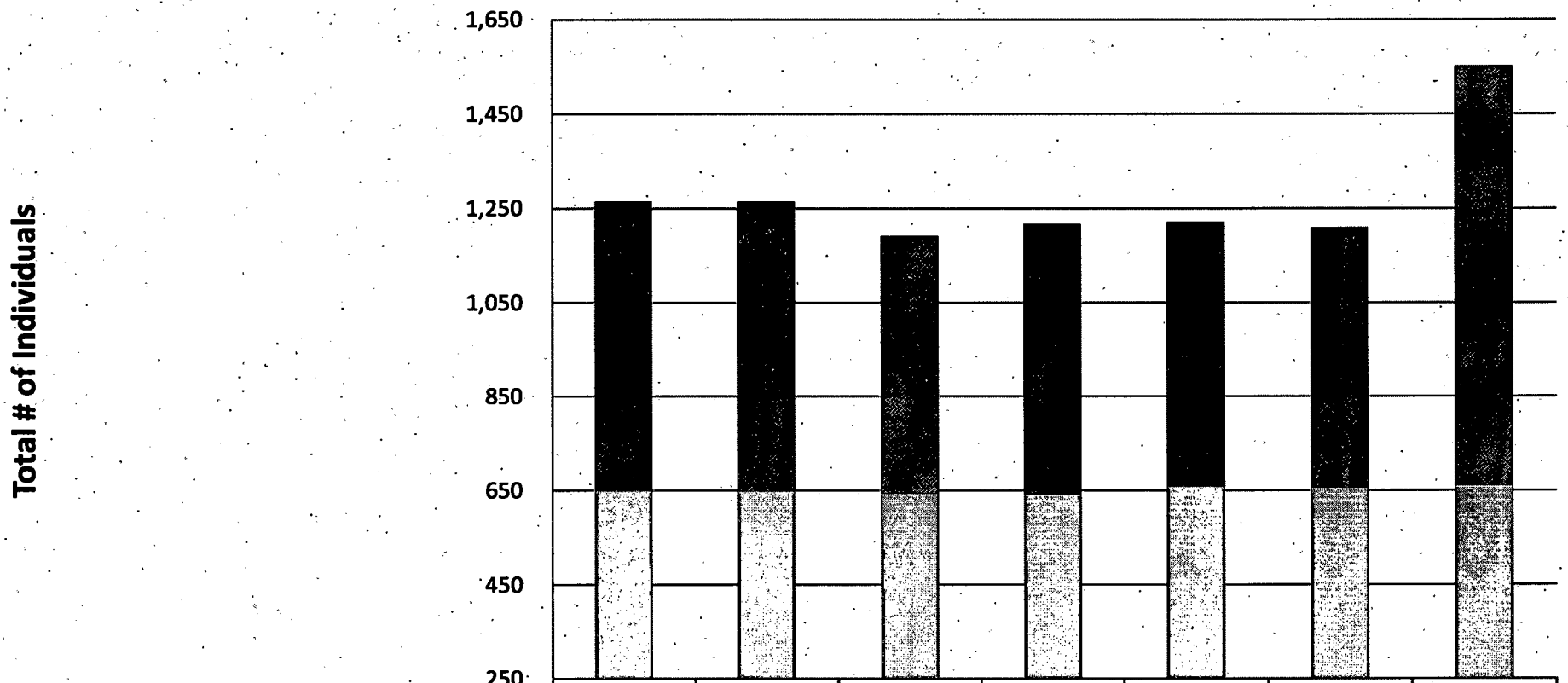
	July	Aug	Sep	Oct	Nov	Dec	Jan
Clinical Denials	1	5	15	29	31	133	334
Administrative Denials	496	552	475	502	538	432	517

Requests for Reconsideration/Appeals



	July	Aug	Sep	Oct	Nov	Dec	Jan
Reconsideration Requests	-	1	1	13	7	14	44
Reconsiderations Decisions Appealed	-	-	1	0	2	0	1

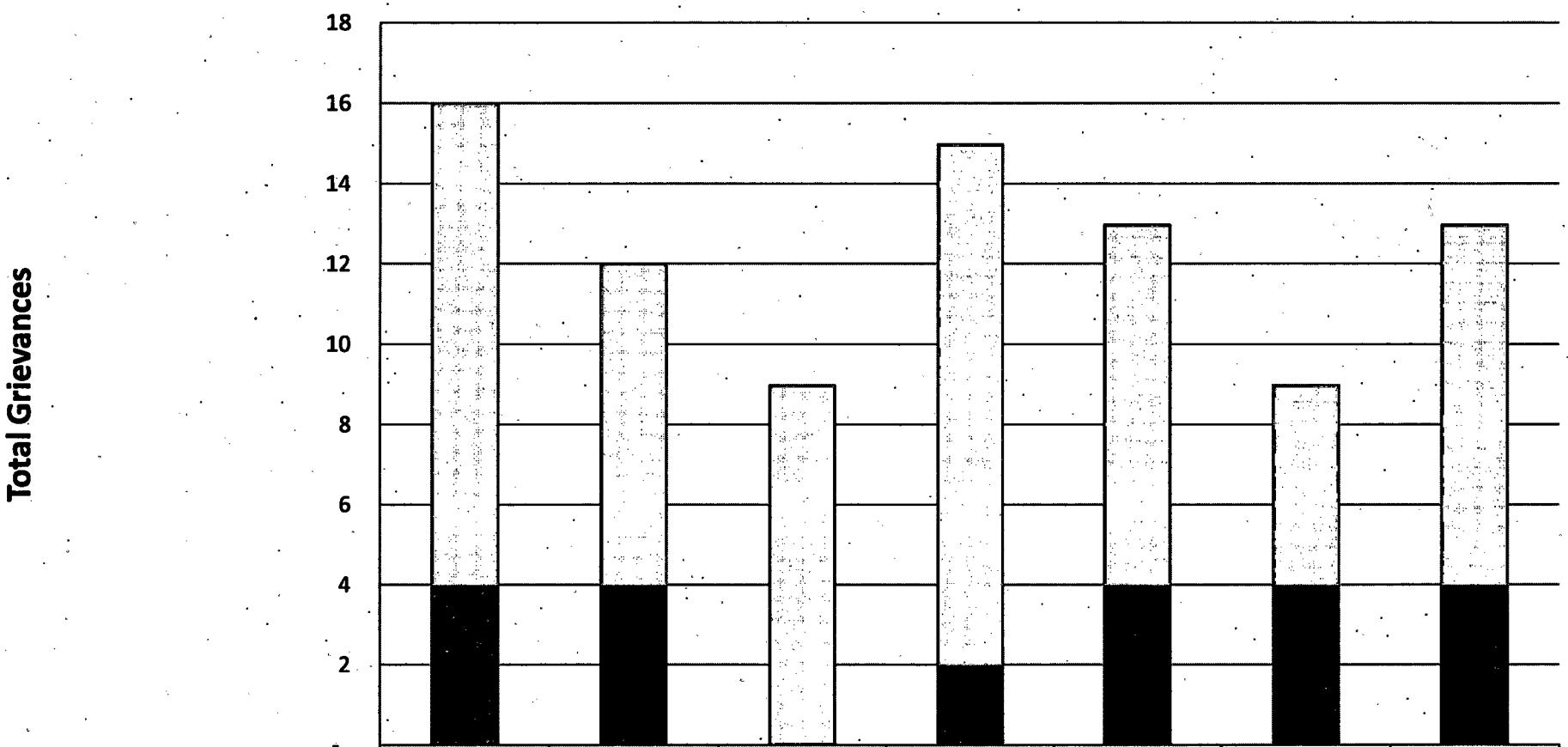
Care Coordination



	July	Aug	Sep	Oct	Nov	Dec	Jan
MH/SA "High Risk" individuals/Families Served by Care Coordinators	616	616	548	576	563	553	891
N Individuals/Families Served by Innovations Care Coordinators	649	648	643	641	658	656	660

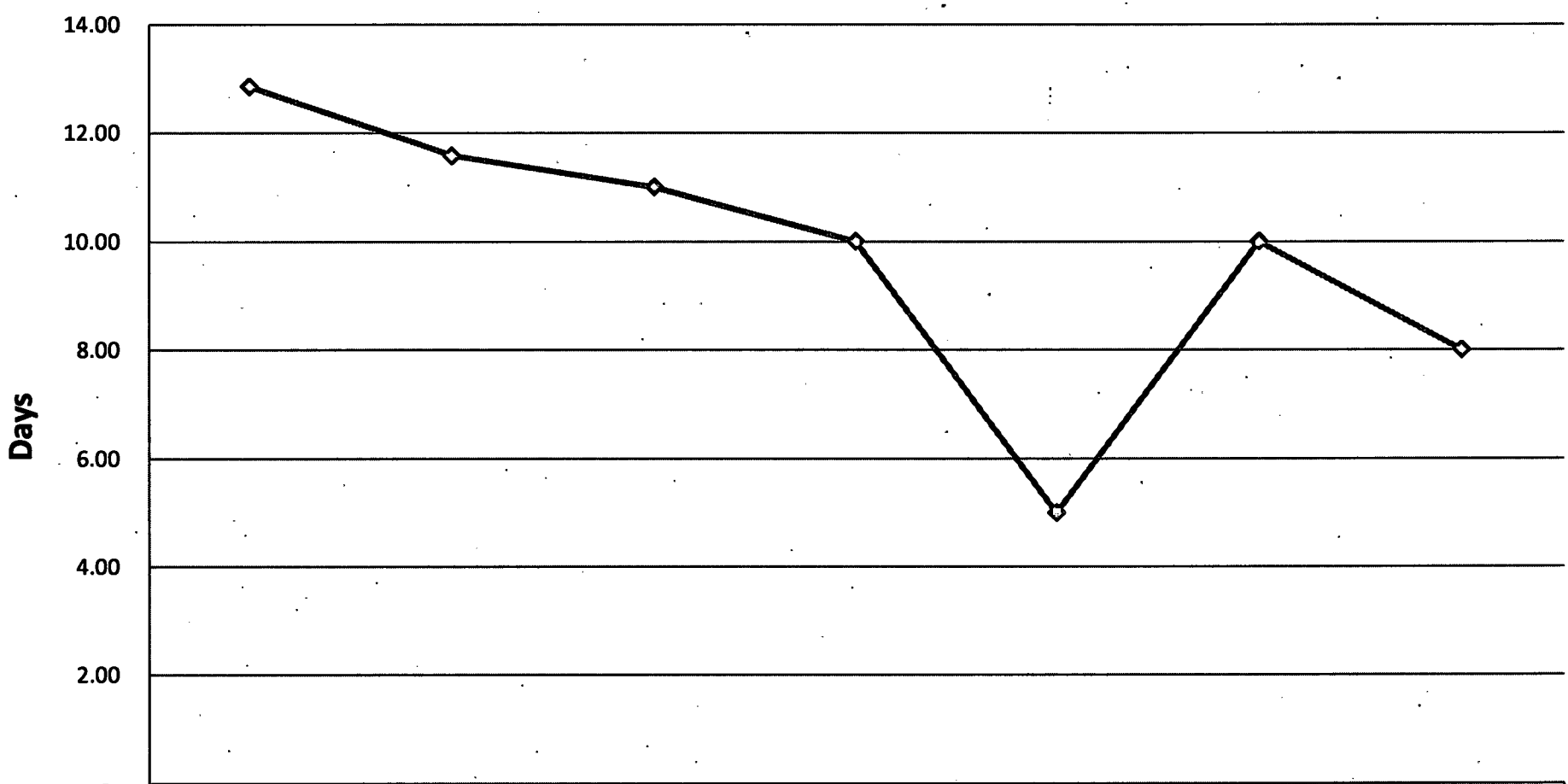
* Total numbers differ prior to January 2013 due to differences in reporting practices. Reporting prior to January 2013 occurred at the beginning of the month. Effective January 2013 totals were calculated based on caseload at any point during the month.

Grievances Filed



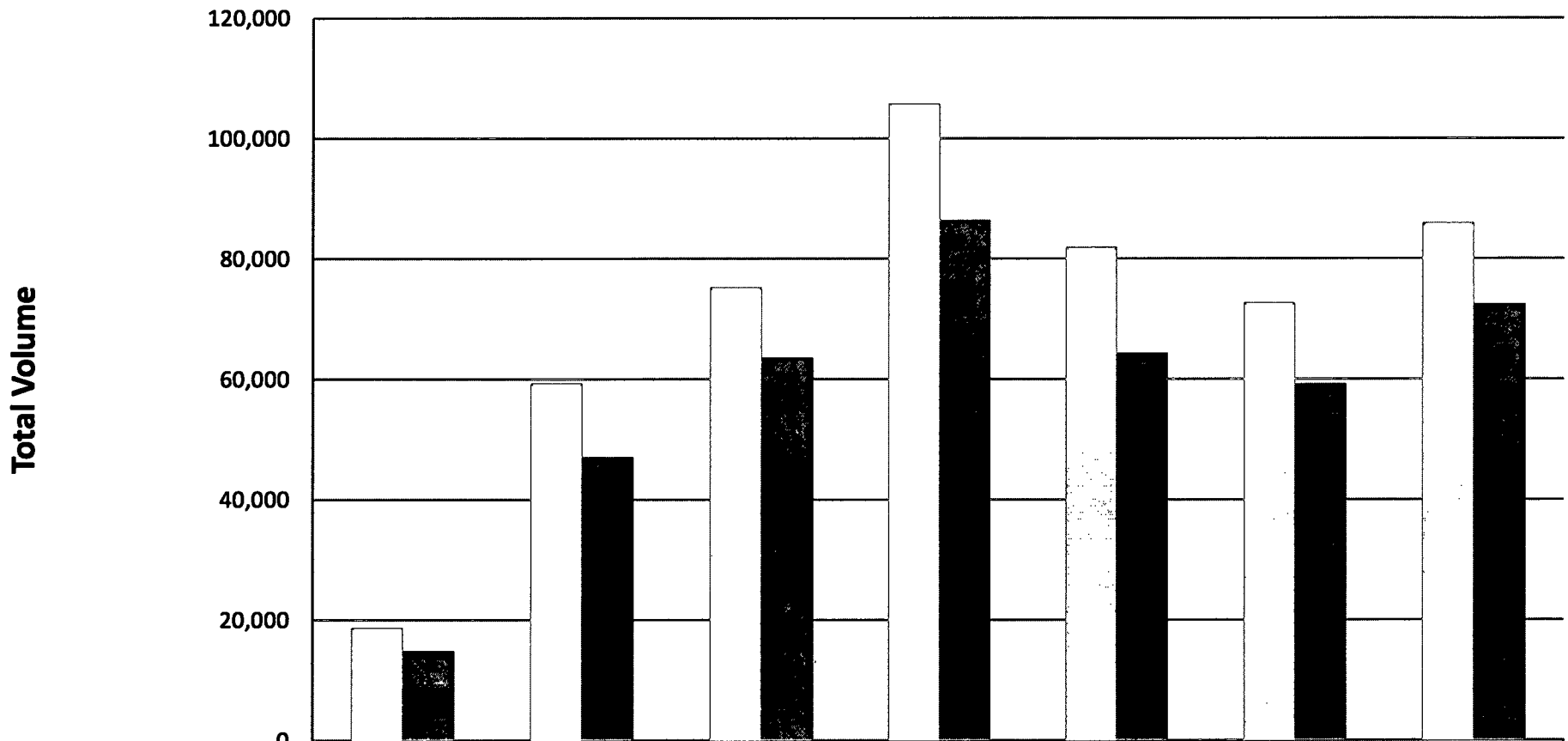
	July	Aug	Sep	Oct	Nov	Dec	Jan
Grievances Filed About Providers	12	8	9	13	9	5	9
Grievances Filed About SMC	4	4	0	2	4	4	4

Average Time to Resolve a Grievance



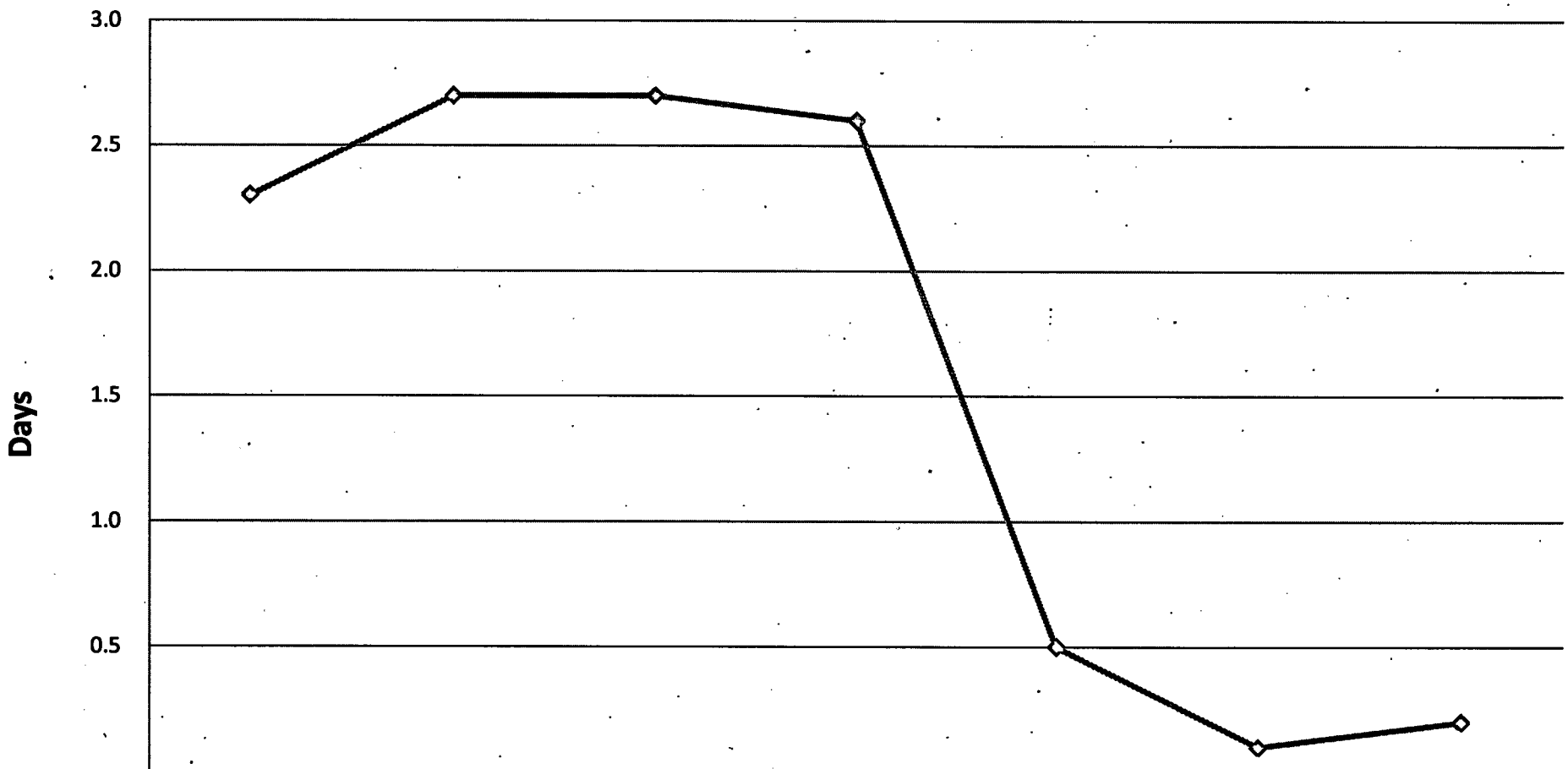
	July	Aug	Sep	Oct	Nov	Dec	Jan
Time	12.85	11.58	11	10	5	10	8

Claims Volume



	July	Aug	Sep	Oct	Nov	Dec	Jan
Claims Processed	18,708	59,317	75,217	105,767	81,937	72,676	85,965
Claims Approved and Paid	14,799	47,042	63,533	86,401	64,338	59,259	72,462

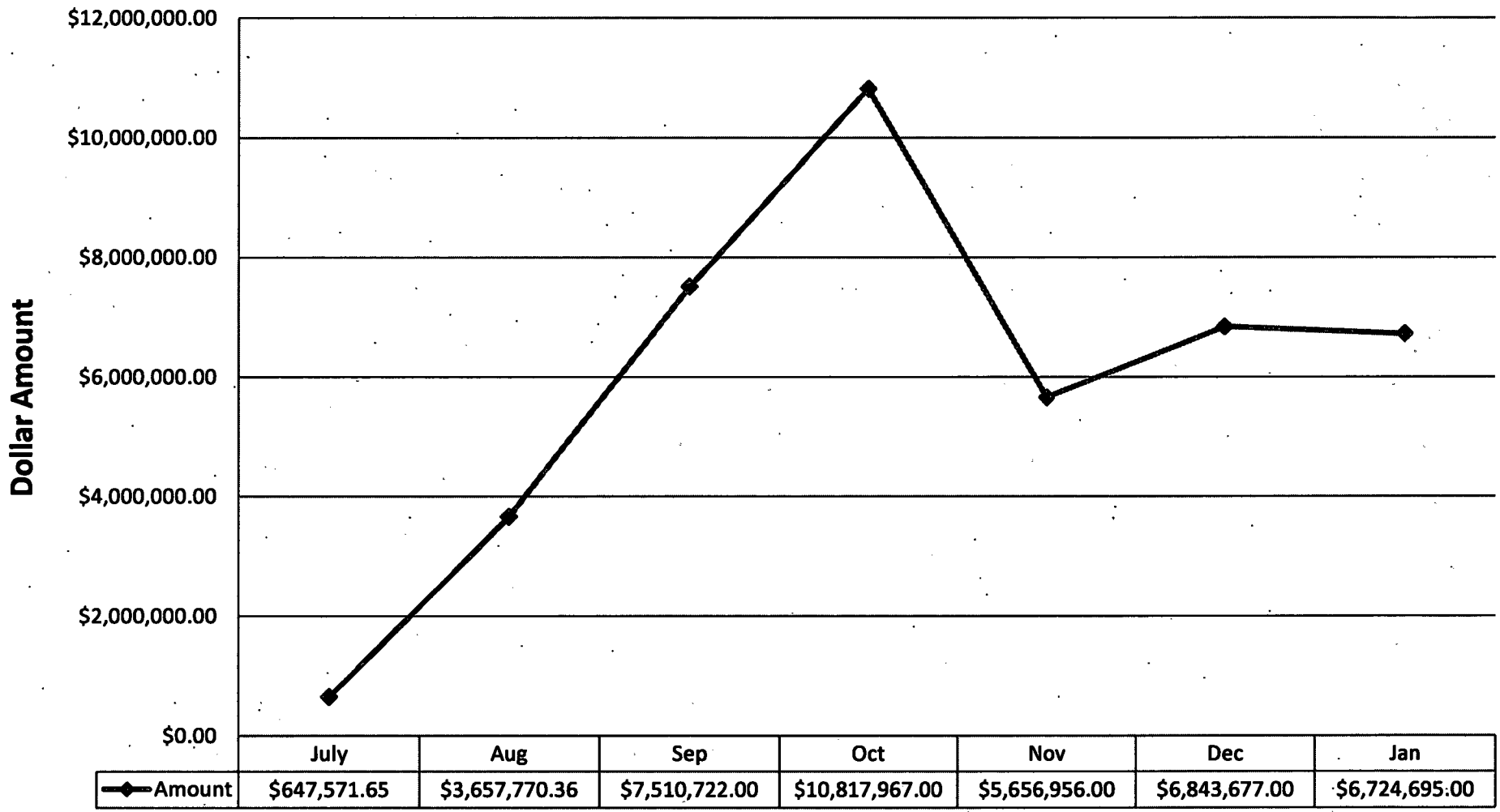
Average Time to Process a Clean Claim



	July	Aug	Sep	Oct	Nov	Dec	Jan
Time	2.3	2.7	2.7	2.6	0.5	0.1	0.2

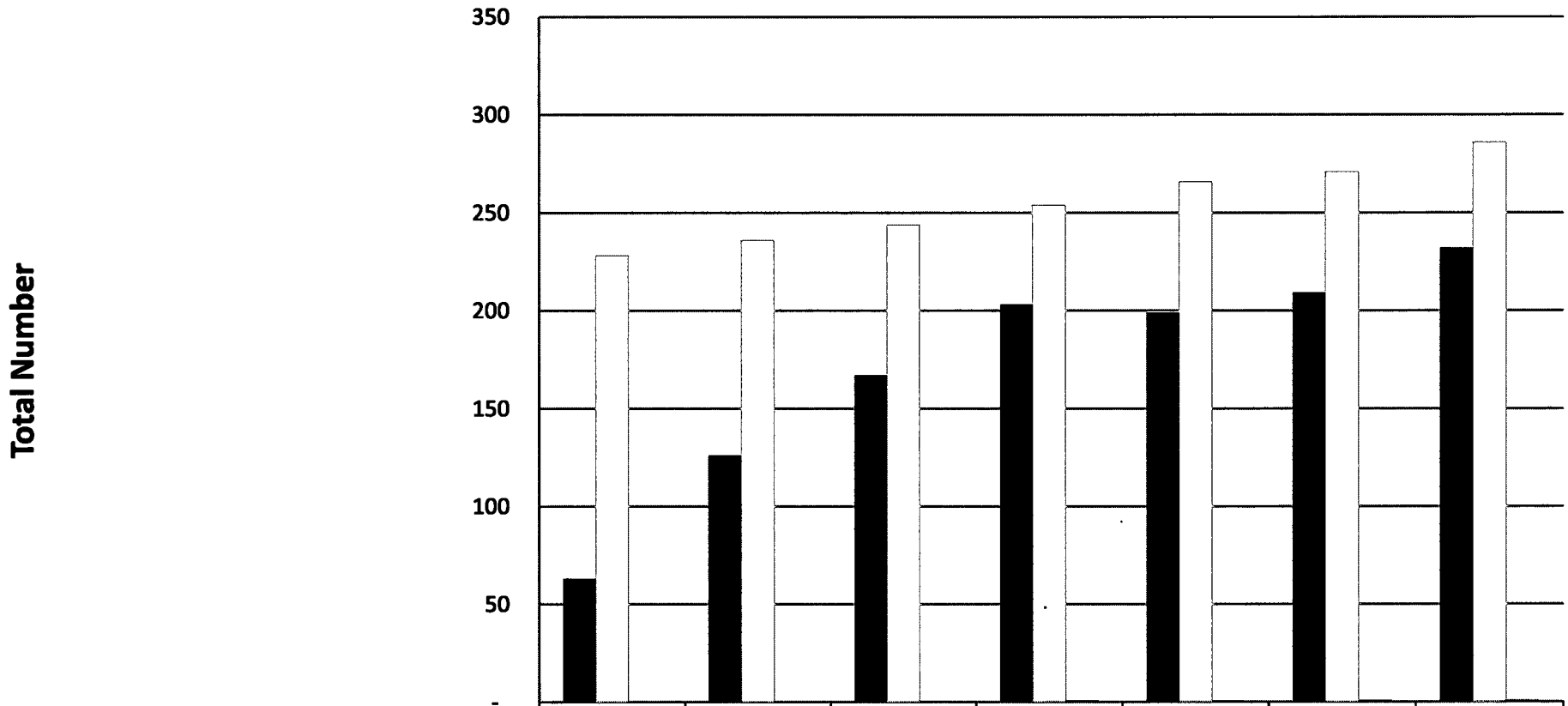
SMOKY MOUNTAIN CENTER

Total Medicaid Dollars Paid to Providers



	July	Aug	Sep	Oct	Nov	Dec	Jan
Amount	$647,571.65	$3,657,770.36	$7,510,722.00	$10,817,967.00	$5,656,956.00	$6,843,677.00	$6,724,695.00

Number of Providers Paid



	July	Aug	Sep	Oct	Nov	Dec	Jan
■ Number of Providers Receiving Claims Payments	63	126	167	203	199	209	232
□ Number of Provider in Network	228	236	244	254	266	271	286
■ Percentage	27.6%	53.4%	68.4%	80.0%	74.8%	81.1%	81.1%

* SMC contracts with six (6) single case agreement Providers.

SMOKY MOUNTAIN CENTER

SMC Efforts to Improve Outcomes for Youth: Managing and Coordinating Care for Children in Residential Settings

SMOKY MOUNTAIN CENTER

In the Beginning...

- On July 1, 2012, SMC received the ValueOptions® Psychiatric Residential Treatment Facility (PRTF) transition list, which identified specific children from the SMC catchment area residing in PRTFs.

- SMC Care Coordinators started immediate outreach to the eighty-one (81) children included on that list.

- SMC Care Coordination implemented standards that required all children in PRTF placements to receive face-to-face visits at least quarterly, and that SMC Care Coordinators would participate in all Child and Family Team meetings, regardless of location.

Level of Care and Lengths of Stay

Based on clinical documentation submitted by PRTF providers and information gathered at Child and Family Team meetings concerns emerged regarding the **level of care and lengths of stay .** This triggered an assertive record review for all consumers in PRTF placement, including:

- Diagnosis;
- Length of stay;
- Prior treatment history;
- Current interventions;
- Current behavioral symptomatology;
- Outcomes; and
- Clinical documentation to support level of care.

Consistent Standards & Expectations

SMC launched an interdepartmental work group to ensure consistency in expectations regarding authorizations, clinical policy, and medical necessity interpretation. Care Managers developed and implemented the following:

- Adherence to NC Division of Medical Assistance Clinical Coverage Policy 8D-1 for PRTFs;
- Development and implementation of Medical Necessity check sheets across all enhanced services, including PRTF; and
- Staffing of all residential cases with the SMC Chief Medical Officer.

Best Practice

- A cross-departmental clinical team reviewed national best practice to determine the most appropriate utilization of PRTF.
- Typically, PRTF is appropriate for short-term crisis intervention.
- Certain diagnoses may or may not benefit from the PRTF level of care (i.e. Conduct and Oppositional Defiant Disorders typically do not benefit).

Educating Providers and Stakeholders

- The team met with PRTF providers and stakeholders (Departments of Social Services, Department of Juvenile Justice and Delinquency Prevention) to provide information regarding best practice treatment models.
- SMC also related its plans to move forward in evaluating individual cases where children were placed in PRTFs, step down plans to community-based services where indicated, and how SMC will address service gaps in more rural counties for step down services.
- SMC staff supported PRTF providers by educating them about new SMC clinical practices and documentation needs for authorization of PRTF and other services in the child services continuum.

SMOKY MOUNTAIN CENTER

Improved Quality of Care

- SMC's efforts improved the quality of care for the identified children by matching their service level to their service need and integrating each child's treatment within their home community.
- Currently, only 22 children are in PRTF, compared to 81 at the outset.
- This community based treatment approach improves the likelihood for better long-term outcomes, and achieves significant reductions in PRTF expenditures (from approximately $776,000 per month to $264,000 per month).
- These savings have opened the door to support creative community based programming to divert high risk children from residential levels of care and to step them down to the community when out of home placement is appropriate.

SMOKY MOUNTAIN CENTER

Case Study #1

S is a 15 year-old male with diagnoses of Oppositional Defiant Disorder, Post Traumatic Stress Disorder, Sexual Abuse (perpetrator), and Depressive Disorder. He was in PRTF placement beginning in November of 2010 (slightly over 2 years), and likely would have remained there without Care Management intervention. This young man had no incidence of sexually inappropriate behavior for an extended period, and had developed a relapse prevention program. Care Coordination was actively involved with him at the facility. The SMC Care Manager staffed this case with the Chief Medical Officer who recommended discharge within 30 days of review. **S** stepped down to a lower level of care and has not required services that are more intensive.

Case Study #2

J is now eighteen and diagnosed with Oppositional Defiant Disorder and Polysubstance Dependence Disorder. She was in placement since March of 2012, and was involved with Juvenile Justice. The Care Coordinator reviewed her case and found that the consumer was stable in placement, and recommended step down to support and prepare J for aging out of the child system and back into the community. The Care Coordinator maintained connection with the Department of Juvenile Justice and the provider who would provide community services for J upon her return home. This team continued staffing J's case while the Care Coordinator worked simultaneously with the facility to prepare a discharge plan. J has successfully stepped down to her father's home, receives Intensive In-Home Services, and is linked with an Independent Living Skills program.

Case Study #3

R is a 15 year-old female in DSS custody, placed in a PRTF and diagnosed with Conduct Disorder, Sexual Abuse, and Depressive Disorder. Care Management became aware of her case through Utilization Management's documentation review process. In the meantime, Care Coordination also began to question whether **R** could step down with the assistance of Child and Family Team involvement. The Care Coordinator facilitated discharge planning, as there were difficulties getting responses from **R**'s DSS Social Worker and the PRTF staff. Care Management did not support further authorization of PRTF due to the lack of medical necessity and based on information showing **R** could receive more effective treatment in a therapeutic foster care setting. Care Coordination worked with the residential facility to prepare an appropriate discharge plan and supported **R** in making a successful transition.

Questions?

Brian Ingraham, CEO
1207 East Street
Waynesville, NC 28786
(828) 586-5501, ext. 1201
brian@smokymountaincenter.com

Smoky Mountain Center manages mental health, substance abuse, and intellectual/developmental disability services in the North Carolina Counties of Alexander, Alleghany, Ashe, Avery, Caldwell, Cherokee, Clay, Graham, Haywood, Jackson, Macon, McDowell, Swain, Watauga and Wilkes.

Toll-free Access to Services 24 hours a day, 7 days a week: 1-800-849-6127 (TTY calls: 1-800-855-2280)
www.smokymountaincenter.com

URAC
ACCREDITED
HEALTH NETWORK
HEALTH UTILIZATION
MANAGEMENT
HEALTH CALL CENTER

SMOKY MOUNTAIN CENTER

HHS Meeting

Wednesday, February 27, 2013

SENATE SGTS. AT ARMS: LESLIE WRIGHT

STEVE WILSON

HOUSE SGTS. AT ARMS: MARVIN LEE

CHARLES GODWIN

SENATE PAGES:

HOUSE PAGES:

Wednesday, February 27	**Room**	**Time**
JOINT APPROPRIATIONS HEALTH & HUMAN SERVICES	643	8:30 am

Name	County	Sponsor
Abby Sparrow	Cabarrus	Tillis
Andre Tyson	Anson	Brody

PAGES ATTENDING

COMMITTEE: Joint: Health & Human Serv. ROOM: 643

DATE: 2-27 TIME: 8:30

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!

Page Name	Hometown	Sponsoring Senator
1 Thomas Byrd	Turkey	Berger
2		
3		
4		
5		
6		
7		
8		
9		
10		

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

VISITOR REGISTRATION SHEET

JT. HHS APPROPRIATIONS SUB-COMMITTEE
Committee Name)

2/27/13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Madison Mackenzie	DOJ
Jessica Eaddy	Governor's Institute
Kathy Baker	Eastpointe
George Smith	Nexsen Pruet
Annaliese Dolph	Dolph Law
Fred Weddle	Eastern Seals UCP
Kerra Bolton	LCA
Gudelia Hawkins	ENGR
Julia Adams	The Arc of NC/NCARF
TRACY COLVARD	AHNC
[illegible]	[illegible]
Dean Plunkett	PS.
[illegible]	[illegible]
Drew Cotton	[illegible]
[illegible]	CSS
Lori Ann [illegible]	[illegible]
Matt Gross	NCPC

09-21-201

VISITOR REGISTRATION SHEET

JT. HHS APPROPRIATIONS SUB-COMMITTEE
Committee Name)

2/27/13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel VanLiere	Vidant Health
Joe Lanier	Nelson Mullins
Jeff Barnhart	McGuireWoods
Pam Shipman	Cardinal Inn
Richard Tapping	Cardinal Inn
Lm B Wilt	NCACT-CF
Johanna Reese	NCACC
John Monroe	Public Group
Mary Bethel	AARP NC
John Hardin	NTSS
	NCRMA
	NCR
	NCSA
James Bond	MIB
Ashley Perkins	Perkins Law
Holly Biola, MD	NCAFP

09-21-201

VISITOR REGISTRATION SHEET

JT. HHS APPROPRIATIONS SUB-COMMITTEE
Committee Name)

2/27/13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Greg Griggs	NCAFP
Bill Piper	ACP
Neil MASHBURN	PAC
Vickie Darry Adams	PAC VH & Moses Cone
Will Parrott	NCMS
Jeff Hock MD	NCAFP
Charles W. Rhodes MD	NCAFP
R.W. WATKINS, MD, MPH	NCAFP
AARON George, DO	NCAFP
Chris Danford	NCAFP
Shawn Dowler MD	NCAFP
Robert "Chuck" Rich MD	NCAFP
Brian Forrest, MD	NCAFP
Andy Chase	KMA
Peter Gaber	NCAFP
Elise McDowell	Troutman Sanders
Debbie Clary	NC Strategy Partners

09-21-201

VISITOR REGISTRATION SHEET

JT. HHS APPROPRIATIONS SUB-COMMITTEE

Committee Name)

2/27/13

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Harry Carlton	MWC

09-21-201

Joint House Committee on Appropriations Subcommittee on Health and Human Services
Thursday, February 28, 2013, at 8:30 a.m.
Room 643

MINUTES

The House Committee on Appropriations Subcommittee on Health and Human Services met at 8:30 on February 28, 2013 in Room 643. Representatives Avila, Farmer-Butterfield, Ford, Fulghum, Hollo, Insko, Lambeth, Martin, and Murry attended. Senators Hise, Pate, McKissick,Robinson, and Barringer attended.

Senator Louis Pate presided.

Senator Pate gaveled the meeting at 8:30 a.m and introduced the Pages and Sergeants at Arms. Pages: Max Scafer, Laura Fowler, Chance Corbin, Jordan Hennessy. Sergeants at Arms: Ed Kesler, Steve Wilson, Fred Hines, Charles Godwin.

Senator Pate introduced Ken Jones, CEO Eastpointe MCO. Mr Jones gave a prespective on the LME/MCO conversion process.

Dr. Nena Lekwauwa from DHHS Divison of Mental Health/Disabilities/Substance Abuse Services presented on services offered through DHHS.

Lorri Unumb, Vice President State Government Affairs Autism Speaks gave an overview of national and state autism programs.

All presentations are attached to these minutes.

The meeting was adjourned at 9:50 a.m.

Senator Louis Pate
Presiding

Susan Lewis, Committee Clerk

JOINT APPROPRIATIONS SUBCOMMITTEE HEALTH AND HUMAN SERVICES

AGENDA

February 28, 2013
Legislative Office Building - Room 643
8:30 a.m.

Senator Louis Pate, Presiding	Welcome, Opening Remarks
Perspective on the LME/MCO Conversion Process	Ken Jones, CEO Eastpointe MCO
Autism Spectrum Disorder Autism Treatment and Program Services Offered through DHHS and the LME/MCOs	Dr. Nena Lekwauwa, M.D. Clinical Director, DHHS Division of Mental Health/Developmental Disabilities/Substance Abuse Services
Overview of National and State Autism Programs and Services	Lorri Unumb, Vice President State Government Affairs Autism Speaks
Adjourn	
Next Meeting:	Tuesday, March 5th, 8:30 a.m.

Autism Spectrum Disorders (Pervasive Developmental Disorders)

Autism Spectrum disorders (ASDs) are a group of developmental disabilities characterized by severe and pervasive impairments in

- Reciprocal social interaction skills
- communication skills
- the presence of stereotyped behavior, interests and activities

Ureh Nnenna Lekwauwa, MD, DFAPA // NC Division of MH/DD/SAS

Prevalence

Identified Prevalence of Autism Spectrum Disorders

ADDM Network 2000-2008

Combining Data from All Sites

Surveillance Year	Birth Year	Number of ADDM Sites Reporting	Prevalence Per 1,000 Children (Range)	This is about 1 in X Children...
2000	1992	6	6.7 (4.5-9.9)	1 in 150
2002	1994	14	6.6 (3.3-10.6)	1 in 150
2004	1996	8	8.0 (4.6-9.8)	1in 125
2006	1998	11	9.0 (4.2-12.1)	1 in 110
2008	2000	14	11.3 (4.8-21.2)	1 in 88

Onset, Symptoms and Signs

- Symptoms are usually evident in the first years of life and persist throughout the individual's life
- These conditions are often associated with some degree of mental retardation
- The qualitative impairments that define these conditions are distinctively deviant relative to the individual's developmental level or mental age

Onset, Symptoms and Signs (Continued)

- People with ASDs may have problems with social, emotional, and communication skills
- They might repeat certain behaviors and might not want change in their daily activities
- Many people with ASDs also have different ways of learning, paying attention, or reacting to things
- ASDs begin during early childhood—usually by age 3—and last throughout a person's life

Communication/Language/Symptoms

- May have little or no speech
- May repeat words or phrases
- May be quite verbal
- Formal pedantic language
- Odd prosody, peculiar voice
- Flat or limited facial expression
- Understands and uses language literally (may miss the meaning of sarcasm or jokes)
- Impairments in comprehension (asks repetitive questions)

What do we see/Symptoms

- Repeating what is said
- Using behavior to communicate
- Upset by jokes
- Asking repetitive questions
- Understand and respond to questions very literally

Social Interactions/Symptoms

- Seek social contact in unusual ways
- Inability to interact with peers; difficulty with turn-taking and other "play"
- Difficulty reading social cues
- Difficulty taking the perspective of another
- Socially/emotionally inappropriate behavior
- Limited use of gestures
- Limited use of facial expression
- Difficulty with facial recognition

What do we see/Symptoms

- Prefers to be alone at times
- May want to make friends, but socially inept
- Not pick up when someone has had enough of a conversation
- Not understand emotions of others - assumes everybody thinks/feels the same as he does
- Appear uncaring/rude to others (show no emotion)
- Overreact (more emotional than situation warrants)
- Interrupt conversations
- Behave the same in different social situations and with different people
- May be fearful of people because cannot predict others' behaviors

Repetitive/restrictive Interests/Symptoms

- Upset by or resists changes; transitions difficult
- Develops rigid routines
- Exhibits strong and inflexible interests
- Exhibits narrow/odd interests

What do we see?

- High stress level when changes occur
- Difficulty accepting mistakes in themselves or others
- Upset when others ignore rules
- Inappropriate conversations surrounding special interests

Sensory Issues

- Oversensitive to some sounds, sights, tastes and odors
- Under-responsive to some input (especially verbal)
- Difficulty with modulating input
- Exhibits unusual response to pain

What do we see/Symptoms?

- Stressed in certain situations (crowds)
- Not responding to questions
- Avoidance of activities
- Not reporting health issues/concerns
- May intensely dislike certain smells or sounds
- Dress inappropriately for weather

Thinking and Learning

- Uneven pattern of skill development
- Difficulty manipulating 2 ideas at once
- Focus on details – miss connections and relationships, relevant vs irrelevant
- Concrete thinking; abstract concepts difficult
- Organization and sequencing problems
- Visual over verbal
- Prompt dependent
- Learn in routines

Thinking and Learning (cont.)

- Difficulty solving problems or generating new or alternative solutions to situations
- Chunks of information that occur close together in time are quickly associated
- Concept of time is impaired
- Language is understood and used literally
- Difficulty with generalization

What do we see?

- Avoids new tasks or situations
- Fails to meet expectations of others
- Difficulty "getting started" due to organizational deficits
- "One track mind"
- Difficulty working as a member of a team

Types of ASD

- Autistic disorder - most common
- Rett's disorder
- Disintegration disorder of childhood
- Asperger's disorder
- Pervasive developmental disorder - not otherwise specified (PDD-NOS)

Features	Autistic Disorder	Retts Disorder	ıtegrative Disorders of Childhood	Aspergers Disorder	Pervasive Development Disorder Not Otherwise Specified
Onset	1st year of life	1st three years of life	2 years of normal growth	1st three years of life	1st three years of life
Gender Prevalence	M>F 5:1	Females only	M=F	M>F 5:1	?
Mental Retardation	+±	+++	++	±	+
Areas of impairment: •reciprocal social interaction •cognitive development •language development	 + + +	 + + +	 + + +	 ++ - -	 + + +
Seizure Disorder	+	+	+	-	?
Anxiety and Depression	±	±	±	+	?
Familial Pattern	Increased risk among siblings—5% of siblings	?	?	Increased frequency among family members. Data are however limited	?

Diagnosing ASD

- Often a two stage process
- First stage involves general developmental screening during well-child checkups
  - Children who show some developmental problems are referred for additional evaluation
- Second stage involves a thorough evaluation by a team of doctors and other health professionals; at this stage a child may be diagnosed with having one of the ASD

Diagnosing ASD (Continued)

- The earlier an accurate diagnosis is made, the sooner specific interventions may begin
- Early intervention can reduce or prevent the more severe disabilities associated with ASD
- Early intervention may also improve the individual's IQ, language and everyday functional skills/adaptive behavior

Diagnosing ASD—Screening

- Well-child checkup should include a developmental screening test with specific ASD screening at 18 and 24 months
- Several instruments are available depending on the age of the child, and examples are:
  - Checklist for autism in toddlers
  - Modified checklist for autism in toddlers
  - Screening tools for autism in 2 year olds
  - Social communication questionnaire
  - Communication and symbolic behavior scales

Diagnosing ASD—Screening (Continued)

- To screen mild ASD or Asperger's syndrome in older children, here are other instruments:
  - Autism spectrum screening questionnaire
  - Australian scale for Asperger's syndrome
  - Childhood Asperger's syndrome test

Diagnosing ASD—Evaluation

- A team of Psychiatrist / psychologist / neurologist / speech therapist or other professionals experienced in diagnosing ASD may do this evaluation
- To rule out other frequently associated conditions, brain imaging, gene tests, in-depth memory, problem solving, hearing and language testing is done

ASD—Prevalence

- The complex nature of these disorders, coupled with a lack of biologic markers for diagnosis and changes in clinical definitions over time, creates challenges in monitoring the prevalence of ASDs. Accurate reporting of data is essential to understanding the prevalence of ASDs in the population, and can help direct research

Treatment Approach

- The main goal of treatment is to improve social, communicative functioning/cognition, and to reduce the impact of repetitive behaviors on learning
- There is emerging evidence that early intervention for children with autism is beneficial and results in improved long term cognition
- No comparative studies between interventions have been reported

Treatment Approach (Continued)

- Little evidence exists about which interventions are best for particular groups
- While some teachers use specific approaches for children, others use a more generic approach—there is no evidence that one of these approaches is better than another
- Interventions are time consuming—up to 40 hours a week—and expensive when done by trained specialists

Types of Therapies—Early Educational and Behavioral Interventions

- Applied behavioral analysis
- Autism pre-school program
- Early start Denver model
- More Than Words and Child's Talk
- Treatment and Education of Autistic and Communication Related Handicapped Children (TEACCH)
- Parent mediated or delivered intervention

Pharmacological Therapy

- No medication is available to treat the core difficulties associated with autism; and medications should be reserved for when behavioral/educational techniques fail
- Risperidone: for older children with challenging behavior, aggression and irritability
- SSRIs Prozac: for use in adolescents with anxiety or depression

Pharmacological and Other Therapies

- Ritalin: for those with hyperactivity
- Picture exchange communication system
- Hormones/diets/lifestyle/other alternative options—no evidence that nutritional supplements, IV secretin, glutein diet are effective

Available Services Contracted Through NC DHHS

- $3.8M Contract with the Autism Society of North Carolina to provide advocacy, clinical training, public education and direct service provision
- $339,890.00 Contract with Mariposa School to provide early intervention services
- $366,703 Contract with EasterSeals/UCP to provide early intervention services
- Even though there are no specific ASD services in the Medicaid State Plan, individuals with ASD are potentially eligible for Medicaid Waiver services under the CAP/DD or Innovation Waivers if, in addition to the diagnosis, they show significant deficits in 3 of 5 life skill areas

Available Services Contracted Through NC DHHS

- Individuals with ASD are also potentially eligible for IPRS ID/DD services. These funds are limited, and are used for services such as developmental therapies, respite and some vocational/day program services

The End

Acknowledgements:

Dr Jill Hinton –of EasterSeals/UCP was especially helpful in the preparation of this presentation and some of these slides are hers.

QUESTIONS??

Evidenced Based Practice in Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is a developmental disability characterized by impairments in social reciprocity and communication, and stereotyped and repetitive behaviors, with onset during early childhood. The incidence of autism spectrum disorder has increased dramatically over the past three decades, with a prevalence of 1 in 88 from the CDC's most recent report.

Autism is estimated to cost the United States $35 billion dollars a year. Thus, the provision of intervention services which improve outcomes for individuals with ASD are extremely important.

Historically, research on the efficacy of intervention and treatment in ASD has been limited. However, more recently, evidenced based practices and established treatments are emerging as a result of three national efforts: the National Research Council, the National Standards Project, and the National Professional Development Center on ASD.

National Research Council

Based on evidence review, The National Research Council (2001) identified three autism treatments as "scientifically based". These included Applied Behavioral Analysis, Discrete Trial Teaching, and Pivotal Response Treatment. Several others were identified as "promising practices": Picture Exchange Communication System, Incidental Teaching, Structured Teaching, Joint Action Routines, Augmentative Communication, and Social Stories.

Based on their review, NRC also made recommendations about the content of effective early intervention programs for ASD.

1) at least 25 hours/week of active engagement,
2) instruction that blends knowledge of autism with principles of direct instruction,
3) intervention aimed at communication, joint attention, and symbolic play,
4) techniques to promote generalization, and
5) parental involvement.

National Standards Project (National Autism Center)

National Standards Project, a multi-year project of the National Autism Center, was completed in 2009. It included review of 775 research studies and was designed to provide information about which treatments have been shown to be effective for individuals with ASD.

A Scientific Merit Rating Scale was developed as a means of objectively evaluating the studies. In addition, each study was rated on its treatment effects. Based on these ratings, 38 treatments were identified which had adequate research support. The Strength of Evidence Classification System was then used to determine effectiveness of each treatment and treatments were put into one of four

categories: Established, Emerging, Unestablished, and Ineffective/Harmful. The following interventions were identified as Established Treatments:

- Antecedent Package – involve modification of situational events that precede behaviors
- Behavioral Package – involve utilizing basic principles of behavior change
- Comprehensive Behavioral Treatment for Young Children –comprehensive treatment programs that include a combination of ABA procedures which are used with young childre
- Joint Attention Intervention – involve foundational skills needed in regulating the behavior of others
- Modeling – demonstration of target behaviors
- Naturalistic Teaching Strategies – using child directed interactions to teach functional skills
- Peer Training Package – teaching individuals without disabilities strategies for facilitating social interactions
- Pivotal Response Treatment – focuses on targeting "pivotal" behavioral areas such as motivation to engage, self-management, responsiveness; involves parents in natural environment
- Schedules – presentation of task lists that communicates series of steps required to complete specific activities
- Self Management – teaching individuals to regulate their behavior by recording incidents, and securing reinforcement
- Story-based Intervention Package –written descriptions of situations where specific behaviors are expected

There were 22 treatments identified as Emerging, including Cognitive Behavioral Intervention, Developmental Relationship-based Treatment, Picture Exchange Communication System, and Structured Teaching (see National Standards Report for complete list).

The report noted that two-thirds of the Established Treatments came exclusively from behavioral literature. Of the remaining one-third, 75% have research support that comes predominately from behavioral literature. This pattern suggests that treatments from behavioral literature have the strongest research support at this time.

National Professional Development Center on ASD

The National Professional Development Center on ASD (NPDC) was created to promote the development and learning of individuals with ASD from birth to 22 years of age by increasing practitioners' use of Evidence-Based Practices (EBPs) in their programs and building states' capacity to implement EBPs. The national center operates through three sites: FPG Child Development Institute at the University of North Carolina at Chapel Hill, the M.I.N.D. Institute at University of California at Davis Medical School, and the Waisman Center at the University of Wisconsin at Madison. Now in its third year, NPDC is funded by the U.S. Department of Education's Office of Special Education Programs.

The National Professional Development Center uses rigorous criteria to determine whether a practice is evidence-based. Currently, the Center has identified 24 evidence-based practices. To be considered an evidence-based practice, efficacy must be established though peer-reviewed research using:

- Randomized or quasi-experimental design studies – two high quality experimental or quasi-experimental group design studies,
- Single-subject design studies – three different investigators or research groups must have conducted five high quality single subject design studies, or
- Combination of evidence – one high quality randomized or quasi-experimental group design study and three high quality single subject design studies conducted by at least three different investigators or research groups(across the group and single subject design studies).

The 24 Evidenced-Based Practices include:

- Prompting
- Antecedent-Based Intervention
- Time Delay
- Reinforcement
- Task Analysis
- Discrete Trial Training
- Functional Behavior Analysis
- Functional Communication Training
- Response Interruption/Redirection
- Differential Reinforcement
- Social Narratives
- Video Modeling
- Naturalistic Interventions
- Peer Mediated Intervention
- Pivotal Response Training
- Visual Supports
- Structured Work Systems
- Self Management
- Parent Implemented Intervention
- Social Skills Training Groups
- Speech Generating Devices
- Computer-aided Instruction
- Picture Exchange Communication
- Extinction

The NPDC on ASD is developing on-line modules for each of these evidenced-best practices. These modules are available on the **Autism Internet Modules (AIM)** website. The NPDC will continue to evaluate the effectiveness of these practices, as well as additional practices.

Summary

The research on evidenced-based practice in ASD is increasing and these three national efforts have improved the access to information on effective treatments. There has been a shift from identifying "programs" as best practice to identifying specific treatment components as best practice. For example, several of the practices identified by NPDC would all fall under the category of "Behavioral Package" in the NSP. The move to more specific treatment elements will allow for more individualized treatments and approaches based on individual needs and preferences.

National Research Council (2001) *Educating Children with Autism*. Committee on Educational Interventions for Children with Autism. Catherine Lord and James P.McGee, eds. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

National Autism Center *National Standards Report: Addressing the Need for Evidence-Based Practice Guidelines for Autism Spectrum Disorders*. National Autism Center: Massachusetts. 2009.

National Professional Development Center on Autism Spectrum Disorders. Autism Internet Modules. www.autisminternetmodules.org

Jill Hinton, PhD

Early Intensive Behavioral Intervention for Young Children with Autism

Background

Autism Spectrum Disorder (ASD) is a developmental disability characterized by impairments in social reciprocity and communication, and stereotyped and repetitive behaviors, with onset during early childhood. The incidence of autism spectrum disorder has increased dramatically over the past three decades, with a prevalence of 1 in 88 from the CDC's most recent report.

Autism is estimated to cost the United States $35 billion dollars a year. Thus, the provision of early intervention services which improve outcomes for individuals with ASD are extremely important.

Research on the efficacy of early intervention in ASD is limited. While the 1987 report by Lovaas that indicated that early behavioral intervention resulted in significant IQ gains created intense interest in early intervention, most studies have lacked methodological rigor. The best established evidence base for efficacy is Early Intensive Behavioral Intervention (EIBI). Since the initial Lovaas study, the intervention model has been adapted to improve generalization of skills. Other promising practices include developmental and relationship-based approaches and TEACCH Structured Teaching. Based on evidence review, The National Research Council made recommendations about the content of effective early intervention programs for ASD. These included: 1) at least 25 hours/week of active engagement, 2) instruction that blends knowledge of autism with principles of direct instruction, 3) intervention aimed at communication, joint attention, and symbolic play, 4) techniques to promote generalization, and 5) parental involvement.

Model

Based on the current evidence base, along with the promising practices, programs have been developed which integrate applied behavior analysis with developmental and relationship-based approaches. One of these programs is the Early Start Denver Model (ESDM), which is a comprehensive early behavioral intervention for infants to preschool-aged children with ASD. ESDM uses teaching strategies that involve social exchange and positive affect, shared engagement with objects and activities, and a focus on verbal and non-verbal communication. The principles of applied behavior analysis are utilized as part of teaching strategies. Twenty therapist-delivered intervention hours are available each week for each child. In addition, parents are taught the basic ESDM strategies and are asked to use them at home during everyday activities.

Population

This intervention targets young children with autism spectrum disorder. Research has shown that children who begin intervention at earlier ages have more gains and better outcomes.

Research Background

The efficacy of the Early Start Denver Model (ESDM) was assessed in a randomized, controlled trial. Forty-eight children with ASD between the ages of 18 and 30 months were randomly assigned to ESDM or referral to community providers for available services in the community. Children in the control group received evaluations, treatment recommendations, referral to providers, and parent resource manuals. Compared with children who received community intervention, children who received EDSM showed significant improvements in IQ, adaptive behavior, and autism diagnosis. Two years after entering intervention. The EDSM children on average improved 17.6 standard score points, compared to 7.0 points in the comparison group. In addition, the ESDM children were more likely to experience a change in diagnosis from autism to pervasive developmental disorder. The results of this study emphasis the importance of early identification and intervention in ASD.

National Research Council (2001) *Educating Children with Autism*. Committee on Educational Interventions for Children with Autism. Catherine Lord and James P.McGee, eds. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

Dawson, Rogers, Munson, Smith, Winter, Greenson, Donaldson, Varley. Randomized, Controlled Trial of an Intervention for Toddlers with Autism: The Early Start Denver Model. *Pediatrics* published online Nov 30, 2009.

Lovaas OI. Behavioral treatment and normal educational and intellectual functioning in young autistic children. *J Consult Clin Psychol.* 1987; 55(1):3–9

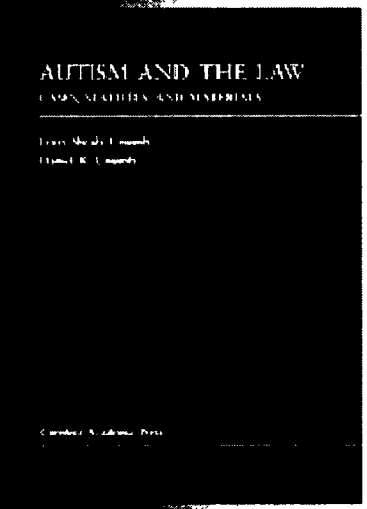
Written for the DD PIC by Jill Hinton, Ph.D.

Update on Autism Spectrum Disorders

Lorri Shealy Unumb, Esq.
Vice President, State Government Affairs, Autism Speaks

THE GEORGE WASHINGTON UNIVERSITY

WASHINGTON, DC

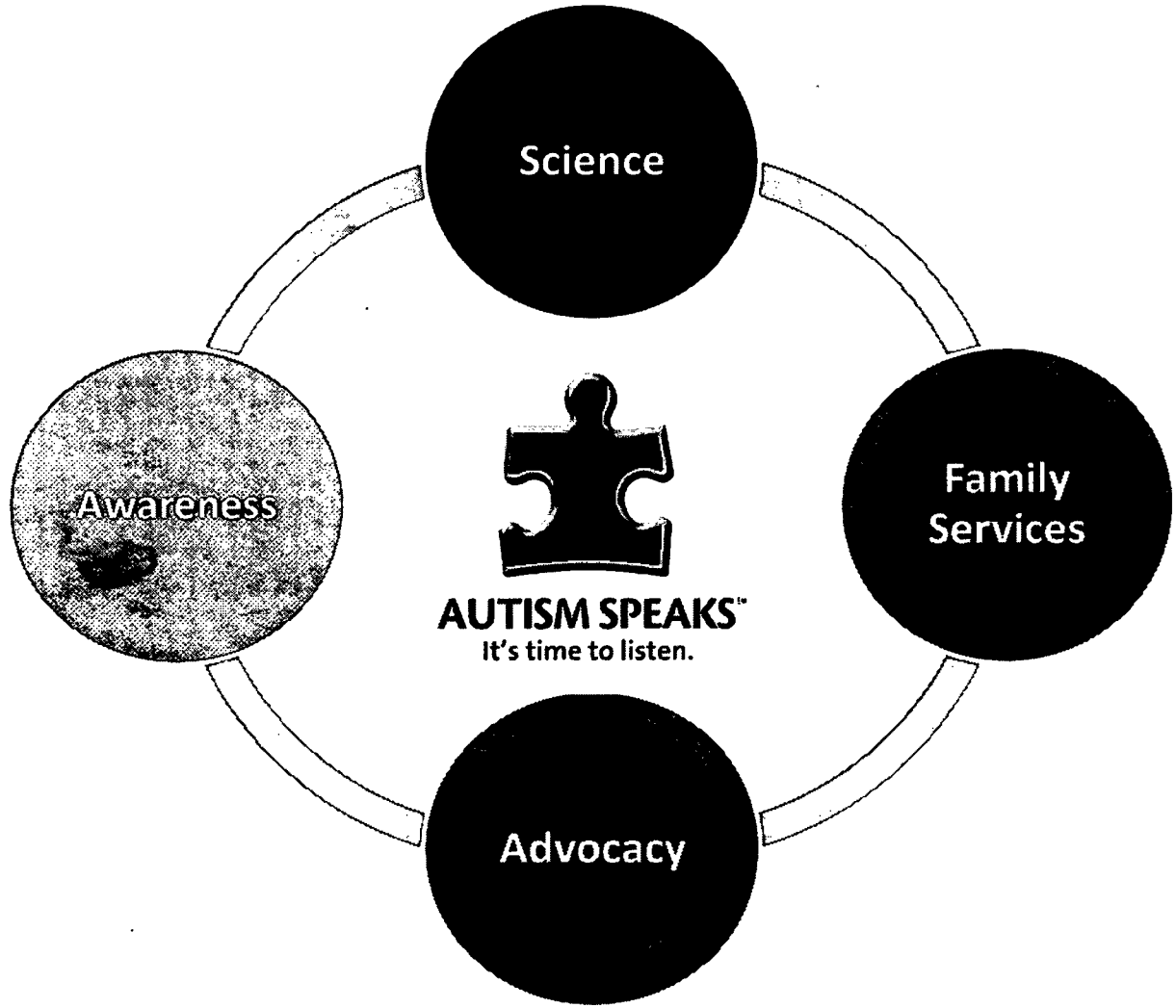


Autism and the Law

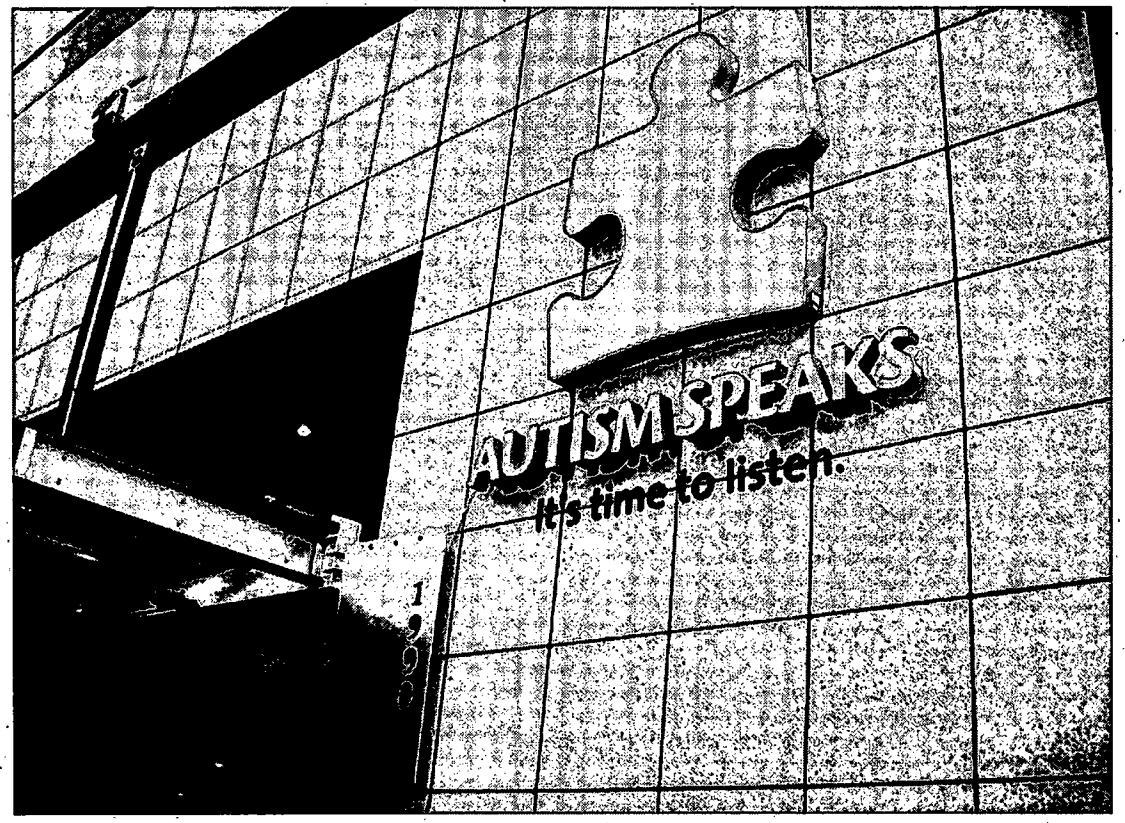
Cases, Statutes, and Materials

by Lorri Shealy Unumb & Daniel R. Unumb

Carolina Academic Press


Science
Awareness
Family Services
AUTISM SPEAKS
It's time to listen.
Advocacy

Autism Speaks Government Relations



Autism Speaks

- Headquartered in New York

Autism Speaks Government Relations

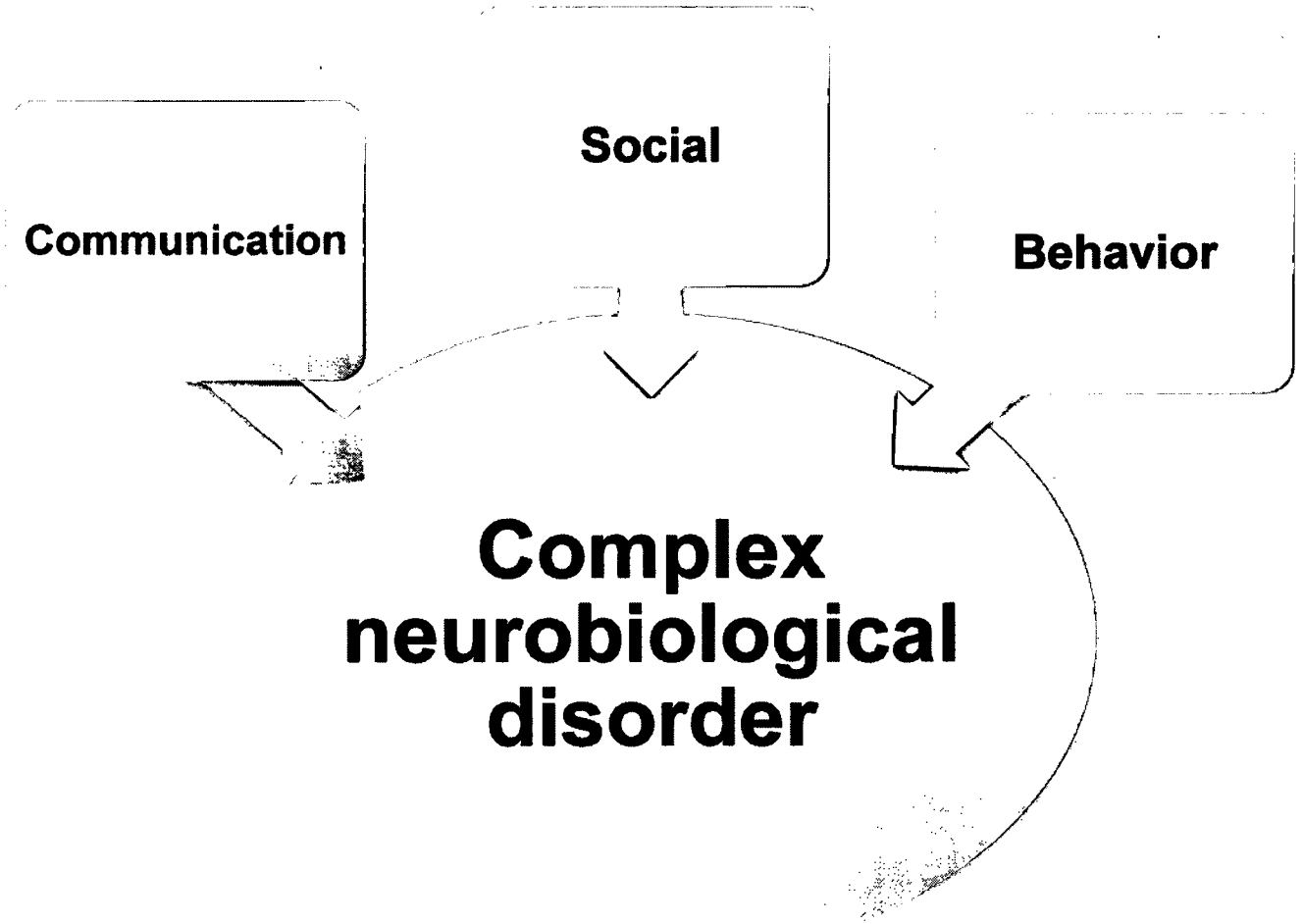
- Headquartered in D.C.

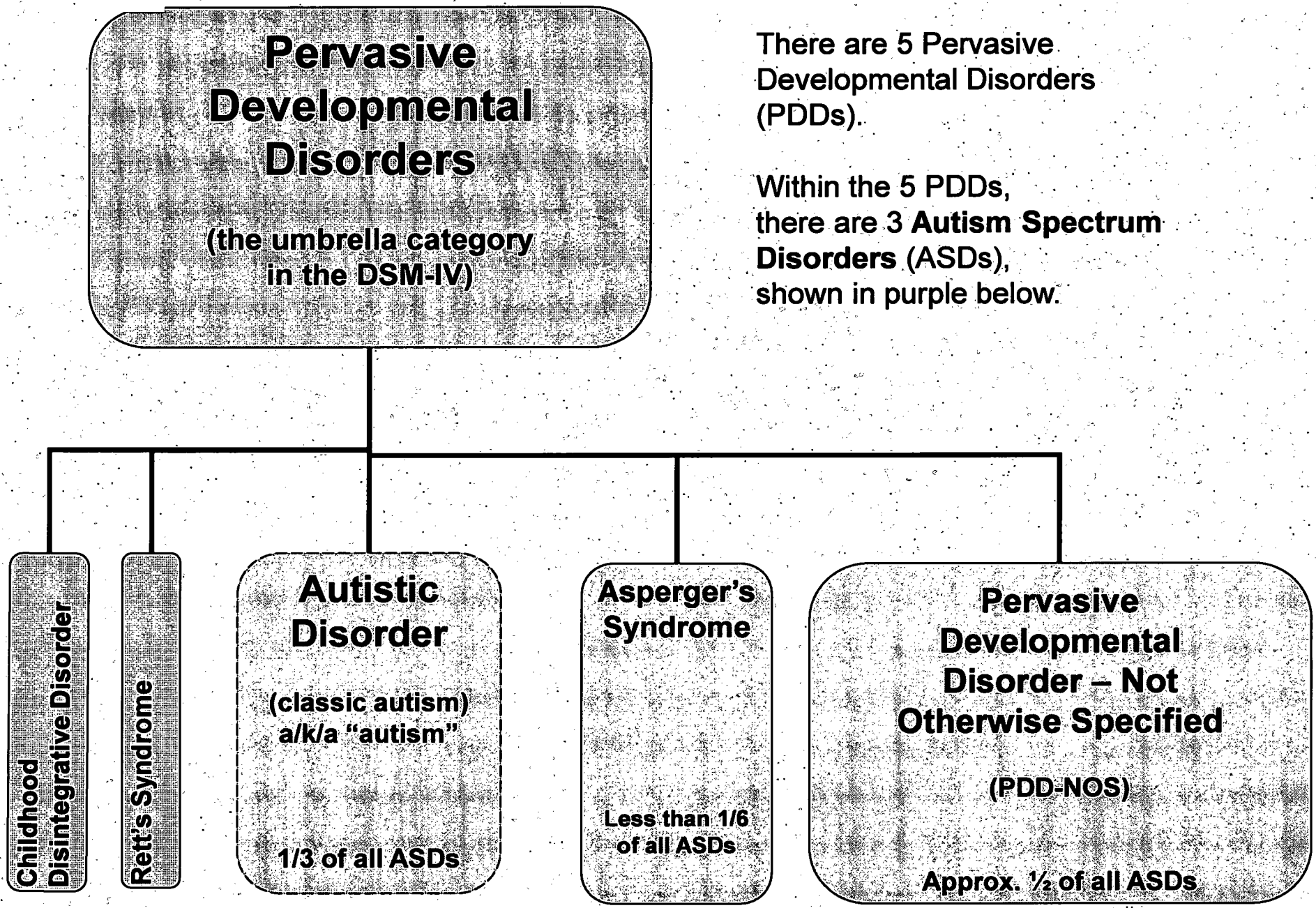
Autism Spectrum Disorder

- A medical condition, brought on through no apparent fault of family
- Diagnosed by doctor or psychologist; often a developmental pediatrician
- Four-five times more common in boys than girls

See new research on "Female Protective Effect" http://www.autismspeaks.org/science/science-news/%E2%80%9Cfemale-protective-effect%E2%80%9D

What is Autism?

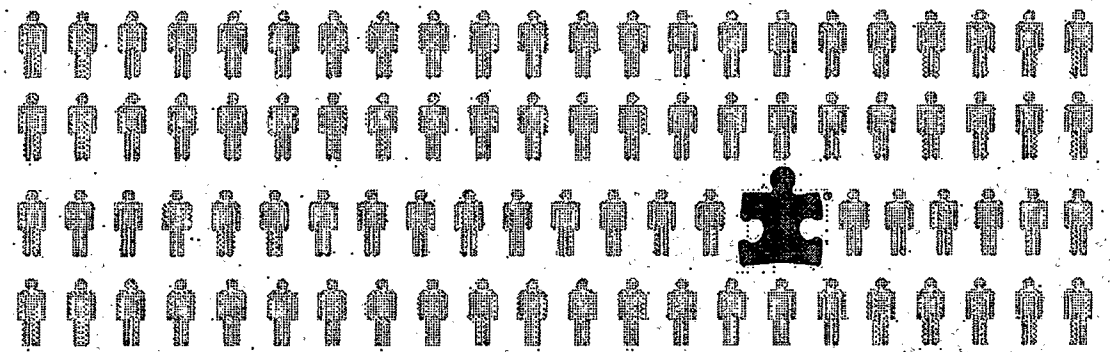



Pervasive Developmental Disorders
(the umbrella category in the DSM-IV)
There are 5 Pervasive Developmental Disorders (PDDs).
Within the 5 PDDs, there are 3 Autism Spectrum Disorders (ASDs), shown in purple below.
Childhood Disintegrative Disorder
Rett's Syndrome
Autistic Disorder
(classic autism) a/k/a "autism"
1/3 of all ASDs
Asperger's Syndrome
Less than 1/6 of all ASDs
Pervasive Developmental Disorder – Not Otherwise Specified
(PDD-NOS)
Approx. ½ of all ASDs

Cause(s)?

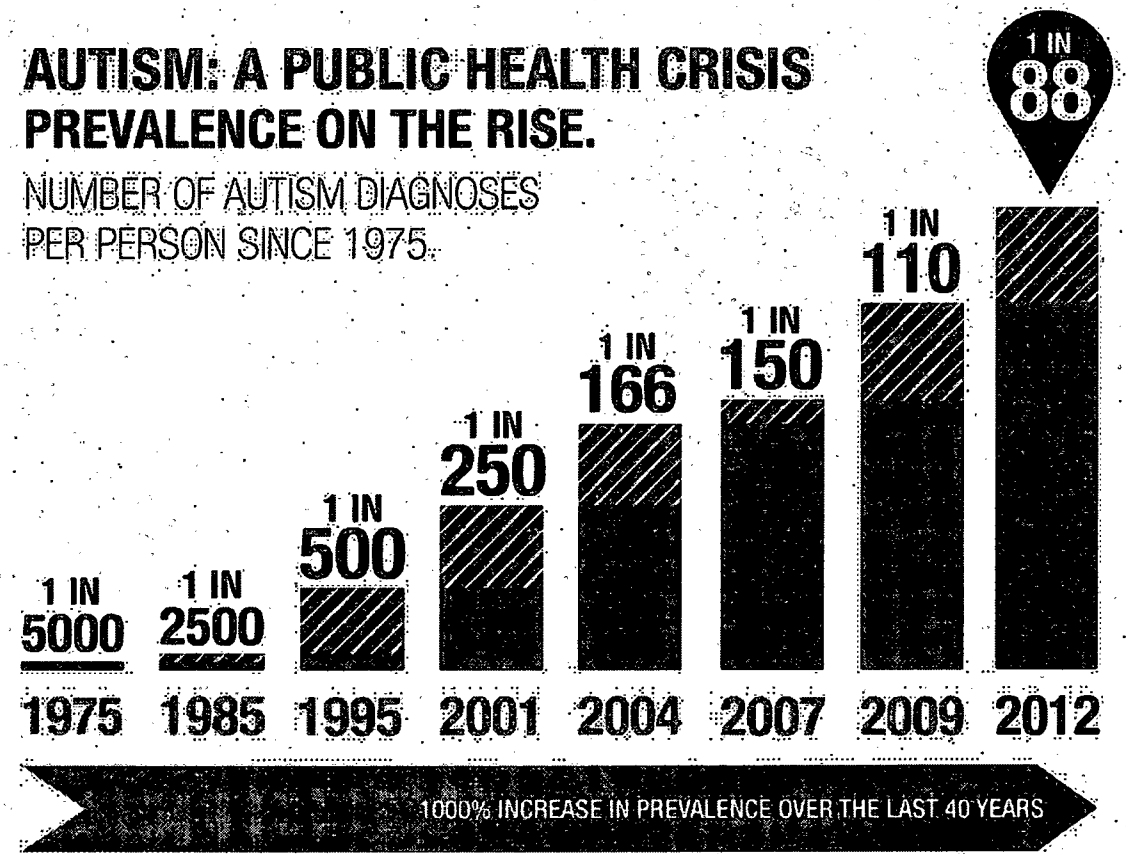
An 30-year-old study looked at 21 pairs of twins, at least one of each pair being affected by autism. It compared identical twins, who share all of their genetic makeup, with fraternal twins, who share around half their genes. It found that when one identical twin had autism, so did the other 83 percent of the time. By contrast, this was true of only 10 percent of the fraternal twins. For decades, it was taken as fact that the causes of autism were almost completely genetic.

That changed this past year with the largest ever autism twin study. A Stanford University study found a significantly lower autism concordance between identical twins—just 70 percent. They also found a much higher than expected overlap between fraternal twins—around 35 percent, considerably higher than the 15 percent or lower concordance we know exists between siblings who are not twins. This strongly suggests that environmental influences play a significant role in autism -prenatal influences being among the most likely.

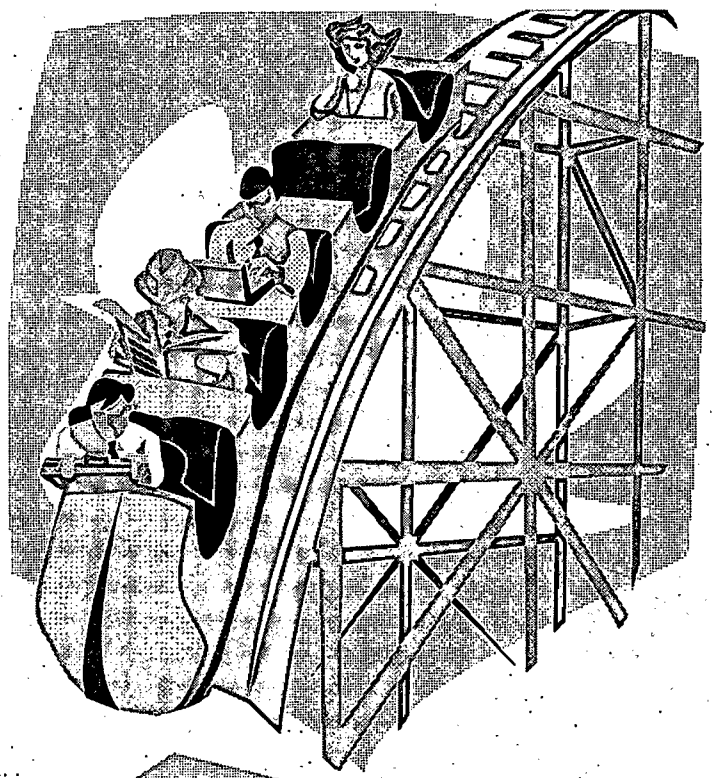


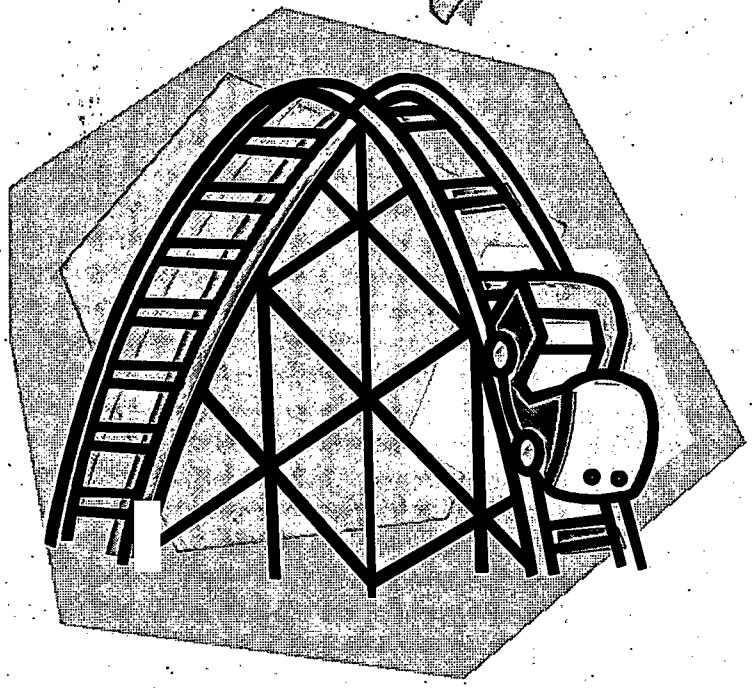
AUTISM: A PUBLIC HEALTH CRISIS
PREVALENCE ON THE RISE.

NUMBER OF AUTISM DIAGNOSES
PER PERSON SINCE 1975.

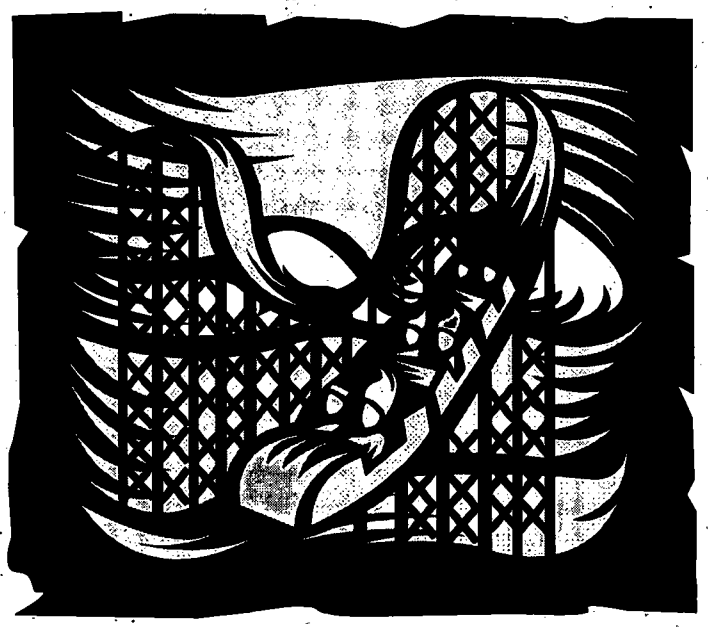


% INCREASE FROM PREVIOUS YEAR





Johns Hopkins University's Kennedy Krieger Institute
Children's National Medical Center
Georgetown University Hospital



Applied Behavior Analysis (ABA Therapy)

- One-on-one therapy
- Up to 40 hours/week
- Uses behavioral stimuli & consequences to produce significant improvement in human behavior
- Breaks down into discrete components the skills that neuro-typical children acquire naturally
- Trains child to acquire skills through repetition, prompting, and positive reinforcement

Applied Behavior Analysis: Sample Therapy Structure

- Consultant
  - Highly educated and trained in ABA
  - Board certified in ABA
  - Evaluates, designs, trains
  - 3-6 hours per month

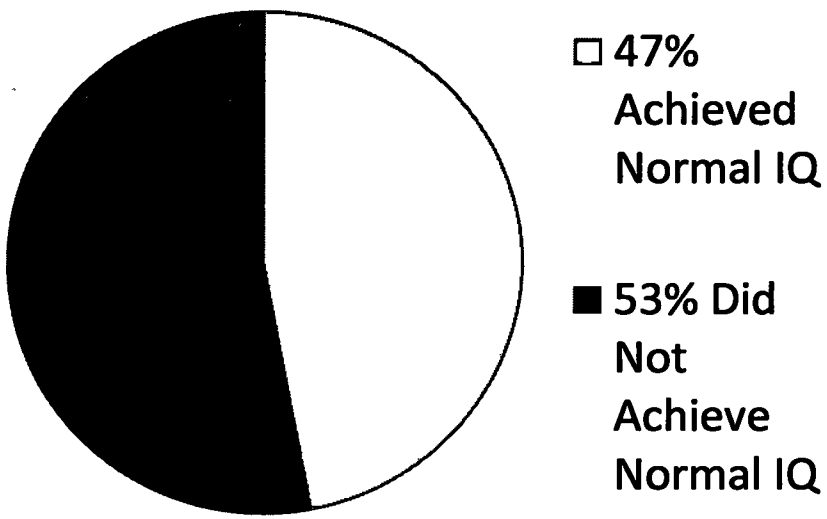
- Mid-level supervisor (lead therapist)
  - Educated and trained
  - May be board certified
  - Updates programming; trains; oversees
  - 6 hours per week

- Line therapists
  - Trained & supervised by above
  - Provide 40 hours per week of direct therapy, usually in 3-hour shifts

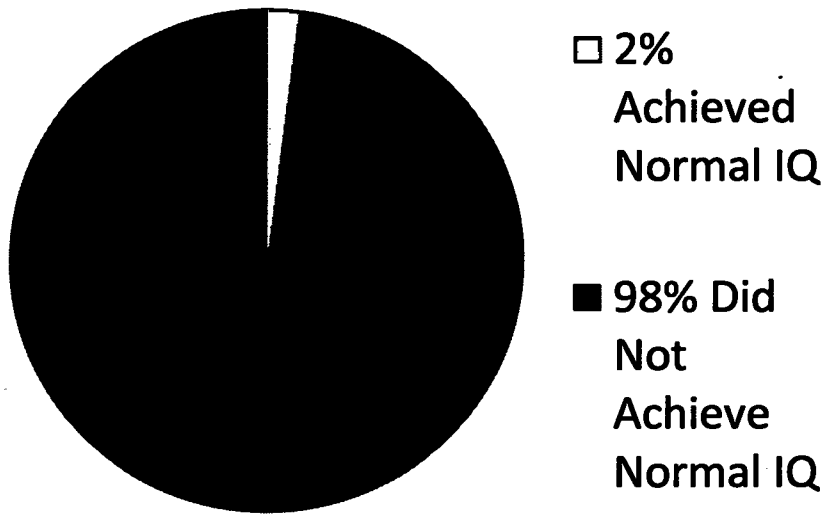
Efficacy of ABA Therapy

Outcome of 1987 UCLA Lovaas Study

ABA Group

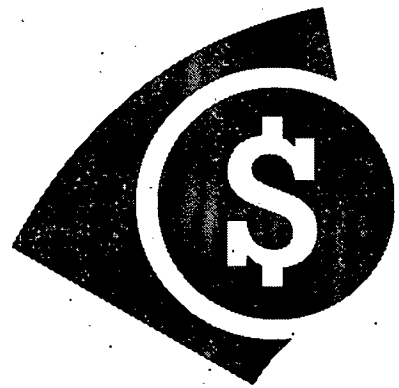


Other Intervention (Control) Group



Applied Behavior Analysis: Cost of a Sample Therapy Program

- Consultant
  - 3-6 hours per month
  - $100-$150/hour
  - 6 hours x $150 = $900/month
  - $900 x 12 months = **$10,800**



- Mid-level supervisor (lead therapist)
  - 6 hours per week
  - $30-$60/hour
  - 6 hours x $60 = $360/week
  - $360/week x 52 weeks = **$18,720**

- Line therapists
  - 40 hours per week
  - $20 - $30/hour
  - 40 hours x $20 = $800/week
  - $800/week x 52 weeks = **$41,600**

- $10,800 + $18,720 + $41,600 = **$71,120**

- **How does a family pay for this?**
- **THANK GOODNESS FOR HEALTH INSURANCE!**

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

June 20, 2012

Testimony of
Vera F. Tait MD, FAAP

On behalf of the
American Academy of Pediatrics

Before the
Subcommittee on Personnel,
Senate Armed Services Committee

- "The effectiveness of ABA-based interventions in ASDs has been well documented through a long history of research in university and community settings. Children who receive early intensive behavioral treatment have been shown to make **substantial gains in cognition, language, academic performance, and adaptive behavior as well as some measures of social behavior**, and their outcomes have been significantly better than those of children in control groups."

American Academy of Pediatrics • Department of Federal Affairs
601 13th Street NW, Suite 400 North • Washington, DC 20005
Tel: 800.336.5475 • E-mail: kids1st@aap.org

ABA is the Standard of Care

United States Surgeon General **(1999)**

*"**Thirty years of research** demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior."*

Centers for Medicare and Medicaid **(2011)**

*" ...**controlled trials have shown both the efficacy** of programs based in the principles of ABA and that certain individual characteristics (age, IQ, and functional impairments) are associated with positive outcomes."*

National Institute of Mental Health **(2011)**

*"One type of a **widely accepted treatment** is applied behavior analysis (ABA). The goals of ABA are to shape and reinforce new behaviors, such as learning to speak and play, and reduce undesirable ones."*

ABA is the Standard of Care

Centers for Disease Control and Prevention (2012)

*"A notable treatment approach for people with an ASD is called applied behavior analysis (ABA). ABA has become **widely accepted** among health care professionals..."*

NATIONAL INSTITUTE OF NEUROLOGICAL (2012) DISORDERS AND STROKE

*"Therapies and behavioral interventions are designed to remedy specific symptoms and **can bring about substantial improvement**...Therapists use highly structured and intensive skill-oriented training sessions to help children develop social and language skills, such as Applied Behavioral Analysis"*

ABA is the Standard of Care

AMERICAN PSYCHOLOGICAL ASSOCIATION (2012)

"The field of applied behavior analysis has grown substantially in the past decade, enabling more children with autism and their families to obtain needed services. This growth appears to be related to an increase in the number of children diagnosed with an autism spectrum disorder and to the ***recognition of the effectiveness of behavior analytic services****."*

The U.S. Office of Personnel Management (2012)

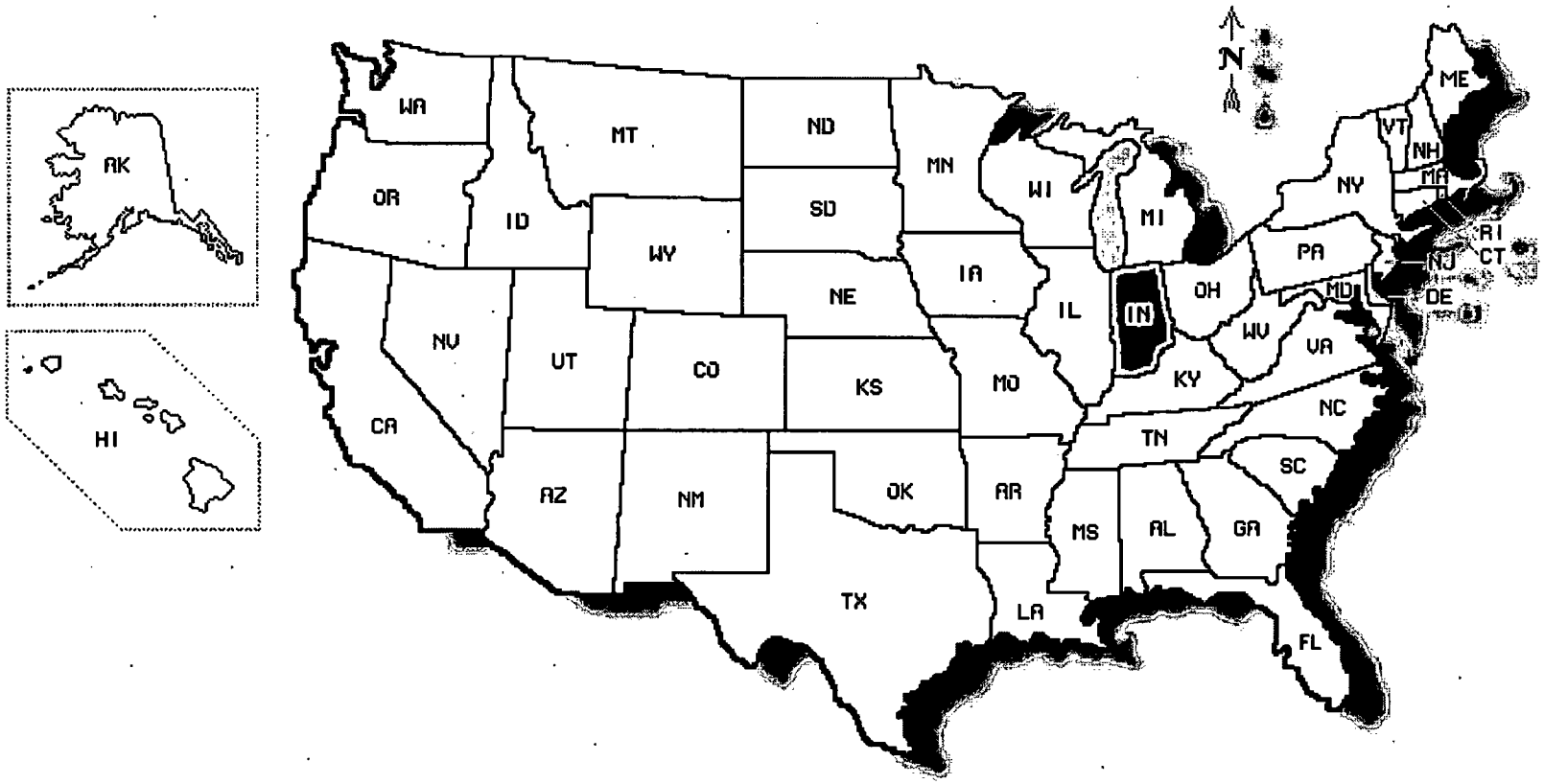
"The OPM Benefit Review Panel recently evaluated the status of Applied Behavior Analysis (ABA) for children with autism. Previously, ABA was considered to be an educational intervention and not covered under the FEHB Program. The Panel concluded that there is now ***sufficient evidence to categorize ABA as medical therapy****. Accordingly, plans may propose benefit packages which include ABA."*

Cost of Autism to Society/State

- **<u>Without</u> appropriate treatment**, the lifetime societal cost has been estimated to be **$3.2 million** <u>per child</u> with ASD (Ganz, 2007)
  - special education
  - adult services
  - decreased productivity

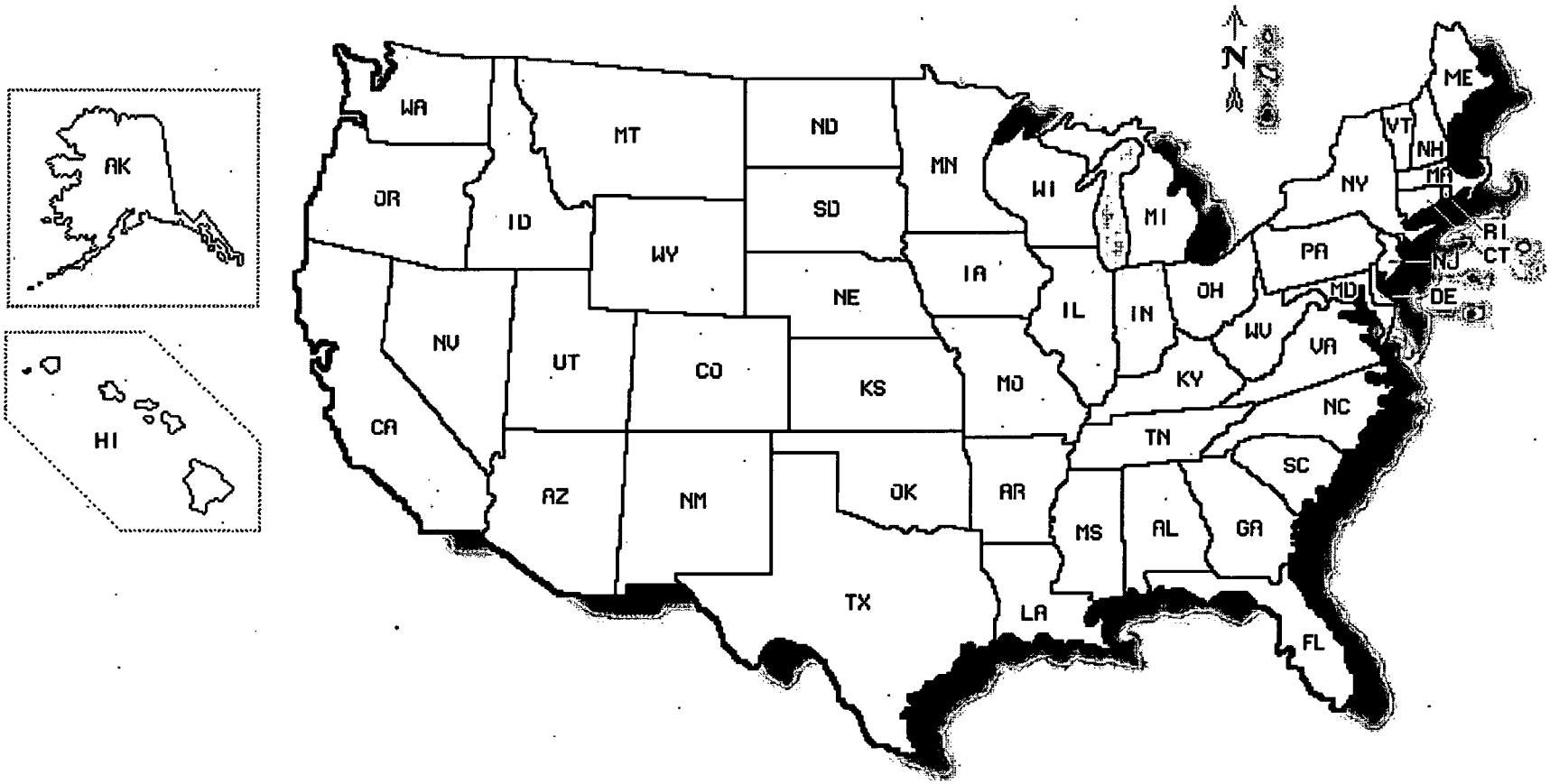
- State estimated lifetime cost **savings** of providing appropriate treatment are $1 million per child (Jacobsen et al, 1998)

2001 Snapshot



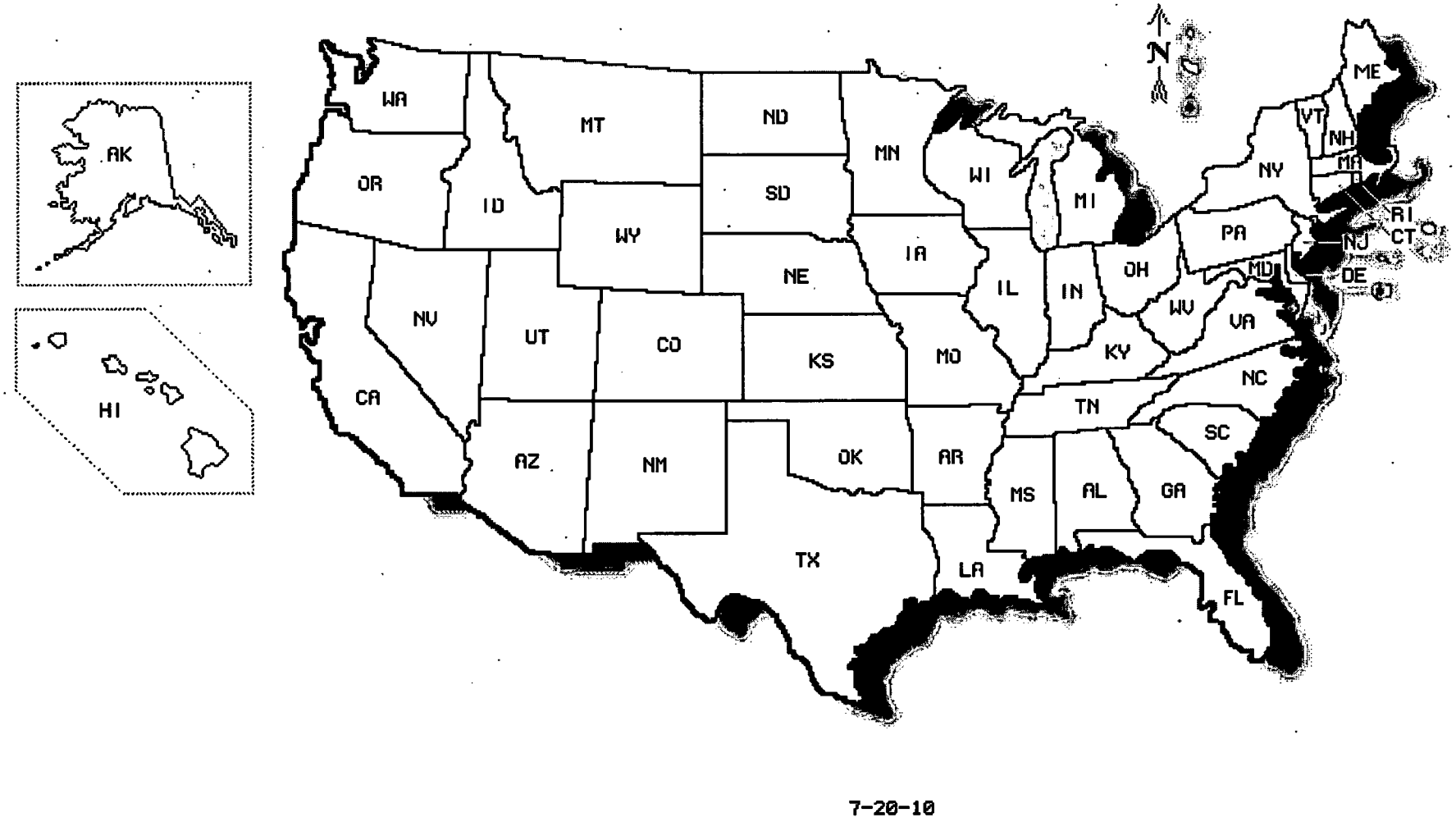
7-20-10

2002 Snapshot

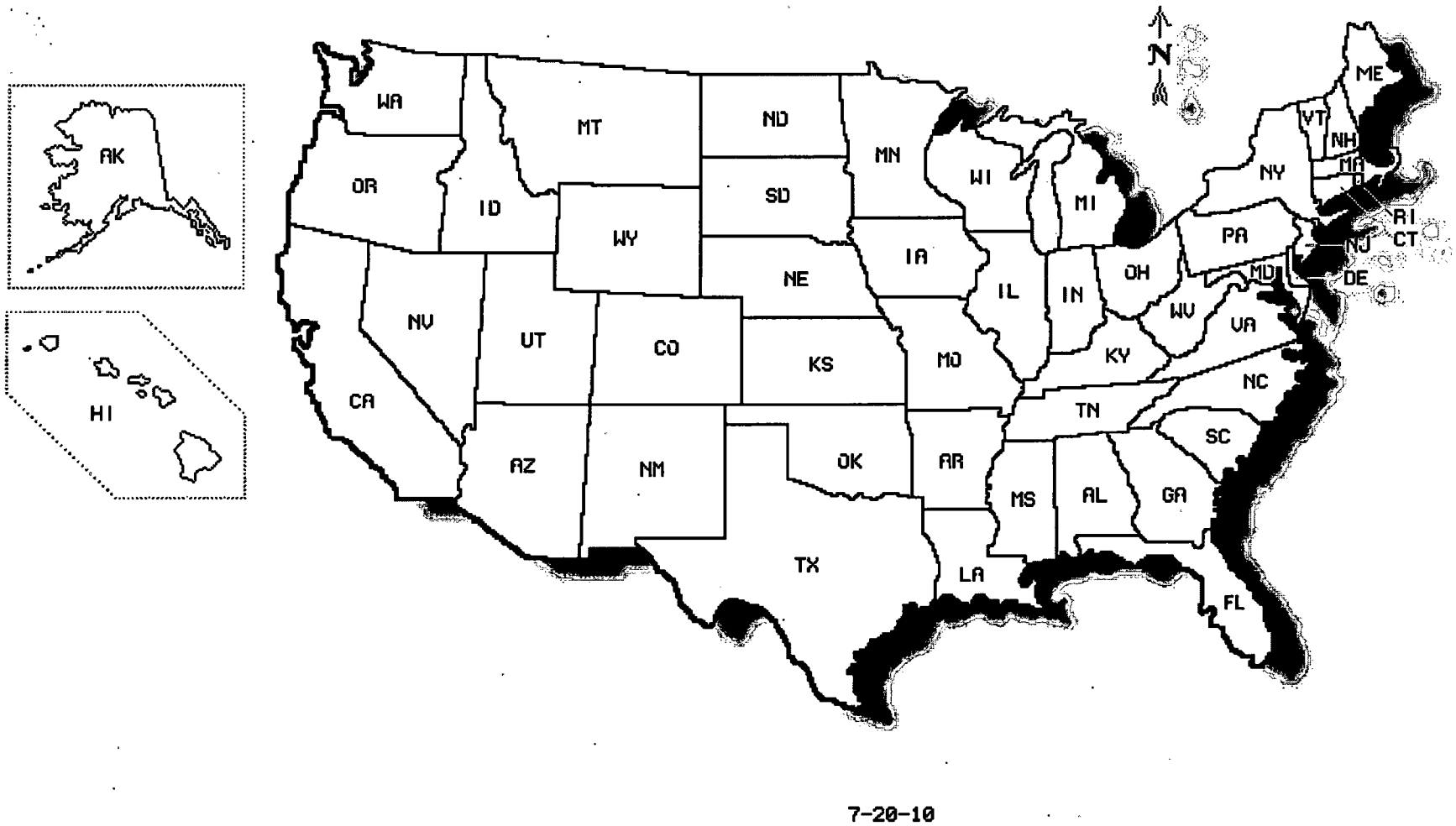


7-20-10

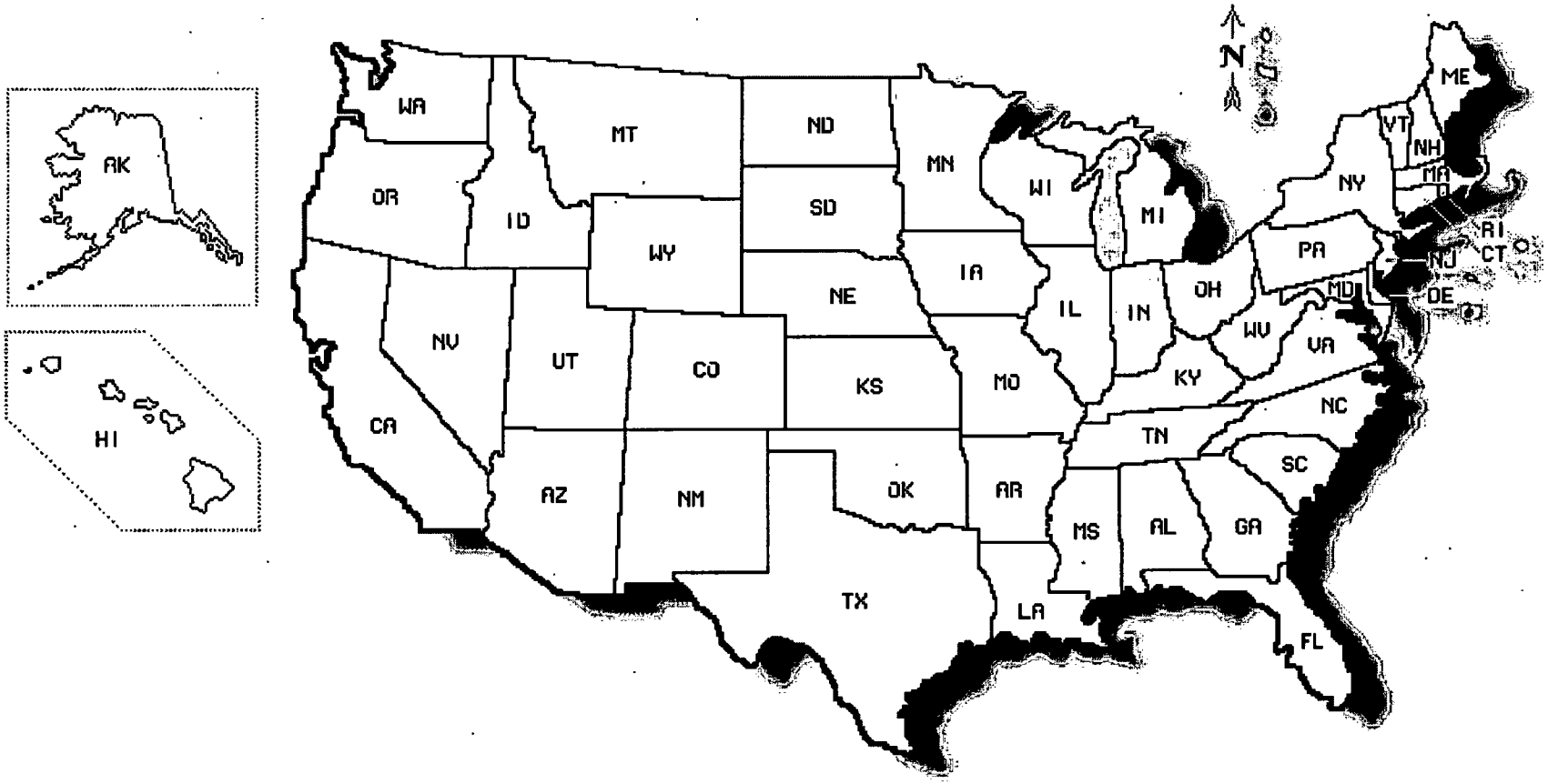
2003 Snapshot



2004 Snapshot

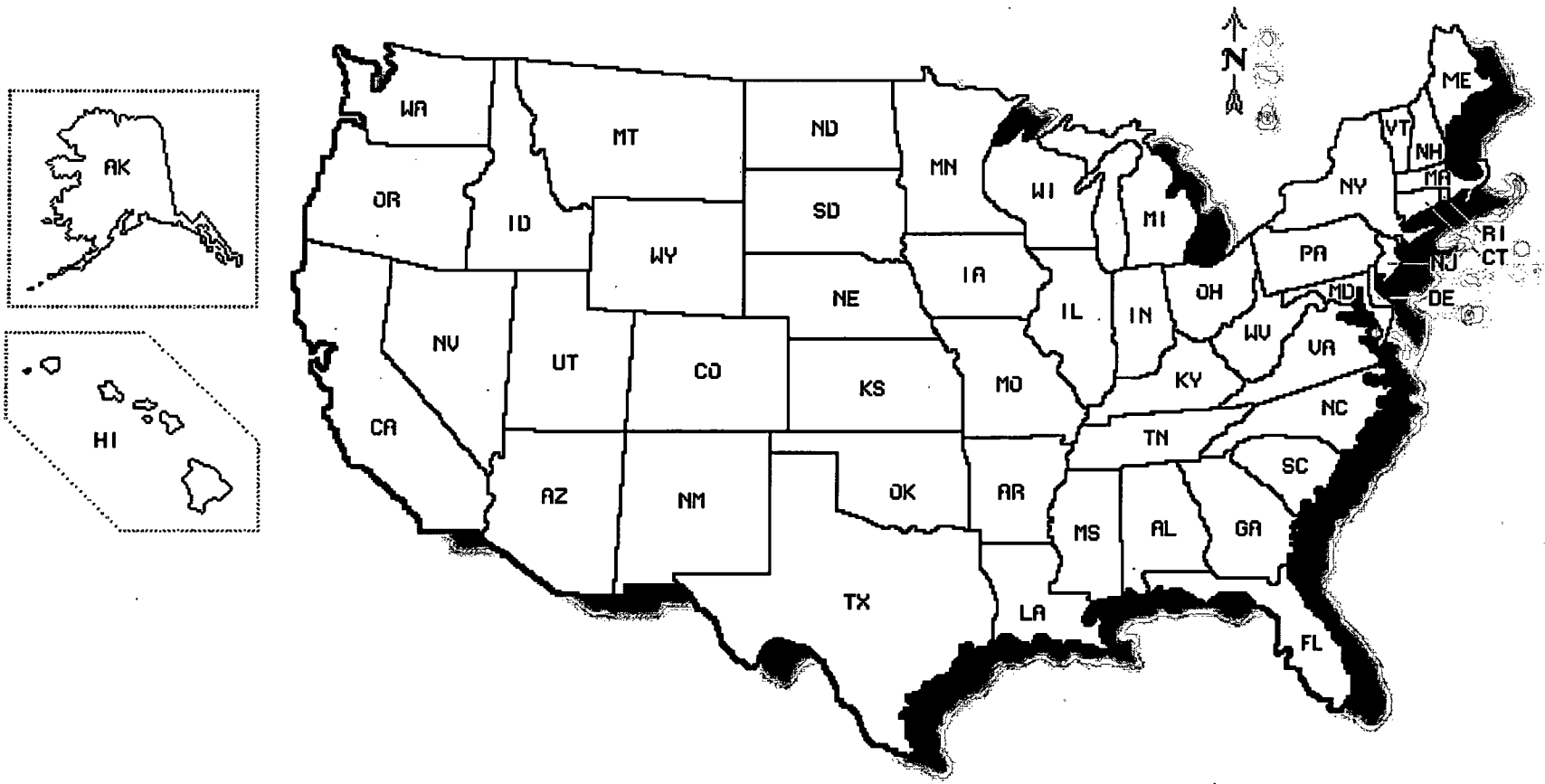


2005 Snapshot



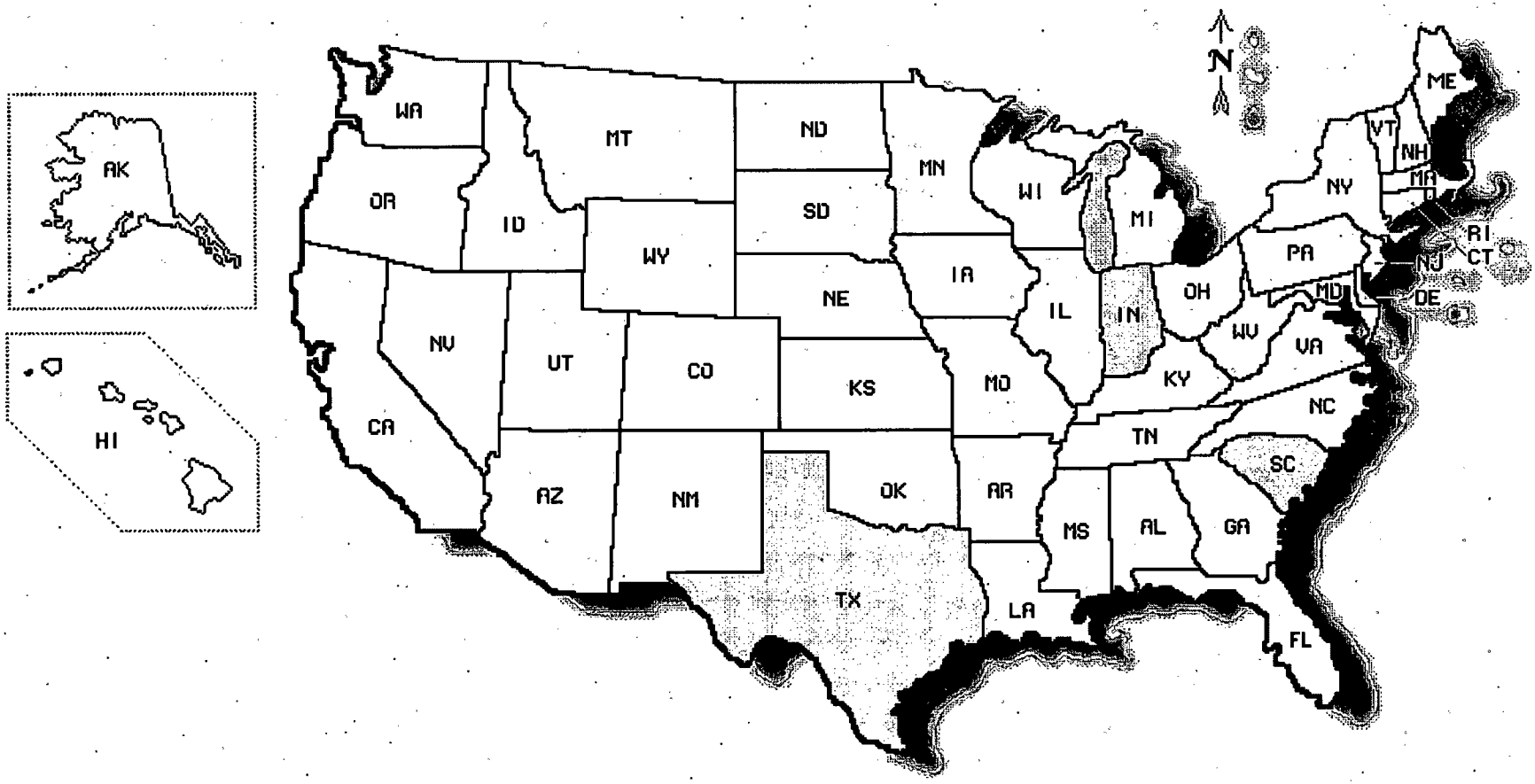
7-20-10

2006 Snapshot



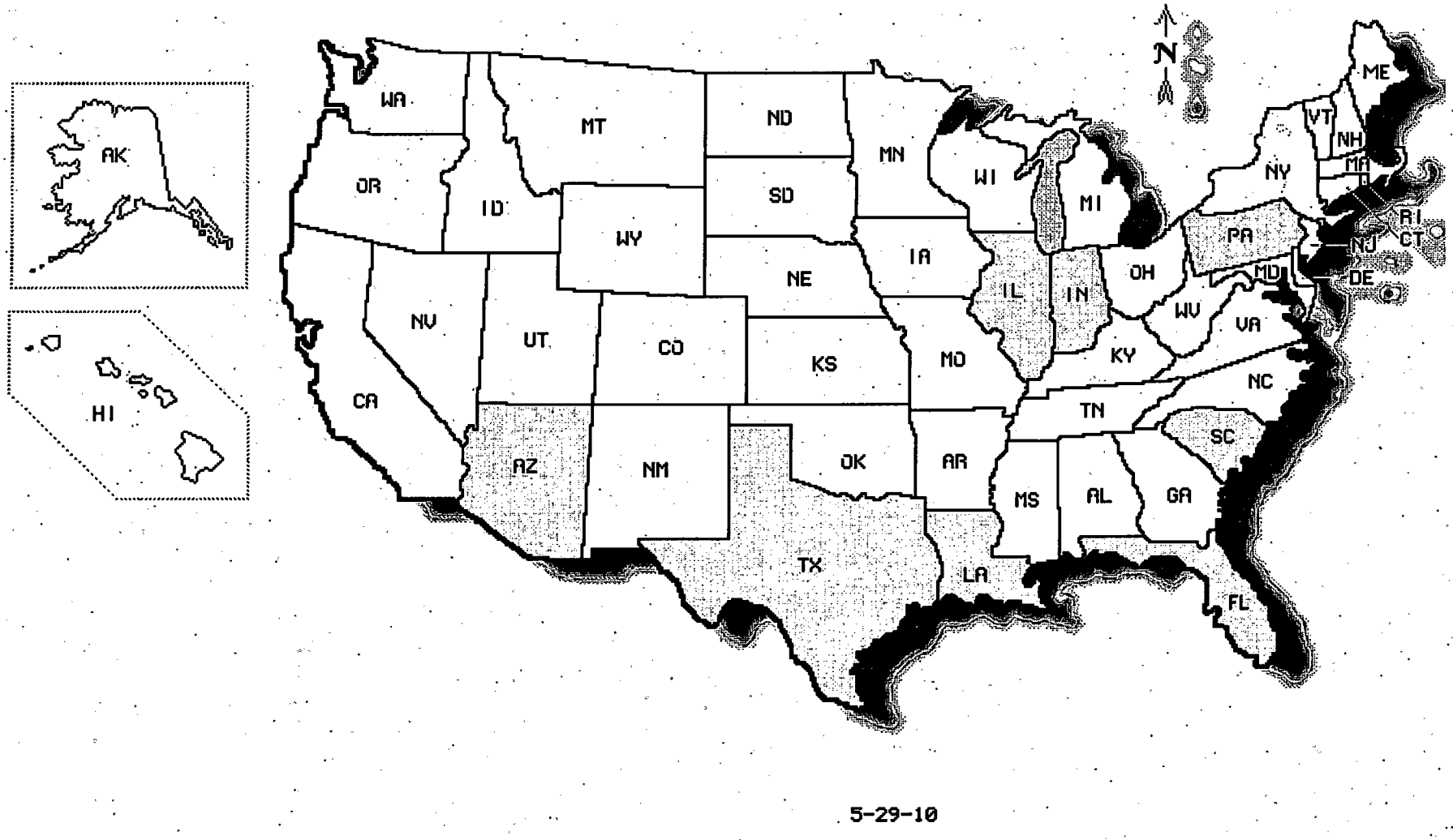
7-20-10

2007 Snapshot

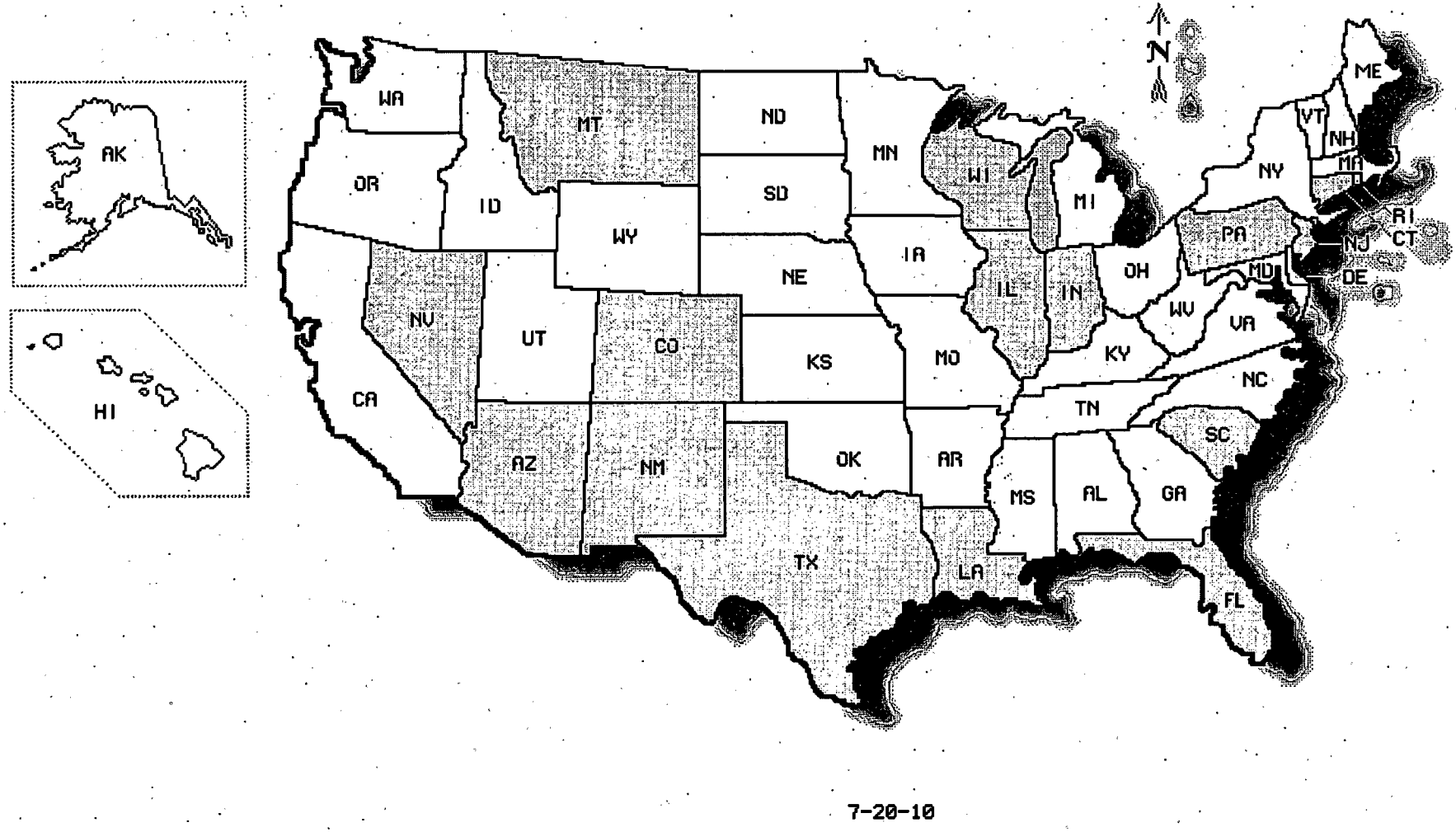


5-29-10

2008 Snapshot

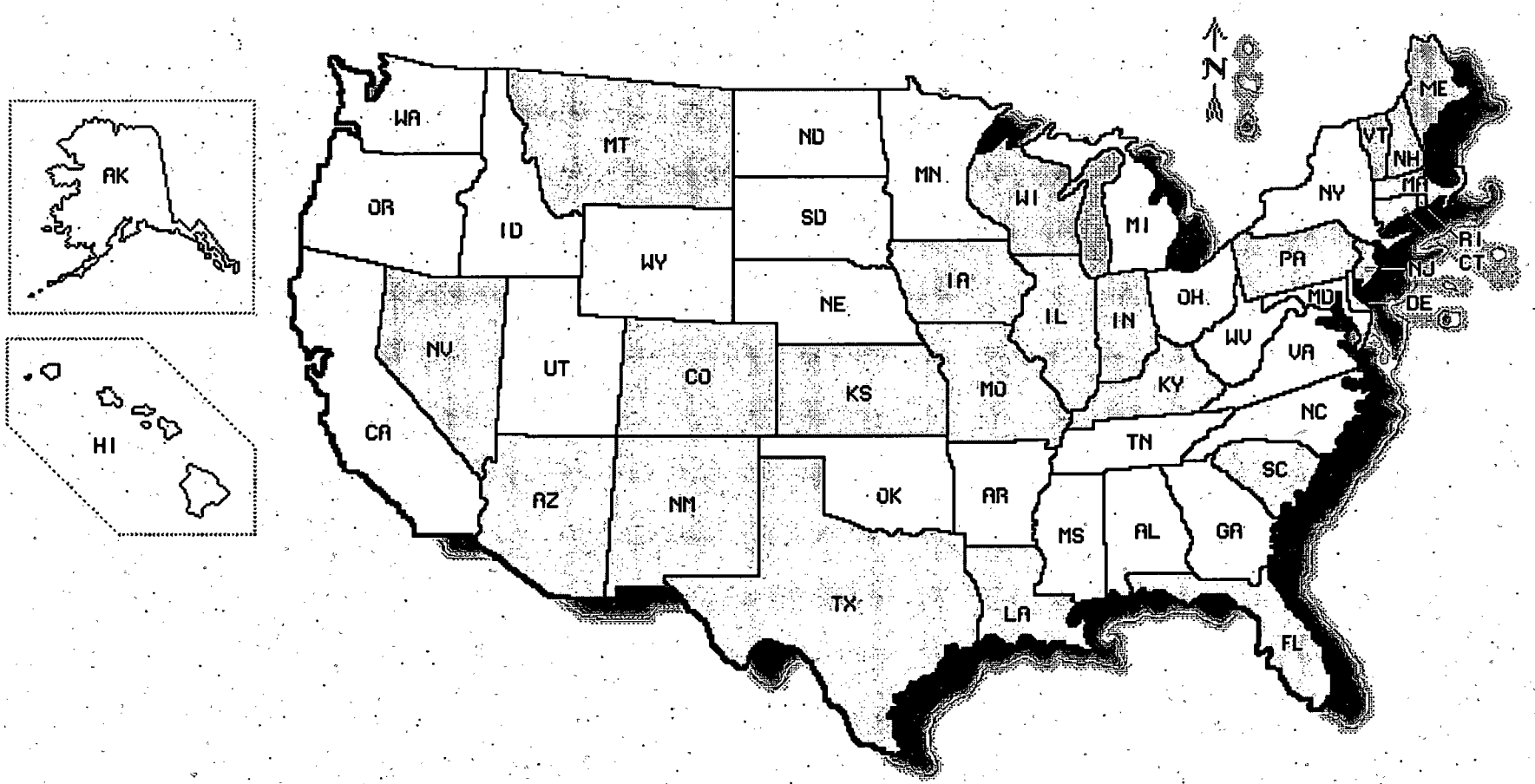


2009 Snapshot

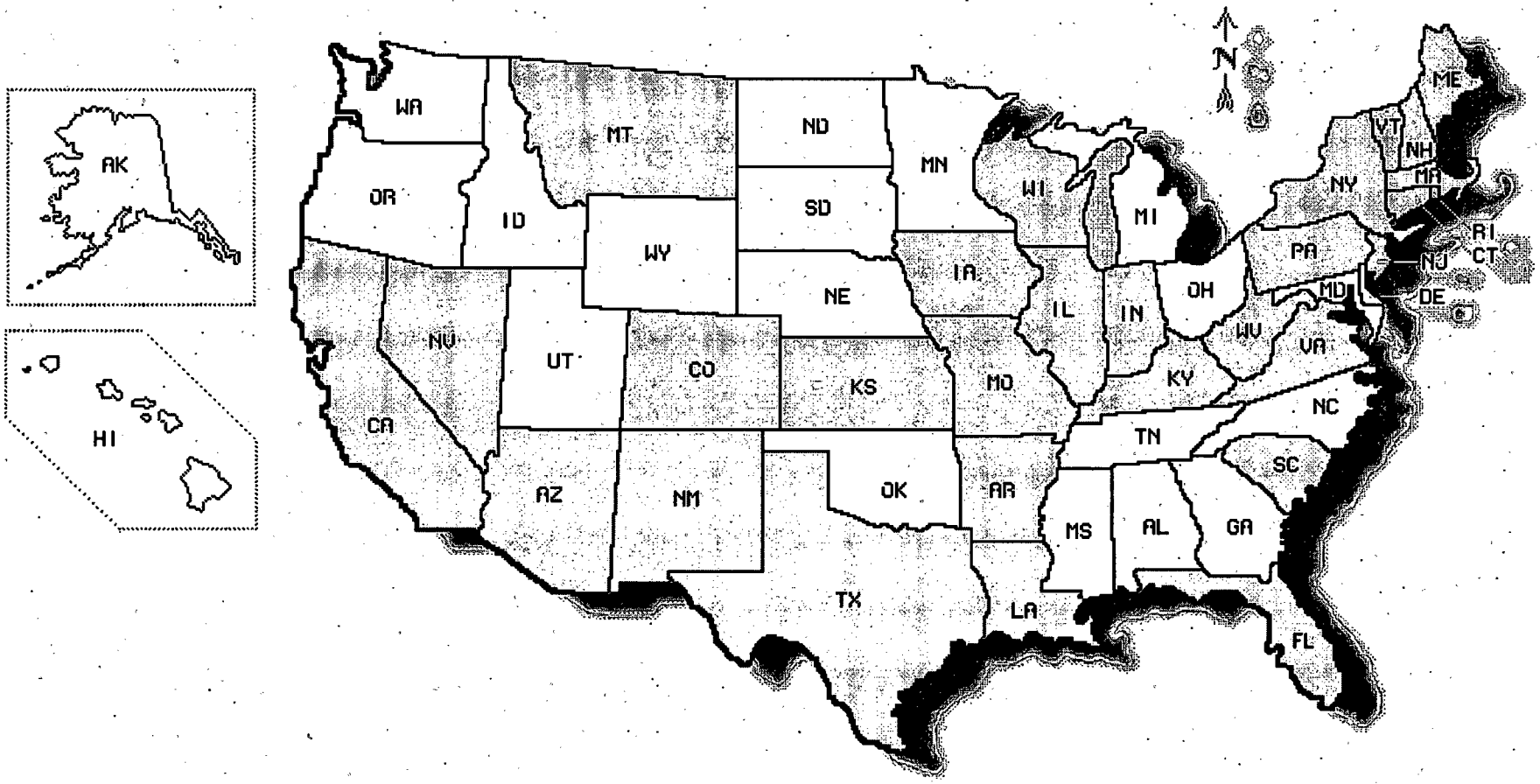


7-20-10

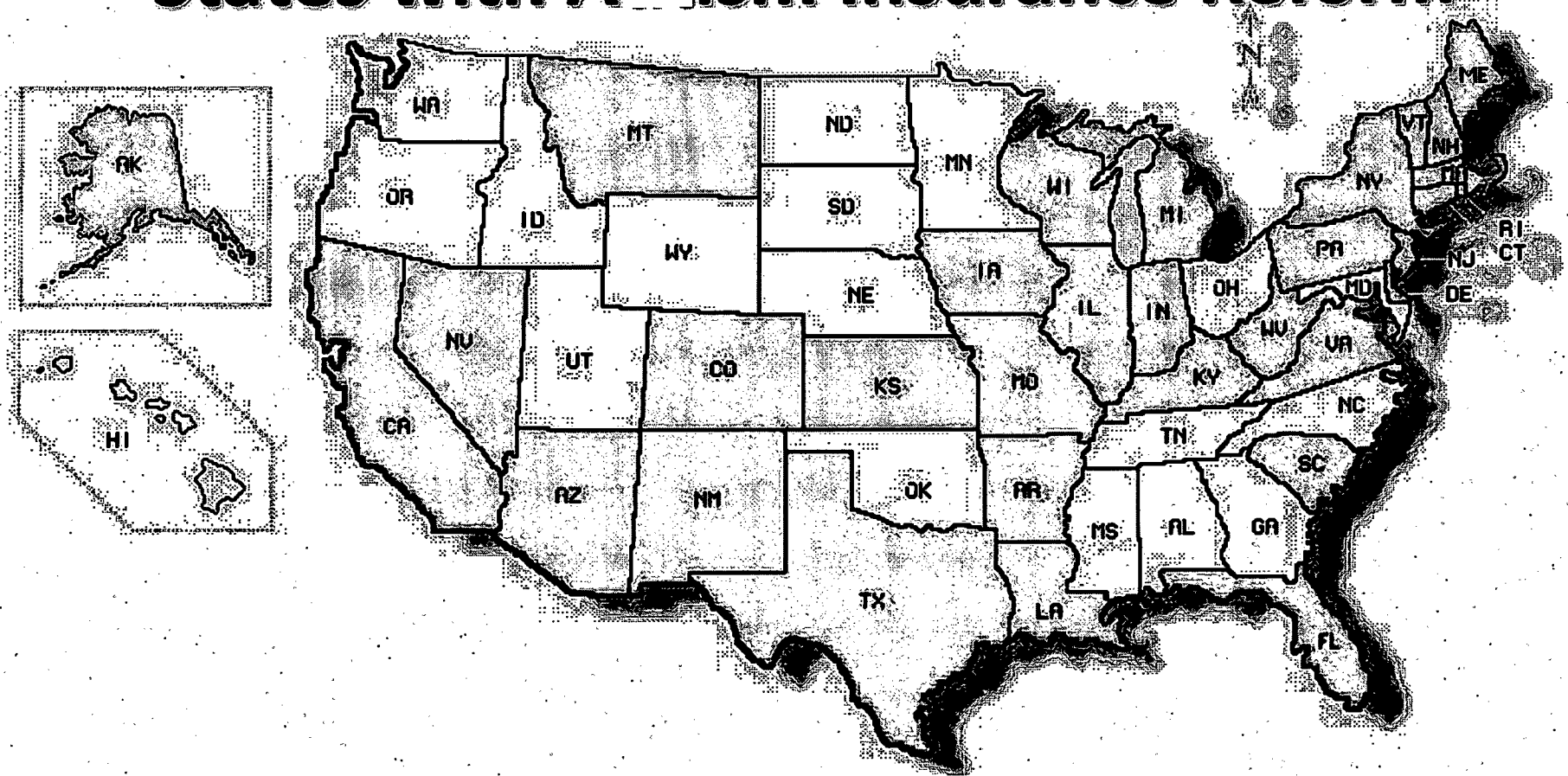
2010 Snapshot



2011 Snapshot



States with A[illegible]ism Insurance Reform



2001 - Indiana

2007 - South Carolina
2007 - Texas

2008 - Arizona
2008 - Florida
2008 - Louisiana
2008 - Pennsylvania
2008 - Illinois

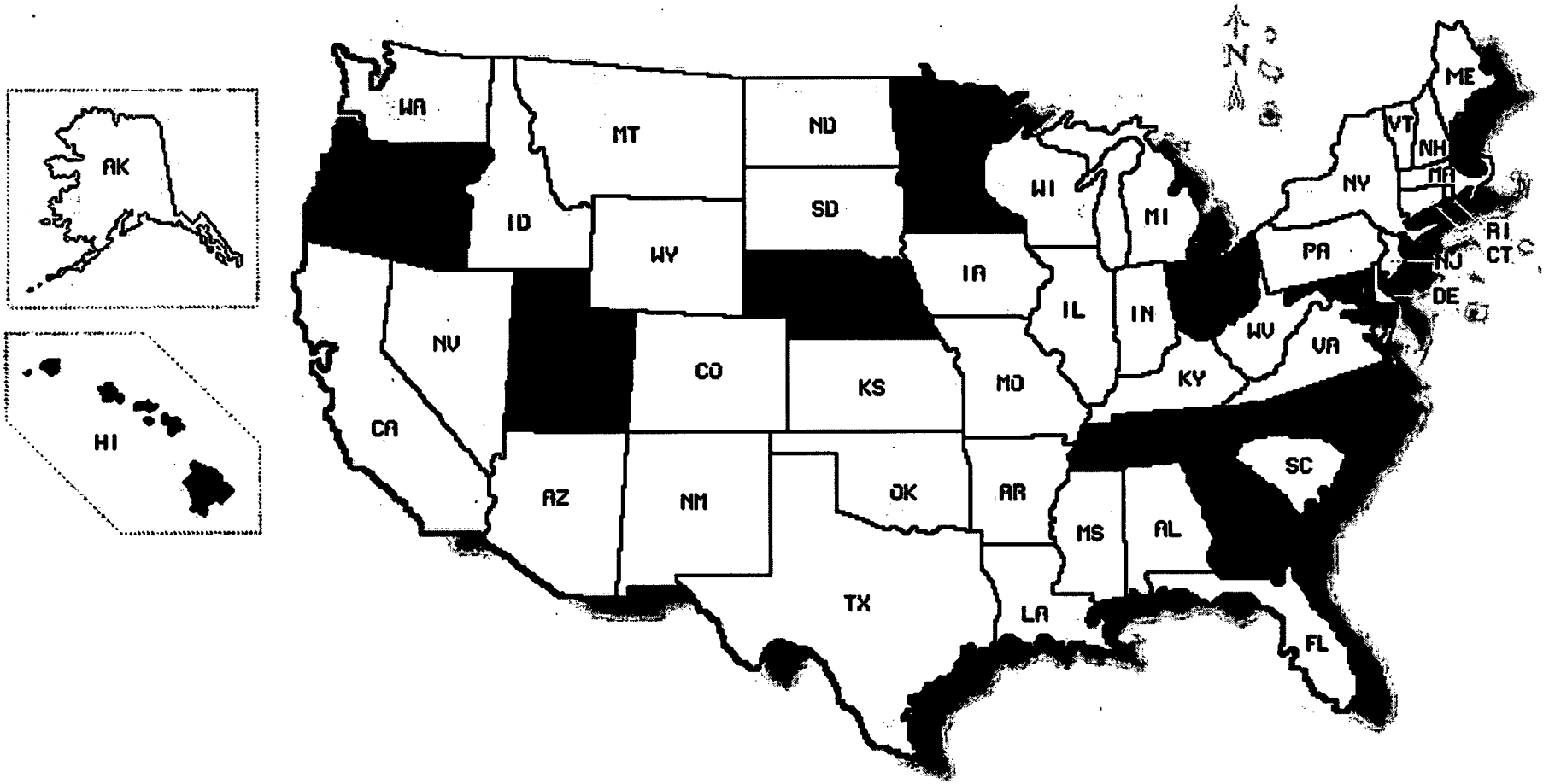
2009 - Colorado
2009 - Nevada
2009 - Connecticut
2009 - Wisconsin
2009 - Montana
2009 - New Jersey
2009 - New Mexico

2010 - Maine
2010 - Kentucky
2010 - Kansas
2010 - Iowa
2010 - Vermont
2010 - Missouri
2010 - New Hampshire
2010 - Massachusetts

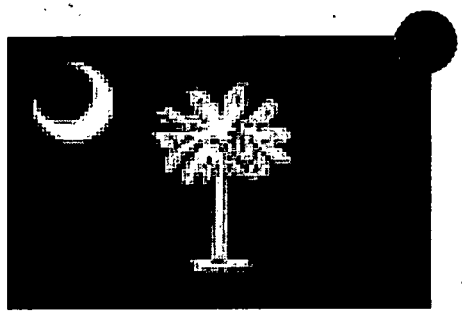
2011 - Arkansas
2011 - West Virginia
2011 - Virginia
2011 - Rhode Island
2011 - California
2011 - New York

2012 - Michigan
2012 - Alaska
2012 - Delaware

Considering Autism Insurance Reform in 2013



South Carolina S a e Employee Plan



APS HEALTHCARE
Healthy Together

- Dates
  - Applicable to state health plan as of 1-1-09
- Population
  - State health plan has 350-390,000 members
- Terms
  - $50,000 cap on ABA
  - To age 16

- Projected Cost

  Original: $18.9 million

  Revised: $9 million
- Actual cost

  2010: **$2,042,392**

  PMPM - 44 cents

  PEPM – 75 cents

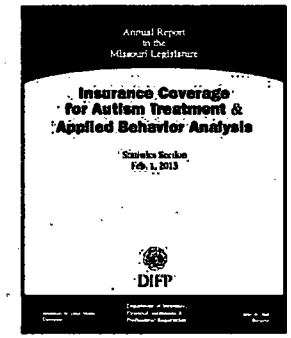
  (228,048 employees/subscribers; 79 kids accessing coverage)

Actual Claims Data

Missouri (2012)

- Implemented Jan 2011
- Terms
- $40,000/yr (cap only applies to ABA)*
- until age 18*

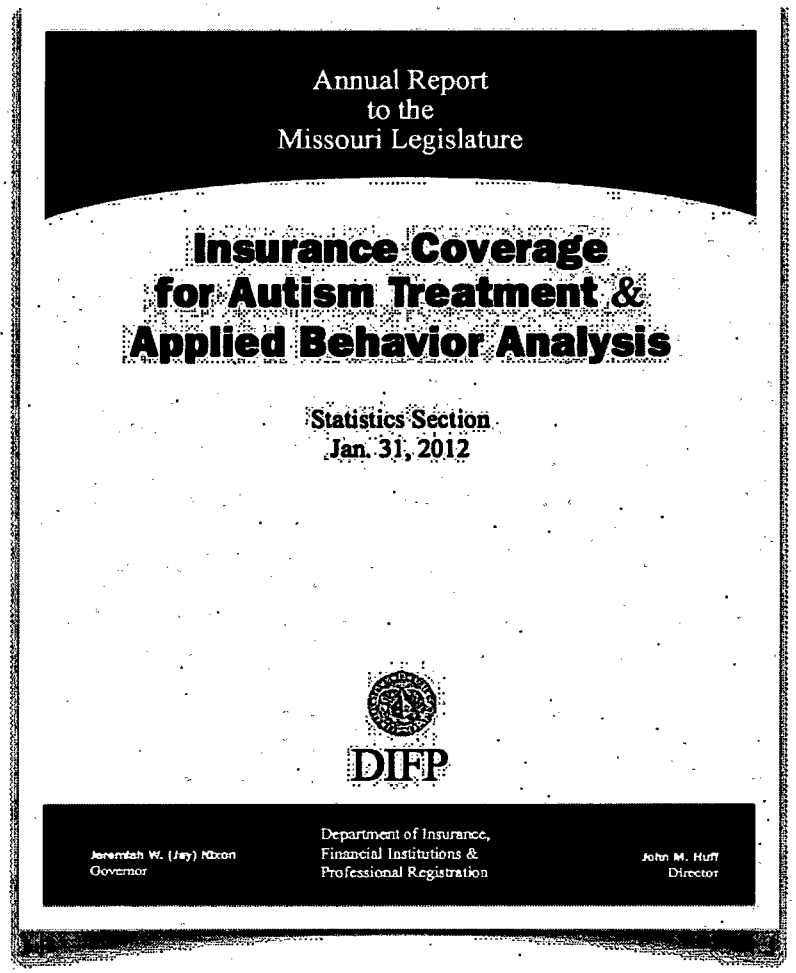
- Total claims paid = $6,555,602
- Total covered lives** = 1,429,153
- Unique claimants = 2,508
- PMPM cost = **38 ¢**



* Caps can be exceeded if deemed medically necessary
** Member months of policies with ASD coverage = 17,149,845

Source: Missouri Department of Insurance, Financial Institutions and Professional Registration, 2012

Effect on Premiums



- Claims incurred for treatment of ASD represent **0.1% of total claims**
- "While claims costs are expected to grow somewhat in the future, it seems very unlikely that costs for autism treatment will have an appreciable impact on insurance premiums."

Cost of Autism Insurance Reform

	Year of coverage	Number of Covered Lives	Total Claims	PMPM cost
South Carolina	2	397,757	$2,042,394	$0.43
Illinois	2	170,790	$197,290	$0.10
Louisiana	2	149,477	$722,828	$0.40
Florida	2	386,203	$1,748,849	$0.38
Arizona	2	130,000	$388,662	$0.25
Missouri	2	1,429,153	$6,555,602	$0.38
Kansas	2	100,000	$266,077*	$0.24
	Average second year cost			$0.31

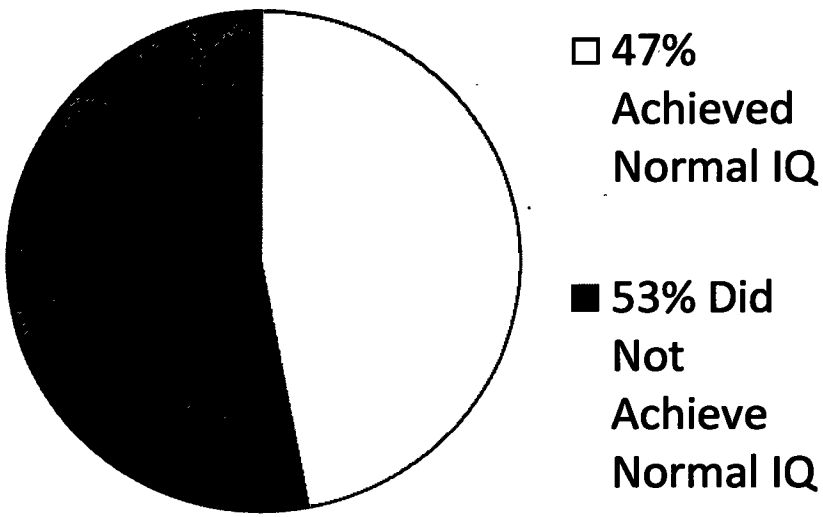
* 11 months (Jan-Nov 2012)

References: Data collected by Autism Speaks from State agencies responsible for administering State Employee Health Benefits Programs (2011); Missouri Department of Insurance, Financial Institutions and Professional Registration (2012); and the Kansas Department of Health and Environment (2012)

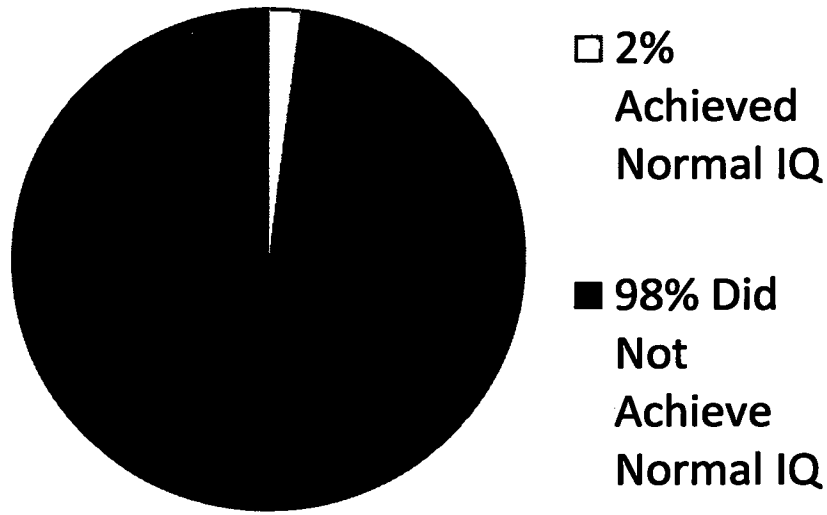
Efficacy of ABA Therapy

Outcome of 1987 UCLA Lovaas Study

ABA Group

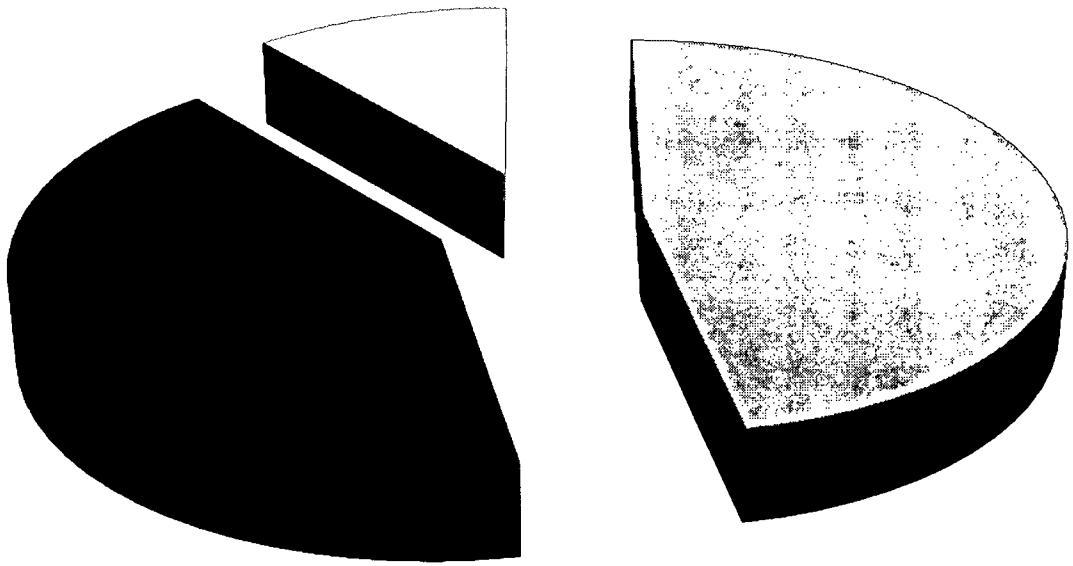


Other Intervention (Control) Group



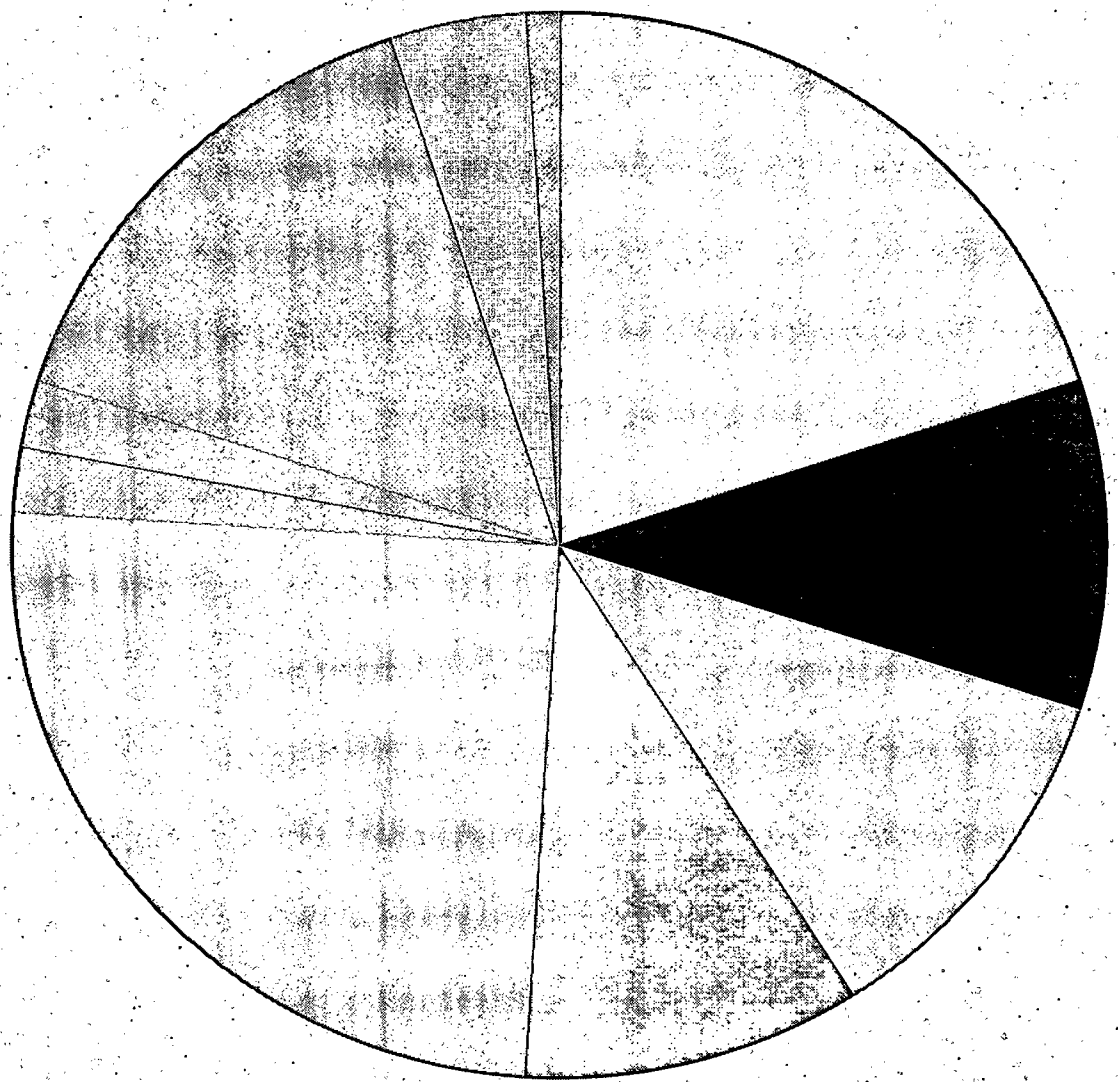
Outcome of 1987 UCLA Study

Educational Placements for Group That Received ABA



- ☐ 47% = Mainstreamed with No Support
- ■ 42% = Low-Intensity Special Education Placement (for language delay)
- ☐ 11% = High-Intensity Special Education Placement (for autism or intellectual disability)

Sources of Health Care Coverage



- Medicaid - 20%
- Medicare - 10%
- Uninsured - 11%
- State Health Plan - 10%
- ERISA - ASO - 25%
- Federal Tricare - 2%
- Federal Civilian - 2%
- Other Insured - Large Group - 15%
- Other Insured - Small Group - 4%
- Other Insured - Individual - 1%

Self-Funded "ERISA" Plans That Cover ABA

- Arnold & Porter
- Eli Lilly
- Ohio State University
- Global Foundries
- Blackbaud
- Lahey Clinic
- Indiana University
- Partners Healthcare
- Wells Fargo
- Capitol One
- White Castle
- Pacific Gas & Electric
- CH2MHill
- Stanford University
- University of Minnesota
- Progressive Group
- Greenville Hospital System
- Symantec
- DTE Energy
- Cerner
- State Street Financial
- Children's Mercy
- EMC
- Sisters of Mercy
- Princeton University
- Pinnacle Casinos
- Squire Sanders & Dempsey
- Newell Rubbermaid
- And many more . . .

Does your self-insured firm or company cover ABA therapy? Please let me know!

State Autism Insurance Reform & Exchanges

AUTISM SPEAKS
It's time to listen.

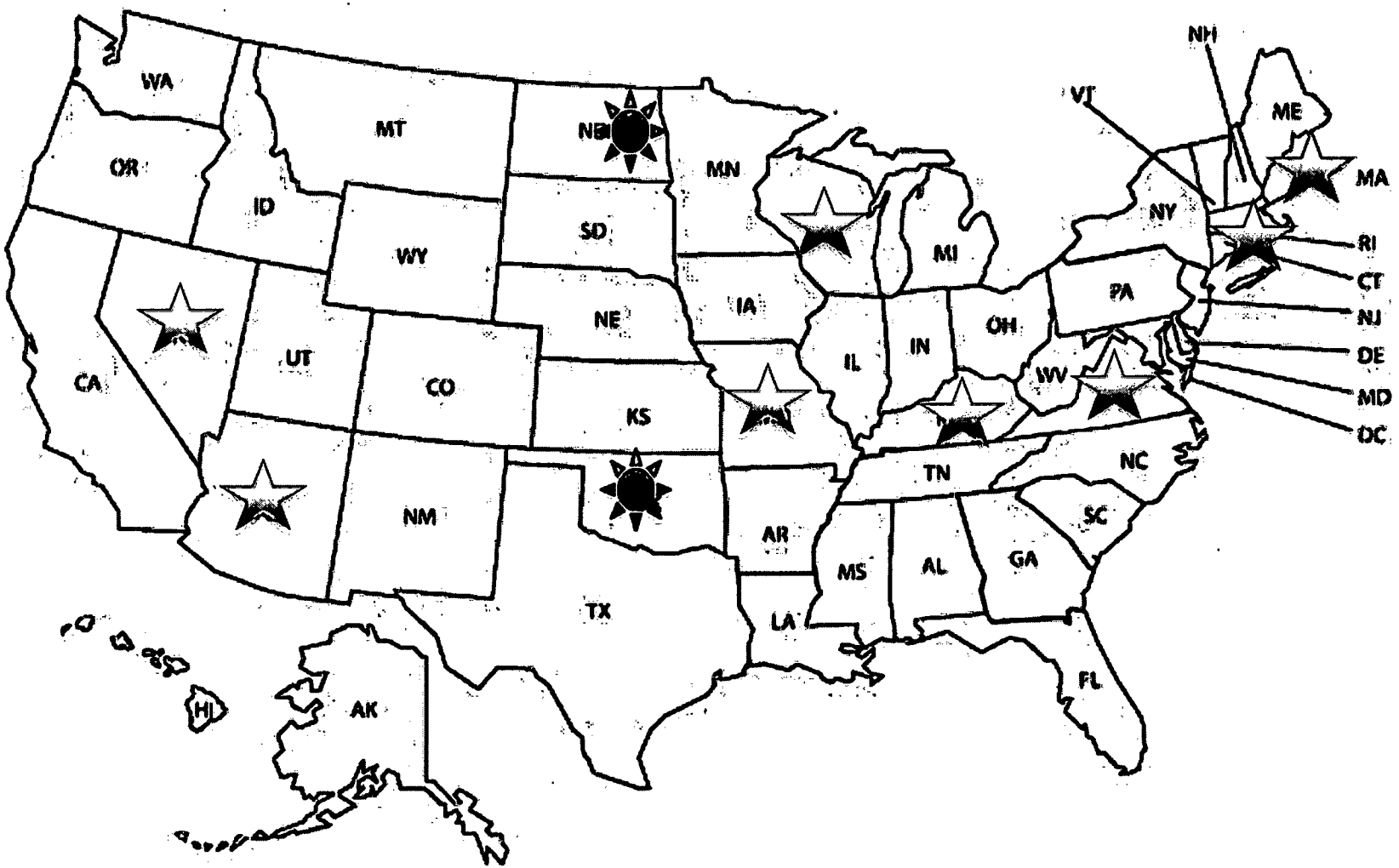
State	Year Enacted	State Population	Annual Dollar Cap	Age Cap	State E'ees?	Small Group?
Indiana	2001	6,484,000	None	None	Yes	Yes
South Carolina	2007	4,625,000	$50K	16	Yes	No
Texas	2007	25,146,000	None	<10	No	No
Arizona	2008	6,392,000	$50K: 0-8, $25K: 9-16	16/17	Yes	No
Louisiana	2008	4,533,000	$36K ($144K lifetime)	<17	Yes	No
Florida	2008	18,801,000	$36K ($200K lifetime)	<18	Yes	No
Pennsylvania	2008	12,702,000	$36K	<21	Yes	No
Illinois*	2008	12,831,000	$36K	<21	Yes	Yes
New Mexico*	2009	2,059,000	$36K ($200K lifetime)	19/22	No	Yes
Montana	2009	989,000	$50K: 0-8, $20K: 9-18	18	Yes	Yes
Nevada	2009	2,701,000	$36K	18/22	Yes	Yes
Colorado	2009	5,029,000	$34K: 0-8, $12K: 9-19	<20	Yes	Yes
Connecticut*	2009	3,574,000	$50K: 0-8, $35K: 9-12; $25K: 13-14	<15	Yes	No
Wisconsin	2009	5,687,000	$50K for 4 yrs, $25K after	None	Yes	Yes
New Jersey*	2009	8,792,000	$36K	21	Yes	Yes
Ohio & Minnesota***						

State Autism Insurance Reform & Exchanges

AUTISM SPEAKS
It's time to listen.

State	Year Enacted	State Population[1]	Annual Dollar Cap	Age Cap	State E'ees?	Small Group?
Maine	2010	1,328,000	$36K	<6	Yes	Yes
Kentucky	2010	4,339,000	$50K: 0-7, $1000/mo: 7-21	1-21	Yes	Yes
Kansas	2010	2,853,000	$36K: 0-7, $27K: 8-19	<19	Yes only	No
Iowa	2010	3,046,000	$36K	<21	Yes only	No
Vermont	2010	626,000	None	1 ½ - 6	Yes	Yes
Missouri	2010	5,989,000	$40K	19	Yes	Yes
New Hampshire	2010	1,316,000	$36K: 0-12, $27K: 13-21	21	Yes	Yes
Massachusetts	2010	6,548,000	None	None	Yes	Yes
Arkansas	2011	2,916,000	$50K	<18	Yes	No
West Virginia	2011	1,853,000	$30K for 3 yrs; $24K up to 18	3-18	Yes	Yes
Virginia	2011	8,001,000	$35K	2-6	Yes	No
Rhode Island	2011	1,053,000	$32K	15	Yes	No
New York	2011	19,378,000	$45K	None	Yes	No
California	2011	37,254,000	None	None	No	No
Michigan	2012	9,836,640	$50K if <7, $40K if 7-12, $30K if 13-18	18	Maybe	Yes
Alaska	2012	722,718	None	21	Yes	>20
Delaware	2012	907,135	$36,000	21	Yes	Yes

Behavior Analyst Licensure Laws

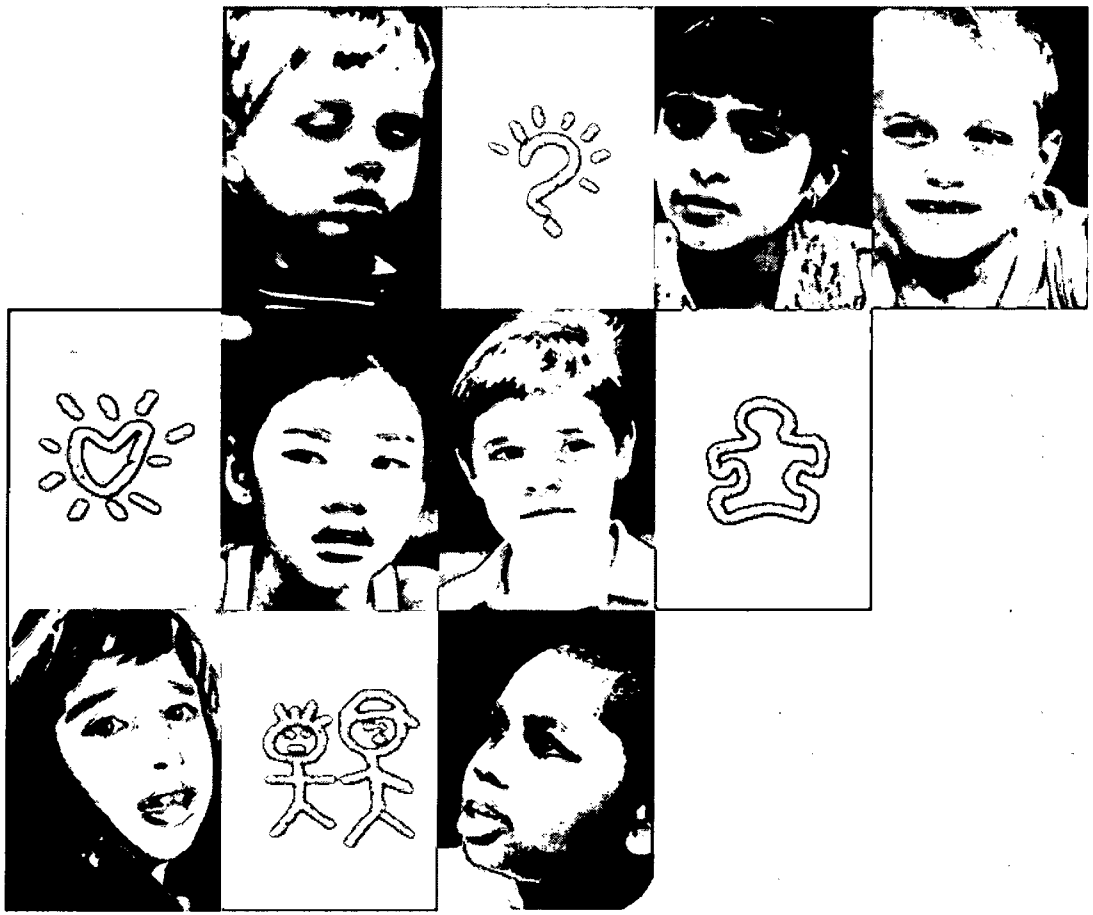


ND has state “certification”

May 27, 2010 at 5:08pm

Subject: thanks

- I just wanted to say thank you for accomplishing what many people would not have attempted. I live in Charleston, SC. My husbands insurance is self funded so we are having to give up custody of our autistic 2 year old to my parents because their insurance is better. ABA is really helping and there is nothing I wouldn't do for him. You are inspirational to me and a hero. God bless you.



"[N]o disability claims more parental time and energy than autism."

New York Times, 12/20/04

VISITOR REGISTRATION SHEET

JT. HHS APPROPRIATIONS SUB-COMMITTEE
Committee Name)

2-28-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Colleen Kochanek	NCCEP
Lauren Absher	NASW-NC
Johanna Lield	NASW-NC
Betsey Veltri	AHA
Karen McLeod	Benchmarks
[illegible]	NCPC / NCCA
Scott Taylor	156 Grace XRD, Cary

09-21-201

VISITOR REGISTRATION SHEET

JT. HHS APPROPRIATIONS SUB-COMMITTEE
Committee Name)

2-28-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kay Paksoy	NASW-NC
John Mirack	Policy Group
[illegible]	N.C. [illegible]
JOE LANIER	NELSON MULLINS
RICHARD TOPPING	CARDINAL INNOVATIONS
PAM SHIPMAN	CARDINAL INNOVATIONS
Sarah Rothacker	Brubaker & Assoc
Will Handley	Ryan Baker & Assoc
John McMillan	MFG
Lee Hedgpeth	NCALTCF
[illegible]	THW
LC [illegible]	CSS
Erica Nelson	NCHA
[illegible]	NP

09-21-201

VISITOR REGISTRATION SHEET

JT. HHS APPROPRIATIONS SUB-COMMITTEE
Committee Name)

2-28-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Richard E Hunter Jr	Clerk of Court - Warren Co.
Denise M. Moulden	Clerk of Ct. Washington Co
Joyce C. Ruggird	Clerk of C. Martin Co.
Angie Sexton	Clerk of Court Tyrrell Co
Joel Jordan	NCAOC
Sam Cooper	CSC - Chatham
Lisa Daniels	CSC - Avery
Melissa Adams	CSC - McDowell Co,
Diane Cornett Deal	CSC - Watauga
Sandra Sutton	CSC - Greene
Terri Sharp	CSC - Craven Co.
CAROL ORWITZ	NC Brain Injury Advisory Council
Dave Richard	The AGC
Fred Wheeler	Eastern Band Cher
Julia Adams	The AGC
Michael Mayberry	MH Commission
Jessica Eaddy	Governor's Institute

09-21-201

VISITOR REGISTRATION SHEET

JT. HHS APPROPRIATIONS SUB-COMMITTEE
Committee Name)

2-28-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robynn Spence	Rutherford County Elected Clerk of Court
Sally Cameron	NC Psychological Association
Mary Bethel	AARP-NC
Annalrese Dolph	Dolph law
Kathy Baker	Eastpointe
TRACY COLVARD	AHHC
Kerri Erb	ASNC
Kab Lammy	RLA
Deb Clary	NCSP
ROSE HOBAN	NC Health News
[illegible]	SEANC
Bob Cottam	UFI
Jennifer Mahan	ASNC
[illegible]	NMSS
[illegible]	atty
Elizabeth Hudgins	CFTF
CASANDRA SKINNER	NCACC

09-21-201

VISITOR REGISTRATION SHEET

JT. HHS APPROPRIATIONS SUB-COMMITTEE
Committee Name)

2-28-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joyce Pate	
Madison Mackenzie	DOJ
Tracey Sheriff	Autism Society of North Carolina
Alexander Myers	Autism Society of NC
James L Mixson III	Clerk of Court Iredell County
Rebecca Brendle	Clerk of Court Surry County
Deborah L Butler	Clerk of Court- Person County
Jo Ann C Averette	clerk Superior Court - Granville Co.
Ellen Holliman	Alliance Behavioral Healthcare
Tracy Hayes	Alliance Behavioral Healthcare
Dean Plunkett	PS
Harry Taylor	MHC
Jimmy Broughton	Womble
Laura DeVine	NCSR
BRUCE THOMPSON	PARKER POE
George Smith	Nexsen Pruet
Elise mcdowell	Youth. Rights.

09-21-201

HHS Meeting

Thursday, February 28, 2013

SENATE SGTS. AT ARMS: Ed Kesler
Steve Wilson

HOUSE SGTS. AT ARMS: Fred Hines
Charles Goodwin

SENATE PAGES: Max Shafer
~~Wake~~ Berger
~~Dublin~~

HOUSE PAGES: ~~Laura~~ Fowler-Union-Arp
Chance Corbin-Wake-Dollar
Jordon Hennessy-Dare-~~Pender~~ Pamlico

Joint House Committee on Appropriations Subcommittee on Health and Human Services
Tuesday, March 5, 2013, at 8:30 a.m.
Room 643

MINUTES

The House Committee on Appropriations Subcommittee on Health and Human Services met at 8:30 am on Tuesday, March 5, 2013 in Room 643. Representatives Avila, Brisson, Farmer-Butterfield, Ford, Fulghum, Hollo, Insko, Lambeth and Martin attended. Senators Hise, Pate, McKissick, Robinson and Barringer attended.

Representative William Brisson presided.

Representative Brisson gaveled the meeting at 8:30am and introduced the Pages and Sergeants and Arms.
House Pages: Zachary Barr, Madison Williams, Trevon Williams.
Senate Pages: Alli Howell and Addison Starnes.
Sergeants at Arms – House: Charles Godwin and Fred Hines
Sergeants at Arms – Senate: Steve Wilson and Leslie Wright

Representative Brisson introduced Ms. Jessica Keith Bradley, Special Advisor on ADA, DHHS. Ms. Bradley gave a presentation on US Department of Justice Settlement Agreement: Execution Plan and Budget.

Representative Brisson introduced Ms. Kelly Crosbie, Assistant Director Behavioral Health Services, DMA. Ms. Crosbie presented DHHS I Option Proposal.

All presentations are attached to these minutes.

The meeting was adjourned at 9:50 am.

Representative William Brisson
Presiding

Caroline Stirling, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 28, 2013 12:34 PM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Tuesday, March 05, 2013 at 8:30 AM

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Tuesday	March 5, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

March 5, 2013
Legislative Office Building - Room 643
8:30 a.m.

Rep. William Brisson, Presiding	Welcome, Opening Remarks
DHHS – U.S. Dept. of Justice Settlement Agreement: Execution Plan and Budget	Jessica Keith Bradley DHHS
DHHS I Option Proposal	Kelly Crosbie, Assistant Director Behavioral Health Services, DMA
Adjourn	
Next Meeting:	Wednesday, March 6th, 8:30 a.m.

Department of Health and Human Services
U.S. Department of Justice Agreement Implementation

Jessica Bradley Keith, Special Advisor on ADA, DHHS
Jessica.Bradley@dhhs.nc.gov; 919-855-4809

Implementation Plan Deliverable	DOJ Settlement Requirement July 1, 2013	January 2013 DOJ Rate	February 2013 Target DOJ Rate	March 2013 Target DOJ Rate	April 2013 Target DOJ Rate	May 2013 Target DOJ Rate	June 2013 Target DOJ Rate
Supported Employment	100	0	0	15	30	60	100
Assertive Community Treatment	32 teams, 3225 individuals	0	0	0	15 teams	25 teams	35 teams
Supportive Housing	100	0	0	15	40	75	120
In Reach and Transition Activity	In Reach Begins February 18, 2013	0	50/0	100/20	200/40	300/80	400/160

US DOJ Settlement Budget (100% State Appropriations Required)

SFY 12-13	SFY 13-14	SFY 14-15	SFY 15-16
$7,098,027.00	$14,134,275.20	$19,694,658.26	$27,774,663.37
SFY 16-17	**SFY 17-18**	**SFY 18-19**	**SFY 19-20**
$35,946,653.94	$44,182,278.63	$52,328,426.08	$58,807,374.16

Settlement Milestones

- In reach training materials developed
  - 3 trainings with MCOs and State Hospitals
  - PASRR trainings- Every Friday in February

- Diversion
  - PASRR Screening and Diversion process began January 1, 2013
  - Hearing on Temp Rule: Rule Passed 2/6/13 in effect March 1st for independent screening process

- Communications
  - Website http://www.ncdhhs.gov/mhddsas/providers/dojsettlement/milestones.htm
  - If staff receive questions: refer to Jessica.Bradley@DHHS.NC.gov or to website

Next Steps to Meet Requirements

In Reach and Transitions

- In-Reach in Adult Care Homes begins February 2013- Settlement requires in reach to begin by February 18th.
  - Letter sent out Monday to ACH Providers about In reach

Housing

- Housing Subsidy Administrator contracts completed monthly cost to administer subsidy program and provide tenancy supports $132,314 plus cost of subsidies. Housing slots for transitions will be available March 1st
  - Each MCO was assigned 15 housing slots for FY 12/13
  - Coastal Care- 4 individuals were approved for housing slots and are currently residing in New Hanover in apartments
  - Completed RFQ sent out of DSSH 2/7/13 for apartment locator with IT enhancements

The Reviewer was in town on the February 11 and 12, 2013. Met with staff responsible for Diversion and Housing Services. Also met with the new Medicaid director and visited Cherry Hospital.

First conference call between Department of Justice and DHHS since signing the agreement will be held February 15, 2013.

Medicaid and Home and Community-Based Services (HCBS) Options for Individuals with Mental Illness (MI) and/or Intellectual/Developmental Disabilities (I/DD)

Among recent new and modified programs designed to expand HCBS and rebalance expenditures while drawing on additional federal funds, there are four options that stand out as popular or useful for states. Most states are combining more than one of these options with additional resources like Health Home plans. These options are:

Feature	1915(c) HCBS Waiver	1915(i) State Plan HCBS	1915(k) Community First Choice	State Balance Incentive Program*
Services (Examples)	• Day services • Home health aide • Personal care • Respite care • Community transition • Supportive housing	• Same as 1915(c) • Community or assisted living • Transportation • Supported employment • Behavioral health • Peer Supports	• Individual need-based care plan • Personal attendant (ADLs/IDLs) • Teaching on acquisition of skills • Assistive technology back-up systems • Training on managing attendants • Transition costs (deposits, utility) • Items to increase independence	Home health care, PCS, and services under an 1115, 1915(c), (d), (i), or (j)
Beneficiary Eligibility/Access	• Can waive conditions to include incomes ≤300% of SSI • Specific # of slots and waiting lists are allowed	• Incomes ≤150% of FPL • Individuals who would otherwise be institutionalized • Option to include incomes ≤300% of SSI • Cannot limit/cap access	• Income ≤150% of FPL or must meet level to qualify for nursing facility services • Can use if enrolled in another waiver • Cannot have waiting list	For the state: less than 50% of Medicaid long term supports and services (LTSS) expenditures for FY 2009 must have been on non-institutional care
Assessment of Need ("Eligibility link")	• Must require hospital, nursing facility, or institutional level of care • Can be stricter than institutional level of care	• Must **be less stringent** than institution level of care • Needs-based/function (ADL/IDL) • Can include state-defined risk factors	• Individual who would otherwise need nursing facility care • Needs-based/functional	As defined by the State Plan/waivers
Populations	• Can target specific groups (and specific geographic locations) • Reside at home/community • ID/DD	• Can offer to specific, targeted populations • Must project the number to be served • Must reside in community • DD, Chronic/Serious MI	• Medicaid eligible • Disabled	As defined by the State Plan/waivers
State-wideness	Can waive this requirement	Mandated state-wide	Mandated state wide	N/A
Funding	Bills to Medicaid	• Bills to Medicaid • Can get federal cost sharing	6% enhanced FMAP	2% or 5% enhanced FMAP
Cost-Neutrality	Must be budget neutral	Not subject to neutrality	Not subject to neutrality	N/A
Notes	• Waiver is not entitlement • Services narrowly targeted • Stringent reporting requirements	• Ideal for recover-focused and supported living services for MI • Can assist in shift of resources to cover specific populations (example, homeless) • Flexible service packages	• Cannot be used to reduce commitment to HCBS • Must maintain or exceed previous HCBS Medicaid expenditures	• Rebalances Medicaid spending between institutional and HCBS • Can only use payments to expand or provide new HCBS • Cannot replace existing infrastructure funds
States	All *except* for AZ, HI, RI, and VT	CA, CO, CT, DC, FL, ID, IN, IA, LA, MT, NV, NM, OR, TX, and WI	AK, CA, LA, MD, NY, RI, and WA	CT, GA, IN, IA, MD, MS, MO, NH, NJ, and TX

* Effective as of 2011, CMS authorizes grants for states making structural reforms to rebalance Medicaid spending between institutional and home and community-based (HCB) long-term services and supports (LTSS) through achieving cost savings, improving consumer utilization, and improving quality.

North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

January 31, 2013

The Honorable Louis Pate, Chair
Appropriations on Health and
Human Services
Room 1028, Legislative Building
Raleigh, North Carolina 27601-2808

The Honorable Ralph Hise, Chair
Appropriations on Health and
Human Services
Room 1026, Legislative Building
Raleigh, North Carolina 27601-2808

Dear Senators Pate and Hise:

Session Law 2012-142, Section 10.23A(b) established the Blue Ribbon Commission on Transitions to Community Living to examine the State's system of community housing and community supports for people with severe mental illness, severe and persistent mental illness, and intellectual and developmental disabilities. The Commission was charged to develop a plan that continues to advance the State's current system into a statewide system of person-centered, affordable services and supports that emphasize an individual's dignity, choice, and independence.

The Blue Ribbon Commission issued its final report on December 19, 2012, which included several directives for the Department of Health and Human Services (DHHS). Recommendation 4 directed DHHS to explore a supplement to be paid on behalf of an Adult Care Home Resident. DHHS, in collaboration with the Division of Aging and Adult Services and the Division of Health Service Regulation, distributed a memo to stakeholders, County Division of Social Services directors, behavioral health managed care entities, and licensed residential providers on January 28, 2013. This letter outlined the conditions which families and responsible persons may be charged for services.

Recommendation 7 directed DHHS to prepare a Medicaid "I" option application with a narrow focus on habilitation services for adults with intellectual and other developmental disabilities. Working with stakeholders, DMA drafted a 1915(i) option State Plan Amendment that includes a proposed service called 'Individualized Support.' Individualized Support consists of habilitation services, i.e. training to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization, and other adaptive areas. Training outcomes will focus on allowing the individual to participate in home life activities and reside as independently as possible in the community.

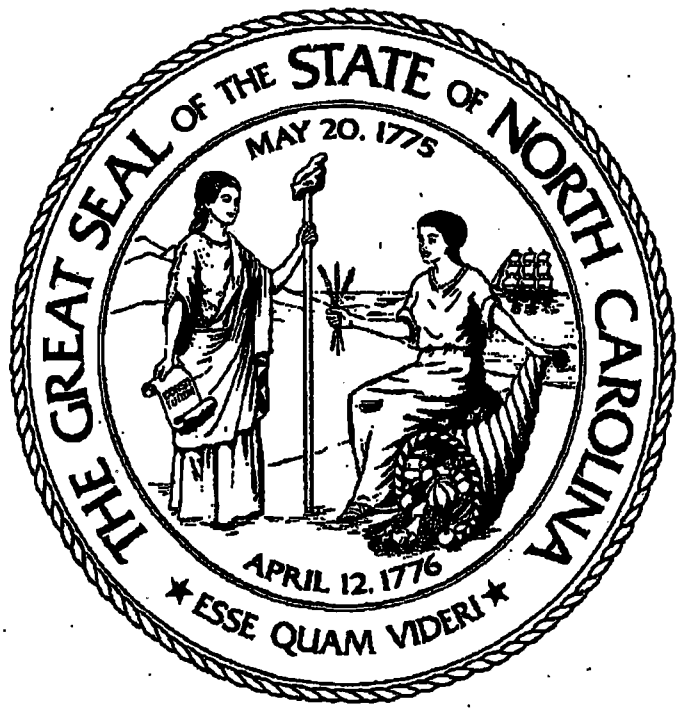
On behalf of the Department, I respectfully submit this report. If you have further questions or need additional information, please contact Carol Steckel, Medicaid Director, at 919-855-4100.

Sincerely,

Aldona Wos, M.D.
Secretary

cc: Carol Steckel
Jim Slate
Matthew McKillip
Pam Kilpatrick
Susan Morgan
Patricia Porter
Legislative Library (one hard copy)

DHHS STATUS REPORTS
BLUE RIBBON COMMISSION ON TRANSITIONS TO COMMUNITY LIVING RECOMMENDATIONS
S.L. 2012-142, Section 10.23A



State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

January 2013

SUMMARY

This report will provide Department of Health and Human Services (DHHS) status updates on recommendations 4 and 7 from the Blue Ribbon Commission on Transitions to Community Living.

BLUE RIBBON SUBCOMMITTEE RECOMMENDATION 4: EXPLORE A SUPPLEMENT TO BE PAID ON BEHALF OF AN ACH RESIDENT

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to explore establishing a process to allow payment by an individual or family member on behalf of a recipient of State-County Special Assistance when that recipient has lost their eligibility for Medicaid Personal Care Services (PCS), and those Medicaid PCS services are not covered under a Medicaid appeal process. The Department shall report findings and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE:

DHHS, in collaboration with the Division of Aging and Adult Services and the Division of Health Service Regulations, distributed a memo to stakeholders, County DSS Directors, Behavioral Health LME/MCOs and licensed 131D and 122C residential providers on January 28, 2013. This letter outlines the conditions which families and responsible persons may be charged for services.

BLUE RIBBON SUBCOMMITTEE RECOMMENDATION 7: HABILITATION SERVICES FOR IDD ADULTS

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to prepare a Medicaid "I" option application with a narrow focus on habilitation services for adults with intellectual and other developmental disabilities. Eligibility for this "I" option must be carefully constructed to consider assessed needs of the individual and to assure that these needs do not meet the criteria and intensity of need for ICF-IDD level of care. This Medicaid "I" option should be incorporated into the support needs process and the management and capitation of the LME/MCOs.

Additionally, cost containment and comparability must be addressed, and projections for costs and number of eligible recipients must be provided when the application draft is submitted for review to the Senate Appropriations Committee on Health and Human Services, and House Appropriations Subcommittee on Health and Human Services, on or before February 1, 2013. The Department shall not take further action on the application until there is approval by the NC General Assembly.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE:

1915(i) Option Stakeholder Workgroup

Session Law 2011-264 House Bill 916, Section 1.(f) directed [that]:

> *By December 31, 2011, the Department shall determine the feasibility of adding habilitation services to the State Medicaid Plan through the 1915(i) Option as a strategy to address the needs of Medicaid enrollees with IDD who are not enrolled in the Innovations Waiver and are not residing in an intermediate care facility for the mentally retarded (ICF-MR facility).*

In response to SL 2011-264, a stakeholder group was formed to explore the development of a 1915(i) option habilitative benefit for adults with Intellectual or Developmental Disabilities (IDD). The workgroup met during SFY 2012 to explore habilitative service options for individuals not otherwise eligible for Medicaid services under a 1915(c) waiver or in an Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF-IIDD). The group's charge was to develop a focused service that could prove to be both a cost-neutral and meaningful benefit to individuals with intellectual and developmental disabilities (IDD). The workgroup included members from the Division of Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), the North Carolina Provider Council, the Autism Society, the Arc of North Carolina, Rubicon (ICF-MR providers who provide home and community based waiver services), the Council on Developmental Disabilities, and First in Families (representing families and consumers). This response reflects the recommendations of that stakeholder workgroup.

What is the Medicaid 1915(i) Option?

The 1915(i) option is outlined in Section 1915(i) of the federal Social Security Act. It allows for states to offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit. The State is able to target the HCBS benefit to one or more specific populations, such as individuals with IDD, and establish additional needs based criteria for eligibility. The State Medicaid agency must submit a State Plan amendment (SPA) to CMS for review and approval to establish a 1915(i) HCBS benefit.

The 1915 (i) option must be developed with federal guidelines which include:

- establishing a process to ensure that assessments/evaluations are independent and unbiased;
- ensuring that the benefit is available to all eligible individuals within the State;
- ensuring that measures will be taken to protect the health and welfare of participants;
- providing adequate and reasonable provider standards to meet the needs of the target population;
- ensuring that services are provided in accordance with a plan of care; and
- establishing a quality assurance, monitoring and improvement strategy for the benefit.

Eligible Medicaid beneficiaries may access this proposed (i) option benefit if they are living in a private residence or a residential setting. The (i) option benefit cannot be targeted by living arrangement except that any living arrangement must meet CMS-approved home and community living standards.

Proposed 1915(i) Option Service in North Carolina

The stakeholder workgroup has proposed a service called 'Individualized Support.' Individualized Support consists of habilitation, i.e. training to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization, and other adaptive areas. Training outcomes focus on allowing the individual to participate in home life activities and reside as independently as possible in the community. This service includes assistance in community activities when the individual is dependent on others to ensure health and safety. Individualized Support also provides assistance with ADLs and instrumental activities of daily living (IADLs). IADLs are meal preparation, medication assistance, and basic home management tasks that are directly related to the qualifying ADLs and essential to the individual's care at home.

Proposed Target Population for the 1915(i) Option

The proposed target population for the 1915(i) option is Medicaid beneficiaries age 18 or older with a documented IDD diagnosis who do not meet eligibility criteria for treatment in an Intermediate Care Facility for Individuals With Intellectual Disabilities (ICF-IID). A physician must attest that the individual's diagnosis limits the individual's ability to

independently acquire, improve, and retain skills needed for the individual to participate in home life or community activities.

Individuals must have physician-documented need for caregiver availability and an unmet need for hands-on assistance with two (2) activities of daily living (ADLs) and set up/supervision assistance including cueing/prompting with an expectation of skill building (habilitation) with one ADL. ADLs that are assessed are bathing, dressing, mobility, toileting, and eating.

Independent Assessment for 1915(i) Option Services

The amount of service provided to the individual will be based on an assessment conducted by an independent entity to determine the individual's support needs. Performance is rated as: totally independent, requiring cueing or supervision, requiring limited assistance, requiring extensive assistance or totally dependent. Individuals are then assigned a number of service increments according to their assessed needs.

Evaluations and reevaluations of individuals for 1915(i) eligibility will be performed by vendors under contract to the Division of Medical Assistance (DMA). DMA has the potential to leverage a current vendor contract and assessment process. DMA currently has a contract with the Carolinas Center for Medical Excellence (CCME) to conduct evaluations. The vendor(s) conducting the evaluations and reevaluations will not under any circumstances be providers of 1915(i) services. The long term goal is to move this assessment process under the MCO/LMEs behavioral health as part of care coordination/utilization review.

Projected Costs of the 1915(i) Option

Cost estimates are based on the rate for a comparable 100 percent state-funded service (Personal Assistance) and an estimate of individuals who could access this service. An estimate of the number of individuals who could potentially qualify for this service was determined by looking at two data sources: 1) individuals living in licensed facilities with IDD who do not meet criteria for personal care services (PCS) under the new PCS assessment process through Carolina's Center for Medical Excellence (CCME), and 2) individuals with IDD who are living in private residences who do not meet criteria for PCS services as determined by the utilization review/assessment contractor (CCME).

According to data collected during the PCS assessment process through December 2012, 21 percent of individuals with IDD living in licensed facilities did not meet the eligibility criteria for PCS. This represents 4153 individuals. It is important to note that not all individuals in these settings will meet eligibility criteria under the proposed 1915(i) option. It is also likely that some of these licensed facilities will not meet CMS-approved home and community characteristics. In those cases, individuals living in those facilities will not be eligible for the new 1915(i) option benefit. A total of 157 individuals with IDD in private homes did not meet criteria for PCS in 2012, according to data reported by CCME.

The Individualized Supports service rate was modeled off of the State-funded service Personal Assistance. This service provides both habilitation and assistance with ADLs for individuals with IDD. The rate of this comparable service is $4.46 per 15 minute unit ($17.84 per hour). This rate is higher than State Plan PCS because staff must have additional training to provide habilitation or training to the individuals and due to documentation requirements.

Finally, the proposed costs will need to be determined based on estimates of service utilization—in this case, the average monthly units of PCS delivered to individuals with IDD in licensed facilities. DMA determined that on average, individuals who receive PCS in facilities access 50.5 hours or 202 units per month, and individuals who receive PCS in private home access 37.5 or 150 units per month. It is important to note that these averages are across diagnostic groups and are not specific to individuals with IDD.

Maintaining individuals in their current average level of service at 186 units (46.5 hours) per month would result in the following service costs from SFY 2013 through SFY 2017:

Option 1

Additional Costs/(Savings)	$2,840,430	$2,931,608	$3,025,712	$3,122,838
Federal Share	$1,866,447	$1,926,359	$1,988,196	$2,052,017
State Share	$973,983	$1,005,248	$1,037,517	$1,070,821

In order to meet cost neutrality or produce cost savings, DMA may need to set a lower benefit limit or further restrict the eligibility group. For example, restricting the benefit limit to 124 units (31 hours per month) would result in the following cost savings from SFY 2013 through SFY 2017:

Option 2

Additional Costs/(Savings)	($11,937,428)	($12,320,620)	($12,716,112)	($13,124,299)
Federal Share	($7,844,084)	($8,095,879)	($8,355,757)	($8,623,977)
State Share	($4,093,344)	($4,224,740)	($4,360,355)	($4,500,322)

A more thorough and comprehensive fiscal note must be completed after the eligibility parameters and service definition for Individualized Supports is finalized through discussions with the Centers for Medicare and Medicaid (CMS).

On-going Development of the 1915(i) Option

In order to begin a more robust development process, the General Assembly must direct DMA to develop and submit a SPA for this new habilitative benefit. Since a draft has already been submitted to CMS (see attached), DMA anticipates receiving technical assistance from CMS as we continue to refine the target population, the service parameters, and the on-going assessment strategy for this proposed new benefit. DMA will rely on

CMS assistance and stakeholder input to further refine the service description and target population.

Once the final service definition is determined, DMA will develop a Clinical Coverage Policy for the benefit. The policy will require approval by the Physician's Advisory Group (PAG) and may require changes to State Administrative Rule. As part of the policy development and State Plan approval process, DMA will need to determine the final rate for this service.

In order to assure appropriate utilization management and qualitative oversight of this service, DMA will amend the 1915(b) waiver to delegate management and oversight of this benefit to the Local Management Entity-Managed Care Organizations (LME-MCOs). CMS must approve the incorporation of the 1915(i) option into the 1915(b) waiver and must approve any new capitation rates.

A comprehensive fiscal note will be completed once the State Plan amendment is finalized to include projected service dollars, administrative costs for training, administration costs for the assessment process, costs for any MMIS system changes, and increased capitation payments to the LME-MCOs.

Analysis of I-Option Program Costs for Adults with IDD (186 units)

	SFY 2013	SFY 2014	SFY 2015	SFY2016	SFY2017
Existing Program Costs					
Facility					
# of Beneficiaries	4153	4,291	4,429	4,571	4,718
Average Units/Month	202	202	202	202	202
Total ACH	$19,529,732	$40,360,143	$41,655,704	$42,992,852	$44,372,923
In-Home Care - Adults					
# of Beneficiaries	157	162	167	173	178
Average Units/Month	150	150	150	150	150
Total In-Home Adults	$548,244	$1,133,001	$1,169,370	$1,206,907	$1,245,649
Total Existing Program Costs	$20,077,976	$41,493,145	$42,825,074	$44,199,759	$45,618,572
FMAP	*0.6551*	*0.6571*	*0.6571*	*0.6571*	*0.6571*
Federal Share	*$13,153,082*	*$27,265,145*	*$28,140,356*	*$29,043,662*	*$29,975,963*
State Share	*$6,924,894*	*$14,227,999*	*$14,684,718*	*$15,156,097*	*$15,642,608*
I-Option Program Costs					
Facility					
# of Beneficiaries	4153	4,291	4,429	4,571	4,718
Average Units/Month	186	186	186	186	186
Total ACH	$0.00	$42,718,639	$44,089,907	$45,505,194	$46,965,910
In-Home Care - Adults					
# of Beneficiaries	157	162	167	173	178
Average Units/Month	186	186	186	186	186
Total In-Home Adults	$0.00	$1,614,935	$1,666,775	$1,720,278	$1,775,499
Total I-Option Program Costs	$0	$44,333,574	$45,756,682	$47,225,472	$48,741,409
FMAP	*0.6551*	*0.6571*	*0.6571*	*0.6571*	*0.6571*
Federal Share	*$0*	*$29,131,592*	*$30,066,716*	*$31,031,857*	*$32,027,980*
State Share	*$0*	*$15,201,983*	*$15,689,966*	*$16,193,614*	*$16,713,429*
Additional Costs/(Savings)	***0***	***$2,840,430***	***$2,931,608***	***$3,025,712***	***$3,122,838***
Federal Share	***0***	***$1,866,447***	***$1,926,359***	***$1,988,196***	***$2,052,017***
State Share	***0***	***$973,983***	***$1,005,248***	***$1,037,517***	***$1,070,821***

Change in Eligibility

SFY 2014	SFY 2015	SFY 2016	SFY 2017
3.33%	*3.21%*	*3.21%*	*3.21%*

$3.88 Cost/Unit

$4.46 Cost/Unit

Notes:

1. *I-Option Program effective date is 07/01/2013*
2. *SFY2013 represents 6 months of existing program costs; additional cost/savings not applicable*
3. *Average Units/Month and Cost/Unit remain unchanged*

Analysis of I-Option Program Costs for Adults with IDD (124 units)

	SFY 2013	SFY 2014	SFY 2015	SFY2016	SFY2017
Existing Program Costs					
Facility					
# of Beneficiaries	4153	4,291	4,429	4,571	4,718
Average Units/Month	202	202	202	202	202
Total ACH	$19,529,732	$40,360,143	$41,655,704	$42,992,852	$44,372,923
In-Home Care - Adults					
# of Beneficiaries	157	162	167	173	178
Average Units/Month	150	150	150	150	150
Total In-Home Adults	$548,244	$1,133,001	$1,169,370	$1,206,907	$1,245,649
Total Existing Program Costs	$20,077,976	$41,493,145	$42,825,074	$44,199,759	$45,618,572
FMAP	*0.6551*	*0.6571*	*0.6571*	*0.6571*	*0.6571*
Federal Share	*$13,153,082*	*$27,265,145*	*$28,140,356*	*$29,043,662*	*$29,975,963*
State Share	*$6,924,894*	*$14,227,999*	*$14,684,718*	*$15,156,097*	*$15,642,608*
I-Option Program Costs					
Facility					
# of Beneficiaries	4153	4,291	4,429	4,571	4,718
Average Units/Month	124	124	124	124	124
Total ACH	$0.00	$28,479,093	$29,393,272	$30,336,796	$31,310,607
In-Home Care - Adults					
# of Beneficiaries	157	162	167	173	178
Average Units/Month	124	124	124	124	124
Total In-Home Adults	$0.00	$1,076,624	$1,111,183	$1,146,852	$1,183,666
Total I-Option Program Costs	$0	$29,555,716	$30,504,455	$31,483,648	$32,494,273
FMAP	*0.6551*	*0.6571*	*0.6571*	*0.6571*	*0.6571*
Federal Share	*$0*	*$19,421,061*	*$20,044,477*	*$20,687,905*	*$21,351,987*
State Share	*$0*	*$10,134,655*	*$10,459,978*	*$10,795,743*	*$11,142,286*
Additional Costs/(Savings)	*0*	*($11,937,428)*	*($12,320,620)*	*($12,716,112)*	*($13,124,299)*
Federal Share	*0*	*($7,844,084)*	*($8,095,879)*	*($8,355,757)*	*($8,623,977)*
State Share	*0*	*($4,093,344)*	*($4,224,740)*	*($4,360,355)*	*($4,500,322)*

Change in Eligibility			
SFY 2014	*SFY 2015*	*SFY 2016*	*SFY 2017*
3.33%	*3.21%*	*3.21%*	*3.21%*

$3.88 Cost/Unit

$4.46 Cost/Unit

Notes:

1. *I-Option Program effective date is 07/01/2013*
2. *SFY2013 represents 6 months of existing program costs; additional cost/savings not applicable*
3. *Average Units/Month and Cost/Unit remain unchanged*

1915(i) State plan Home and Community-Based Services

Administration and Operation

The State implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for disabled individuals as set forth below.

1. **Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Individualized Supported Services

2. **Statewideness.** *(Select one)*:

●	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
○	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. *(Specify the areas to which this option applies)*:

3 **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one)*:

●	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	● The Medical Assistance Unit *(name of unit)*:	Division of Medical Assistance, North Carolina Department of Health and Human Services
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit. This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
○	The State plan HCBS benefit is operated by *(name of agency)*	
	a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the State assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(Check all agencies and/or entities that perform each function)

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☑	☐
2 Eligibility evaluation	☐	☐	☑	☐
3 Review of participant service plans	☑	☐	☑	☐
4 Prior authorization of State plan HCBS	☐	☐	☑	☐
5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☑	☐

8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Items 1, 2, 4, 5 (HCBS enrollment, eligibility, service authorization and utilization management): DMA contracts with a private vendor to determine eligibility for 1915(i) services, complete the independent assessment/reassessment, and authorize the appropriate amount of service for each individual according to 1915(i) service criteria. The private vendor will not be a provider of the 1915(i) benefit. DMA retains full and final responsibility and authority for all Individualized Support operations including services provided by contracted entities and providers. DMA monitors the operations through the quality assurance program. DMA monitors contractors according to the State's performance based contracting requirements.

Items 6 & 7 (provider enrollment): DMA contracts with Computer Sciences Corporation (CSC) to credential and enroll qualified providers. CSC has been selected to be the new MMIS vendor and the transition of all MMIS activities from Hewlett Packard to CSC is currently underway.

Item 10 (QA/QI): The administrative entity under contract to DMA will assist with remediation when quality of care issues are identified.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

Note: The assessments are completed by an independent entity and the plans of care are completed by the provider based on assessment findings. The independent assessor determines eligibility for service and the amount of service and the provider completes the plan of care based on the needs identified in the assessment and the individual's preferences as to how/when/by whom the service will be provided.

Plans of care are reviewed by the independent assessor for compliance with the assessed limits, duration, and scope. Once reviewed by the independent assessor, the State Medicaid Agency monitors the plan of care for services approved for compliance and reimbursement through this web based assessment and care planning tool.

The Independent Assessment Entity reviews all completed plans of care for compliance with the results of the independent assessment of the individual. Once approved by the IAE, plans of care are sent to the State Medicaid Agency for final approval.

The State's quality improvement strategy also includes performance measures addressing the timeliness, appropriateness and the required IAE review of plans of care.

6. ☑ **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Target Group(s)

☒ **Target Group(s).** The State elects to target this 1915(i) State plan HCBS benefit to a specific population. With this election, the State will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the State may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C).

Target Population	Adults with I/DD Diagnoses
Population Definition Age, Diagnoses, and Physician*-Documented Functional Limitations	Medicaid beneficiaries age 18 or older with a documented I/DD diagnosis that a physician attests limits the person's ability to independently acquire, improve, and retain skills needed for the beneficiary to participate in home life or community activities.

(*Specify target group(s)*):

* "Physician" may be the individual's primary care physician or a designee who is a nurse practitioner (NP) or physician's assistant (PA).

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/1/13	1/1/14	4500

2. ☑ **Annual Reporting.** *(By checking this box the State agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

2 **Medically Needy.** *(Select one):*

☐	The State does not provide State plan HCBS to the medically needy.
☑	The State provides State plan HCBS to the medically needy *(select one):*
☐	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
☑	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (c). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

○	Directly by the Medicaid agency
☑	By Other *(specify State agency or entity with contract with the State Medicaid agency)*:
	Evaluations and reevaluations of individuals for 1915(i) eligibility will be performed by entities under contract to the Division of Medical Assistance (DMA). Due to the large volume of applicants/participants, DMA will contract with as many qualified vendors as needed to ensure that evaluations are completed in a timely manner while maintaining oversight with these evaluations. DMA currently has a contract with the Carolinas Center for Medical Excellence (CCME) to conduct evaluations. The vendor(s) conducting the evaluations and reevaluations will not under any circumstances be providers of 1915(i) services. Written conflict of interest safeguards will be included in the contracts/agreements with the entities to address any potential conflicts.

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified as defined in 42 CFR §441.568. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Evaluators must meet the requirements of the NC DHHS job classifications of Public Health Nurse I, II or higher or Social Worker I, II or higher, as follows:

NC Office of State Personnel - Public Health Nurse I Position Description Requirements:

Knowledge, Skills, and Abilities - Considerable knowledge of and skill in the application of nursing theory, practices, principles, and techniques employed in the field of public health and related programs; general knowledge of and ability to apply the principles and practices of public health; working knowledge of current social and economic problems relating to public health; working knowledge of available resources and organizations. Ability to deal tactfully with others and to exercise good judgment in appraising situations and making decisions; ability to secure the cooperation of clients; to elicit needed information and to maintain effective working relationships; ability to record accurately services rendered and to interpret and explain records, reports and medical instructions; some ability to plan, coordinate, and supervise the work of others.

Minimum Training and Experience - Graduation from a four-year college or university with a B.S. Degree in Nursing which includes a Public Health Nursing rotation - or graduation from an accredited school of professional nursing and one year of professional nursing experience, or an equivalent combination of training and experience. Necessary Special Qualifications - A current license to practice as a Registered Nurse in North Carolina by the North Carolina Board of Nursing.

NC Office of State Personnel - Social Worker I Position Description Requirements:

Minimum Education and Experience Requirements: Bachelor's degree in a human services field from an accredited college or university; Bachelor's degree from an accredited college or university and one year directly related experience. "Directly related experience is defined as human services experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy and treatment planning. Degrees must be received from appropriately accredited institutions.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The process begins with a written referral for an assessment for 1915(i) services from the individual's physician, nurse practitioner or physician assistant. The referral documents the individual's overall health status and characteristics related to the target population criteria, including primary and secondary diagnoses, need for caregiver availability, and risk for falls, skin breakdown, malnutrition, and complications from medication noncompliance. If the referred individual meets target population criteria, an independent assessment entity under contract to the Division of Medical Assistance will have 15 business days from receipt of the referral to contact the applicant, complete an evaluation of eligibility and a face-to-face assessment. The independent assessment will determine both eligibility for 1915(i) services and authorized service level. The assessor will also document the beneficiary's provider of choice. If a beneficiary or family doesn't have a provider of choice, the assessor will give

the beneficiary a list of providers in the beneficiary's geographic area.

Individualized Support Services may be provided in two settings: the person's private residence or a HCBS compliant licensed residential facility. The assessment will identify options as to living arrangement for the receipt of services and refer eligible individuals to the provider(s) of their choice.

The existing In-Home Care population undergoes an independent assessment conducted by an independent assessor (qualified RN) using a standardized assessment tool that is used to determine benefit eligibility and service level. Maintaining the Patient Centered focus, the provider agency RN incorporates the beneficiary needs identified in the assessment based on service definitions to create the individualized plan of care. The tool addresses the same qualifying ADLs and IADLs that are included in the proposed Individualized Support eligibility criteria. Level of assistance needed is scored as supervision/set up; limited hand-on; extensive; or total/full dependence.

The state asserts that all In-Home beneficiaries who qualified on the basis of an independent assessment conducted within the 12 months prior to implementation of the 1915(i) Individualized Support benefit and using the current in-home assessment tool meet the proposed eligibility criteria. The State will use the same standardized tool to assess all current ACH residents to determine eligibility and level of service under the 1915(i) Individualized Support benefit. Annual reassessment will be required of all beneficiaries to determine continuing eligibility and service levels, and all beneficiaries transitioned on the basis of a previous assessment under the In-Home Care program will be revaluated within 12 months of the previous assessment. If a beneficiary changes location (such as moving from a residential setting to home and is eligible for Medicaid) and has received an independent assessment within the last 12 months, then Individualized Support services will continue. The State will use the standardized assessment tool or a comparable alternative to assess all new Individualized Support referrals and continuing beneficiaries post-implementation.

The evaluation/assessment process and tools are used for all annual reevaluations/reassessments and reevaluations/reassessments due to change in needs.

4. ☑ **Needs-based HCBS Eligibility Criteria:**

Eligibility Criteria. *(By checking this box, the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria.)*

Applicants will be assessed for 1915(i) eligibility based on their independent support needs (i.e. their need for assistance with qualifying activities of daily living (ADLs) and IADLs).

Activities of Daily Living:

Activities of Daily Living (ADLs) are common self-care tasks necessary for independent living. In North Carolina, for the purposes of the 1915(i), there are a total of five (5) assessed ADLs: Bathing, Dressing, Mobility, Toileting, and Eating. Need for assistance with one or more ADLs is determined by an independent assessment. Depending on the specific target group, the need for these ADLs must be linked to a documented condition or risk. Applicants may also benefit from habilitation services aimed at acquiring, improving, and retaining these skills.

Instrumental Activities of Daily Living (IADLs):

Instrumental activities of daily living are specific activities that are crucial to an individual's welfare. In North Carolina, for the purposes of the 1915(i), there are only two (2) qualifying IADLs: Meal Preparation and Medication Assistance.

The following Table outlines the Basic Eligibility Criteria for the three 1915(i) target populations.

Target Population	Adults with I/DD Diagnoses
Eligibility Criteria Established by the individual's physician-documented risk and need for caregiver availability and an independent functional assessment of the person's individual support needs.	Individuals have physician-documented need for caregiver availability and any of the following need profiles: Unmet need for hands-on assistance with two (2) ADLs and set up/supervision assistance including cueing/prompting with an expectation of skill building with one ADL.

5. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

Needs-Based/Level of Care (LOC) Criteria

Column III
ICF IID (& ICF IID LOC waivers)

In order to be Medicaid-certified at an ICF IID level of care, an individual must meet the following criteria:

1. Require active treatment necessitating the ICF IID level of care; **and**
2. Have a diagnosis of intellectual disability, Intelligence Quotient (IQ) test results indicating intellectual disability, or a condition that is closely related to intellectual disability.
   a. Intellectual Disability is characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability manifests before age 18.
   b. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets ALL of the following conditions:
      i. is attributable to:
         (a) Cerebral palsy, epilepsy, or
         (b) Any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services similar to those required for these persons; **and**,
      ii. The related condition manifested before age 22; **and**
      iii. Is likely to continue indefinitely; **and**
      iv. Have a diagnosis of intellectual disability or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas:
         (a) Self-Care (ability to take care of basic life needs for food, hygiene, and appearance);
         (b) Understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally);
         (c) Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations);
         (d) Mobility (ambulatory, semi-ambulatory, non-ambulatory);
         (e) Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life);
         (f) Capacity for independent living (age-appropriate ability to live without extraordinary assistance).

Note: Reports by physicians, psychologists, and other appropriate disciplines are evaluated to determine whether an individual has a substantial functional limitation in a major life activity.

(By checking the following boxes, the State assures that):

6. ☑ **Reevaluation Schedule.** Needs-based eligibility reevaluations are conducted at least every twelve months.

7. ☑ **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii). However, if the State chooses to revise its needs-based eligibility criteria, it must continue offering 1915(i) services in accordance with individual service plans to participants who do not meet the new revised needs-based criteria, but continue to meet the former needs-based criteria, for as long as the State plan HCBS option is authorized.

8. ☑ **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

North Carolina's 1915i State Plan Individualized Support Services benefit requires Individualized Support to be individualized based on the individual's needs identified through an independent assessment and person centered planning process. There is not an automatic process for individuals to receive Individualized Support services. An individual must be referred to Individualized Support through a physician referral that is submitted to the independent assessment entity designated by the Division of Medical Assistance (DMA). An individual is given choice to select a provider to receive Individualized Support. A provider is required to use a person centered planning process to develop a plan of care (POC) for an eligible beneficiary. The beneficiary and the provider decide together on the delivery of Individualized Support.

The choice of living and receiving Individualized Support in a private residence or a residential setting is determined by the beneficiary or beneficiary's responsible party. In accordance to licensure rules 10A NCAC 13F & G, and 27D the residential setting providers shall have a resident admission contract or agreement upon admission to the facility.

Recipients are informed at the time of assessment that Individualized Support may be provided in a private residence or residential setting and asked to indicate their preferred setting and provider. Depending on the beneficiary preference, individuals applying for Individualized Support will be asked to select preferred providers from those serving the beneficiary's preferred geographic location(s) and setting, which may be a private residence and/or residential facility. Continuing beneficiaries may elect at reassessment or at any time by requesting a change of provider to receive services from a different provider and/or a different setting.

The beneficiary has rights in accordance with North Carolina General Statutes § 131D-19 Article 3 adult care home residents' bill of rights or North Carolina General Statutes § 122C-51 Article 3 clients' rights. The beneficiary's rights are promoted through the use of the person centered planning process. The opportunity to exercise personal freedom in all domains will be promoted through qualified staff of the residential care settings. Participation in community events, activities and resources will be supported and limits exercised only where required to assure safety. Personal freedom and choice must be applied to all beneficiaries of residential care settings except where such activities or abilities are contraindicated specifically in an individual's person centered plan as discussed during the person centered planning process. Community integration has many elements and is dependent on the beneficiary's preferences and availability. Establishing choices for each beneficiary as a process of asking, learning, and providing the accessibility to services, supports and naturally occurring activities offered to anyone in the community.

North Carolina's 1915i State Plan Option Individualized Support Services is offered in private residences and in residential settings other those of private residences. The residential settings are Adult Care Homes and Supervised Living Facilities. The state has administrative rules and quality oversight that assure individual's rights and safety in these residential settings. These settings are not located in buildings that are publicly or privately operated facilities that provide inpatient institutional treatment or in buildings on the grounds of, or immediately adjacent to, a public institution or disability-specific housing complex.

- **Adult Care Home** is defined in North Carolina General Statutes as an assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or, for scheduled needs, through formal written agreement with licensed home care or hospice agencies. NC General Statute 131D-19 implements a bill of rights for residents of adult care homes to ensure residents right to privacy, autonomy, and independence, and the right to be treated with respect and dignity. The statute calls for residents to have maximum choice and decision making while putting processes in place to prevent abuse, neglect and exploitation. All residents receive upon admission to the adult care home a written copy of the bill of rights. State law requires adult care homes to provide and maintain specific services and living arrangements that promote a home environment which maximizes consumer choice, control and privacy, and enables consumers to participate in community activities with both other consumers and non-consumers.

- **Supervised living facilities** described in North Carolina Administrative Code 10A 27G .5601-.5603 are group homes for adults with mental illness or developmental disabilities. These homes can be licensed to serve a maximum of six adults at any given time. North Carolina General Statutes § 122C-51 encourages that client's rights include the right to

dignity, privacy, humane care, and freedom from mental and physical abuse, neglect and exploitation. The "5600A" homes are for adults with a primary diagnosis of mental illness and "5600C" homes are for adults with a primary diagnosis of a developmental disability. Supervised living facilities are subject to licensure by the Division of Health Service Regulation. The homes are located in residential neighborhoods for maximum community integration, which provides residents with easy access to community activities, programs and supports.

Home and Community Living Standards

The 1915i State Plan Individualized Support Services benefit requires that all residential providers adhere to the North Carolina General Statutes § 131D-19, Adult Care Home Residents' Bill of Rights and the North Carolina General Statutes § 122C-51, Clients' Rights and Advance Instruction. The North Carolina Department of Health and Human Services (DHHS), Division of Health Service Regulation (DHSR) inspects and licenses residential providers on an annual basis. This annual review will assist in the ongoing monitoring to ensure Residential providers are continuing to meet HCBS.

Article 3
Adult Care Home Residents' Bill of Rights

§ 131D-19

It is the intent of the General Assembly to promote the interests and well-being of the residents in adult care homes and assisted living residences licensed pursuant to Part 1 of this Article. It is the intent of the General Assembly that every resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed and that the facility shall encourage and assist the resident in the fullest possible exercise of these rights. It is the intent of the General Assembly that rules developed by the Social Services Commission to supplement Article 1 and Article 3 of Chapter 131D of the General Statutes encourage every resident's quality of life, autonomy, privacy, independence, respect and dignity and provide the following:

(1) Diverse and innovative housing models that provide choices of different lifestyles that are acceptable, cost-effective, and accessible to all consumers regardless of age, disability, or financial status.

(2) A residential environment free from abuse, neglect, and exploitation.

(3) Available, affordable personal service models and individualized plans of care that are mutually agreed upon by the resident, family, and providers and that include measurable goals and outcomes.

(4) Client assessment, evaluation, and independent case management that enhance quality of life by allowing individual risk-taking and responsibility by the resident for decisions affecting daily living to the greatest degree possible based on the individual's ability, and

(5) Oversight, monitoring, and supervision by State and county governments to ensure every resident's safety and dignity and to assure that every resident's needs, including nursing and medical care needs if and when needed, are being met. (1981, c. 923, s. 1; 1995, c. 535, s. 12; 2009-462, s. 4(g).)

Article 3
Clients' Rights and Advance Instruction

§ 122C-51

It is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment.

It is further the policy of this State that each client who is admitted to and is receiving services from a facility has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse. Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities. (1973, c. 475, s. 1; c. 1436, ss. 1, 8; 1985, c. 589, s. 2; 1989, c. 625, s. 7; 1997-442, s. 15.)

North Carolina Residential Settings
Home and Community Setting (HCBS) Characteristics

Residential setting providers shall adhere to the NC Home and Community Living characteristics and North Carolina General Statutes § 131D-19 and § 122C-51 (Adult Care Home Residents' Bill of Rights and Clients' Rights and Advance Instruction) in order to be eligible to provide home and community based services (HCBS).

Home and community setting characteristics must be met by all residential settings. Home and community setting characteristics must be applied to all individuals in the facility except where such activities or abilities are contraindicated specifically in an individual's person centered plan and applicable due process has been executed to restrict any of the characteristics or rights. Individuals must be respectful to others in their community and the facility has the authority to restrict activities when those activities are disruptive or in violation of the rights of others living in the community.

A. Telephone Access

Review of person centered plan to determine if any phone limitations are individualized, based individual safety and

treatment needs and documented in the Person Centered Service Plan. Observation of facility phone area for ease of access and privacy, staff and individual interviews to determine if 24/7/365 access and assistance are available.

B. Visitors

Review of person centered plan to determine if any limitations on visitors are individualized, based on individual safety and treatment needs and documented in the Person Centered Service Plan. Individual interviews about their ability to have visitors and any restrictions placed on visitation by the facility. Staff interviews to determine their understanding of the facility visitation policy and how it is implemented. Review of facility visitation policy. "Facilities maintain the right to restrict or ban visitors identified to be disruptive or dangerous to the health and safety of other residents."

C. Living Space

Review of person centered plan to determine if any limitations on individuals' abilities to lock their rooms, decorate, roommate choice and come and go at will are individualized, based on individual safety and treatment needs and documented in the Person Centered Service Plan. Review of facility policy. Staff interviews to determine their understanding of the facility policies and how they are implemented in the facility.

D. Service Customization

Review of the person centered plan to determine individual's involvement is documented. Observation of individual and staff interaction to assure treatment and privacy needs are met. Conduct resident interview to determine individual understanding of their individualized plan and their involvement in development of the plan. Facility staff interview to determine their understanding of the individual's individualized plan and the individual's role in directing service delivery.

E. Food Access

Review of person centered plan to determine if any limitations on individuals' abilities to access the kitchen are individualized, based on individual safety and treatment needs and documented in the Person Centered Service Plan. Observation of meal and/or food storage in residential setting. Interview with individuals regarding their opportunity to have input into the food served, when and with whom they dine.

F. Group Activities

Review of person centered plan to determine if any limitations on individuals' abilities to participate in recreational choices are individualized, based on individual safety and treatment needs and documented in the Person Centered Service Plan. Observation of recreational activities if possible during survey. Individual and staff interview to determine what choices of recreational activities are offered and individual's input into decisions regarding participation.

G. Community Activities

Review of person centered plan to determine if any limitations on individuals' abilities to participate in community activities are individualized, based on individual safety and treatment needs and documented in the Person Centered Service Plan. Observation of community activities if possible during survey. Individual and staff interview to determine what choices of community activities are available and individual's input into decisions regarding participation.

H. Community Integration

Review of person centered plan to determine if any limitations on individuals' abilities to participate in community integration are individualized, based on individual treatment needs and safety and documented in the Person Centered Service Plan. Individual interview to determine in what ways the individual feels the facility is part of the community and their desired activities to strengthen community involvement.

Person-Centered Planning & Service Delivery

(By checking the following boxes the State assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
   - An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
   - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
   - An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
   - An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
   - If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports) or the individual's representative, to exercise budget and/or employer authority; and
   - A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.
2. ☑ Based on the independent assessment, the individualized plan of care:
   - Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
   - Takes into account the extent of and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
   - Prevents the provision of unnecessary or inappropriate care;
   - Identifies the State plan HCBS that the individual is assessed to need;
   - Identifies the individual's choice of setting from among all available alternatives;
   - Includes those services, the purchase or control of which the individual elects to self-direct,
   - Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
   - Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.
3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. *(Specify qualifications):*

The independent assessment entities are responsible for conducting both the evaluation for service eligibility and the face-to-face assessments. These activities are conducted by registered nurses or social workers who meet the following requirements:

Evaluators must meet the requirements of the NC DHHS job classifications of Public Health Nurse I, II or higher or Social Worker I, II or higher, as follows:

NC Office of State Personnel - Public Health Nurse I Position Description Requirements:

Knowledge, Skills, and Abilities - Considerable knowledge of and skill in the application of nursing theory, practices, principles, and techniques employed in the field of public health and related programs; general knowledge of and ability to apply the principles and practices of public health; working knowledge of current social and economic problems relating to public health; working knowledge of available resources and organizations. Ability to deal tactfully with others and to exercise good judgment in appraising situations and making decisions; ability to secure the cooperation of clients; to elicit needed information and to maintain effective working relationships; ability to record accurately services rendered and to interpret and explain records, reports and medical instructions; some ability to plan, coordinate, and supervise the work of others.

Minimum Training and Experience - Graduation from a four-year college or university with a B.S. Degree in Nursing which includes a Public Health Nursing rotation; or graduation from an accredited school of professional nursing and one year of professional nursing experience, or an equivalent combination of training and experience. Necessary Special Qualifications - A current license to practice as a Registered Nurse in North Carolina by the North Carolina Board of Nursing.

NC Office of State Personnel - Social Worker I Position Description Requirements:

Minimum Education and Experience Requirements: Bachelor's degree in a human services field from an accredited college or university; Bachelor's degree from an accredited college or university and one year directly related experience. "Directly related experience as defined as human services experience in the areas of case management, assessment and referral, supportive counseling, intervention, psycho-social therapy and treatment planning. Degrees must be received from appropriately accredited institutions.

In addition, trainees must undergo additional State developed training including but not limited to: conducting the evaluation/assessment using the State's Independent Assessment tool; using the web based system for recording assessment data; participating in appeals; identifying and reporting alleged fraud, abuse and neglect.

4. **Responsibility for Plan of Care Development.** There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

Providers of Individualized Support Services, including home care agencies, adult care homes and supervised living facilities, develop the plan of care. These plans of care are driven by the information provided through the 1915(i) Independent Assessment including the suggested plan of care and all identified triggers. Please see the provider qualifications section for more detail about licensure requirements and other qualifications. Plans of care must be developed within 15 days of acceptance of the beneficiary who has been evaluated and assessed by DMA's independent assessment entity. All plans of care must be reviewed by the independent assessment entity for correctness and then approved by DMA before

payment of services can commence.

The plan of care must incorporate paid and unpaid services as it relates to participant needs - including health, safety and welfare requirements.

Plans of care must have a back-up or emergency plan to address unanticipated needs such as last-minute unavailability of the aide, need for additional services short-term due to a change in status, etc. There will be flexibility within the service allocation during individual months and from month to month as long as the overall annual limit is not exceeded. Family/informal supports will be expected to participate in the back-up/emergency plan. The back-up plan and flexibility with service hours address temporary changes in need. If a person's needs appear to be changing over the long term, the individual will be assessed for other services, levels of care and/or service settings.

Individualized Support Services will be provided based on individual needs as identified in the independent assessment and on a one-to-one basis whether in a group setting or private home. If it is determined that an individual does not meet or ceases to meet the criteria for Individualized Support under 1915(i), notice will be provided and the individual will have appeal rights.

Residents may be admitted by choice in an adult care home, family care home, or supervised living home prior to being assessed for 1915(i) services. However, 1915(i) services will not be provided until the independent assessment is conducted and services authorized except on an emergency basis as approved by the State.

A Web-based Automated Tool is the platform for the 1915(i) independent assessment and the individual plan of care. Recipients may request and receive a copy of the completed assessment at any time from the Independent Assessment Entity. INDIVIDUALIZED SUPPORT provider organizations will maintain copies of completed assessments and also may provide copies to beneficiaries.

The Automated Web-based Tool which coordinates the 1915(i) Independent Assessment and the 1915 (i) Individual Plan of Care is accessible by:

- 1915(i) independent assessment entities
- 1915(i) service providers
- State Medicaid Agency (SMA) and
- DHHS Division of Health Service Regulation

Independent assessor evaluates eligibility for need of 1915(i) services and the level of service need, the assessment tool identifies the individual's specific needs for assistance and the service provider finalizes the plan of care based on the assessment data and the consumer's preferences as to how and when and by whom services will be delivered.

Plans of care are reviewed by the independent assessor for compliance with the assessed limits, duration, and scope. Once reviewed by the independent assessor The State Medicaid Agency monitors the plan of care for services approved for compliance and reimbursement through this web based assessment and care planning tool.

5. **Supporting the Participant in Plan of Care Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Meetings to develop the plan of care are scheduled taking into consideration times that are convenient for the participant and others involved in the care planning process. Participants are informed verbally of their authority, both by the assessment entity and the provider, to determine who will be included in the care planning process. The participant is the sole authority when making decisions unless a responsible party or guardian has been given authority to make decisions on the participant's behalf.

Regarding children under the age of 21 who apply for 1915(i) services it should be noted that when DMA or DMA's vendors review covered state Medicaid plan services requests for prior approval or continuing authorization for an individual under 21 years of age, the reviewer will apply the EPSDT criteria to the review. This means that requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a beneficiary under 21 years of age is a request for EPSDT services. The decision to approve or deny the request will be based on the beneficiary's medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health condition]. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do **NOT** apply to beneficiaries under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

6. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the plan of care):*

The Independent Assessment Entity provides the participant with a list of all enrolled Medicaid providers of 1915(i) services within the participant's geographic area. The participant will be asked if any preferences exist such as a certain county or location. The IAE also provides beneficiaries with information on any available ratings or findings by regulatory or oversight agencies that might help them in making an informed decision or select a provider that meets their specific needs. The list is randomized electronically so facilities are never listed in the same order.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The Independent Assessment Entity reviews all completed plans of care for compliance with the results of the independent assessment of the individual. Once approved by the IAE, plans of care are sent to the State Medicaid Agency for final approval.

The State's quality improvement strategy also includes performance measures addressing the timeliness, appropriateness and the required IAE review of plans of care.

8. **Maintenance of Plan of Care Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☑	Medicaid agency via web-based assessment/care planning system	☐	Operating agency	☐	Case manager

☑	Other (*specify*):	Provider

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title: Individualized Support (IS)

Service Definition (Scope):

Individualized Support provided under this 1915(i) Benefit consists of training to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization, and other adaptive areas. Training outcomes focus on allowing the beneficiary to participate in home life activities and reside as independently as possible in the community. This includes assistance in community activities when the beneficiary is dependent on others to ensure health and safety.

Individualized Support also provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for adults with a diagnosis of Intellectual/Developmental Disability. ADLs, for the purposes of this benefit, are defined as eating, dressing, bathing, toileting, and mobility. IADLs are meal preparation, medication assistance, and basic home management tasks that are directly related to the qualifying ADLs and essential to the beneficiary's care at home.

Individualized Support is provided during community activities, in the beneficiary's home by paraprofessional aides employed by licensed home care agencies, in licensed adult care homes, or supervised living homes by residential staff. For the purposes of this benefit, the beneficiary's home may be a private living arrangement a residential facility licensed by the State of North Carolina as an adult care home, a family care home, or a supervised living facility for adults with Intellectual/Developmental Disabilities.

The amount of service provided is based on an assessment conducted by an independent entity to determine the individual's support needs. Performance is rated as totally independent, requiring cueing or supervision, requiring limited assistance, requiring extensive assistance or totally dependent. Individuals are then assigned a number of service increments according to their assessed needs.

Additional needs-based criteria for receiving the service, if applicable *(specify)*:

The following additional requirements must be met for an individual to receive the service in his or her private living arrangement:

1. The home environment is safe and free of health hazards for the beneficiary and IS provider(s), as determined by an in-home environmental assessment conducted by Medicaid or its designee. An environmental assessment looks at the physical characteristics of the home to determine whether it is habitable or poses obvious risks

to individuals living and/or providing services in the home; for example, does the home have electricity, a source of heat in cold weather, infestation by rodents/insects or rotting floors that are dangerous to walk on.

2. The home is adequately equipped to implement needed services.

3. There is no available, willing, and able household member to provide the authorized services on a regular basis.

Specify limits (if any) on the amount, duration, or scope of this service for ***(check each that applies)*****:**

☑ **Categorically needy** ***(specify limits)*****:**

Adults 21 years of age and older may be authorized for no more than 60 hours of service per month.

When medication assistance is delivered in private residences it consists of medication self-administration assistance as allowed by state law in 10A NCAC 13I .1107. When medication assistance is delivered in adult care homes it may include medication administration as defined in 10A NCAC 13F & G .1004. When medication assistance is delivered in supervised living homes it may be done in accordance to 10A NCAC 27G .0209. Authorized Individualized Support hours in adult care homes do not cover basic meal preparation or errands services that duplicate state- and county-funded room and board services.

☑ **Medically needy** ***(specify limits)*****:**

Same as above.

Provider Qualifications ***(For each type of provider. Copy rows as needed)*****:**

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Adult Care Homes	Licensed in accordance with NC General Statute 131D and North Carolina Administrative Code Title 10A, Chapter 13, Subchapters F and G.		Service is provided by the Adult Care Home either through their own staff or through qualified staff under contract to provide the service. Staff providing services must meet the training, competency and other requirements applicable to direct care workers found in 10A NCAC 13F and 13G. Staff who prepare and administer medications must meet all applicable requirements for medication aides in 10A NCAC 13F and 13G. Medications must be stored, maintained and managed according to the requirements of 10A NCAC 13F and 13G. Criminal records and health care registry checks are required for all adult care home staff.

Supervised Living	NC General Statute 122-C and 10A NC Administrative Code 27G .5600, Supervised Living Facilities, designated as type A and C homes		•Staff must meet the requirements for paraprofessionals in 10A NCAC 27G.0200 •Staff must have a high school diploma or GED •Staff must meet participant specific competencies as identified by the participant's person-centered planning team and documented in the Person Centered Plan •Staff must successfully complete First Aid, CPR and DMH/DD/SAS Core Competencies and required refresher training •Paraprofessionals providing this service must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline •Must have a criminal record check •A healthcare registry check is required in accordance with 10A NCAC 27G.0200
Home Care Agencies	Licensed under NC Administrative Code Title 10A, Chapter 13, Subchapter J		Criminal background checks must be conducted on all In-Home Aides before they are hired. In-Home Aides cannot be hired if listed on the North Carolina Health Care Registry as being under investigation or as having a substantiated finding of previous client abuse or neglect, misappropriation of client property, diversion of client or facility/program drugs, or fraud as an employee of one of the reporting health facility types.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Adult Care Homes	The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses adult care homes. DHSR reviews will include monitoring to ensure facilities continue to meet HCBS criteria.	Annually
Supervised Living	The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses supervised living homes. DHSR reviews will include monitoring to ensure facilities continue to meet HCBS criteria.	Annually
Home Care Agencies	The North Carolina Department of Health and Human Services, Division of Health Service Regulation inspects and licenses home care agencies.	Annually

Service Delivery Method. *(Check each that applies)*

☐ Participant-directed	☑ Provider-managed

2. ☒ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) how the State ensures that the provision of services by such persons is in the best interest of the individual; (c) the State's strategies for ongoing monitoring of services provided by such persons; (d) the controls to ensure that payments are made only for services rendered; and (e) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Services may not be provided by relatives and/or legal guardians of 1915(i) participants.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction.** *(Select one):*

◉	The State does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. *(Specify criteria):*

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

N/A

3. **Limited Implementation of Participant-Direction.** *(Participant-direction is a mode of service delivery, not a Medicaid service, and is not subject to statewideness requirements. Select one):*

◉	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. *(Specify the areas of the State affected by this option):*
	N/A

4. **Participant-Directed Services.** *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
N/A	☐	☐
	☐	☐

5. **Financial Management.** *(Select one)*

◉	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☒ **Participant-Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

N/A

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

☑	The State does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*
☐	**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
☐	**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

☑	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*
	N/A

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency/ies that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	**Assurance 1**: All new referrals admitted to (i) Option Individualized Support Services (IS) benefit will receive an Independent Eligibility Assessment (IEA). 1) Performance Metric: Number and percent of cases sampled where individuals admitted to Individualized Support as new referrals in the previous month received a IEA. A) Numerator = Number of new referrals admitted to Individualized Support in prior month receiving a IEA. B) Denominator = Total number of new referrals admitted in the review period.	Data Source: QiRePort Sampling: 1) Type of Sample: Random sample of new referrals admitted to Individualized Support in previous month. 2) Sampling Frequency: Monthly 3) Sample Size: Determined each month for the previous month based on the 95% confidence level.	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: Program Administration Contractor's (PAC) QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
	Assurance 2: All (i) Option Individualized Support participants will be re-assessed for continuation of services prior to their annual review date. 1) Performance Metric: Number and percent of Individualized Support participants in sample of individuals with an annual review date in the previous month who received a re-assessment prior to their annual review date.	Data Source: QiRePort Sampling: 1) Type of Sample: Stratified random sample. 2) Strata: Strata include re-assessments performed on 1915(i) benefit participants receiving Individualized Support in: a) Adult Care Homes (ACH) b) Family Care	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	A) Numerator – Number of participants who received an annual re-assessment prior to their annual review date B) Denominator – Number of participants reviewed during the review period	Homes (PCH) c) Supervised Living Homes (SLH) d) Privately Owned Homes (POH) 3) Sampling Frequency: Monthly 4) Sample Size: Determined each month for previous month for each strata based on the 95% confidence level				
	Assurance 3: All new referrals, re-assessments, and change of status reviews for Individualized Support will be assessed within 15 business days of a valid request. Cases where technical denials have been generated are not included in the sampling. 1) Performance Metric: Total number and percent of previous month sample of new referral assessments and re-assessments performed within the 15 business day timeframe. A) Numerator – Number of PEA assessments and re-assessments conducted in previous month that were performed within the required timeframe B) Denominator – Number of assessments performed in review period	Data Source: QiRePort Sampling: 1) Type of Sample: Random sample of assessments and re-assessments performed in previous month 2) Sampling Frequency: Monthly 3) Sample Size: Determined each month for previous month based on the 95% confidence level	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
	Assurance 4: All assessments and re-assessments shall be conducted by a qualified assessor. 1) Performance Metric:	Data Source: QiRePort Sampling: 1) Type of Sample: Random sample of assessments and re-	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues:	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	Total number and percent of assessments and re-assessments conducted by a qualified assessor. A) Numerator – Number of cases reviewed where the assessment was conducted by a qualified assessor. B) Denominator – Number of cases reviewed in the review period.	assessments performed in previous month. 2) Sampling Frequency: Monthly 3) Sample Size: Determined each month for previous month based on the 95% confidence level. Who Aggregates and Analyzes: DMA QI Analyst			PAC QI Manager Who Tracks Remediation: DMA QI Manager	
	Assurance 5: All Individualized Support Providers accepting new referrals for Individualized Support will complete a person-centered POC that addresses the assessed needs of the Individualized Support participant. 1) Performance Metric: Number and percent of POCs submitted to and approved by the Program Administration Contractor. A) Numerator – Number of POCs reviewed that meet program standards and criteria for plan of care. B) Denominator – Number of POCs reviewed during review period.	Data Source: QiRePort Sampling: 1) Type of Sample: Random sample of plans of care submitted in previous month. 2) Sampling Frequency: Monthly 3) Sample Size: Determined each month based on plans of care submitted in previous month based on the 95% confidence level.	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
	Assurance 6: All Individualized Support Providers will complete an updated person-centered POC following an annual re-assessment within 20 business days of the reassessment. 1) Performance Metric:	Data Source: QiRePort Sampling: 1) Sample Type: Random Sample 2) Sampling Frequency: Monthly 3) Sample Size: Determined each month	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	Number and percent of POCs submitted to and approved by the DAC A) Numerator – Number of participants with updated POCs within time frame B) Denominator – Number of participants reviewed during review period	for the previous month based on the 95% confidence level			Remediation: DMA QI Analyst	
	Assurance 7: Each POC shall document participant choice of provider 1) Performance Metric: Total number and percent of plans of care that document participant choice of provider A) Numerator – Number of participants reviewed with a plan of care that documents provider choice B) Denominator – Number of participants reviewed during review period	Data Source: QI RePort Sampling: 1) Sample Type: Random sample of plans of care submitted in previous month 2) Sampling Frequency: Monthly 3) Sample Size: Determined each month for previous month based on the 95% confidence level	IT Support Vendor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
Providers meet required qualifications.	Assurance 1: All Individualized Support furnished to qualified beneficiaries in their private residences shall be provided by home care agencies licensed by the North Carolina Division of Health Services Regulation (DHSR) and properly enrolled with North Carolina Medicaid to provide an Individualized Support in POHS 1) Performance Metric: Number and percent of home care agencies that received appropriate licensure by the DHSR prior to the provision of 1915(i) benefit services to	Data Source: MMIS report Sampling: 1) Sampling Type: Random sample of claims filed by home care agencies to determine how many were denied because they were not enrolled providers 2) Sampling Frequency: Quarterly 3) Sample Size: Determined each quarter for claims filed by home care agencies for services to	DMA QI Analyst	Quarterly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Quarterly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	participants in the POH setting. A) Numerator – Number of home care agencies providing services that received appropriate licensure by DHSR prior to providing services to 1915(i) benefit participants. B) Denominator – All home care agencies submitting claims during the review period.	beneficiaries in the POH setting for previous quarter based on the 95% confidence level.				
	Assurance 2: All Individualized Support furnished to qualified beneficiaries in the adult and family care homes will be provided by adult and family care homes licensed by the North Carolina DHSR and properly enrolled with North Carolina Medicaid as an adult or family care home provider, as applicable. 1) Performance Metric: Number and percent of adult and family care homes that received appropriate licensure by the DHSR prior to the provision of 1915(i) benefit services. A) Numerator – Number of adult and family care homes that received appropriate licensure by DHSR prior to providing services to participants. B) Denominator – All adult care homes submitting claims during the review period.	Data Source: MMIS report. Sampling: 1) Sampling Type: Random sample of claims filed by adult and family care homes to determine how many were denied because they were not enrolled providers. 2) Sampling Frequency: Quarterly. 3) Sample Size: Determined each quarter for claims filed by adult and family care homes for Individualized Support provided to residents for previous quarter, based on the 95% confidence level.	DMA QI Analyst	Quarterly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Quarterly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	Assurance 3 - All Individualized Support furnished to qualified beneficiaries in Supervised Living Homes that received appropriate licensure by DHSR prior to provision of 1915(i) benefit services. 1) Performance Metric: Number and percent of SLHs that continue to be licensed by the DHSR on an annual basis. A) Numerator = Number of supervised living homes that received appropriate licensure by DHSR prior to providing services to 1915(i) benefit participants B) All supervised living homes submitting claims during the review period	Data Source: MMIS reports Sampling: 1) Sample Type: Random sample of claims filed by supervised living homes to determine how many were denied because they were not enrolled providers. 2) Sampling Frequency: Quarterly 3) Sample Size: Determined each quarter for claims filed by Supervised Living Homes for Individualized Support provided to qualified beneficiaries in the SLH for previous quarter based on the 95% confidence level.	DMA QI Analyst	Quarterly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Quarterly
	Assurance 4 - All Individualized Support shall be provided by paraprofessional aides meeting the qualifications and training competencies specified in licensure requirements for home care agencies, adult care homes, family care homes, and supervised living homes, as appropriate. 1) Performance Metric: Number and percent of cases reviewed where services are provided by an individual meeting all professional requirements for paraprofessional aide applicable to home care agencies, adult care homes, family care homes, and	Data Sources: 1) Desktop reviews of selected cases where providers are asked to confirm that specified aides meet all professional qualification and training requirements 2) On-site review of personnel and training records Sampling: 1) Sample Type: Stratified random sample 2) Strata include: A) Adult Care Homes B) Family Care Homes	DMA QI Analyst	Monthly	Who Aggregates and Analyzes: PAC QI Manager Who Addresses Individual Issues: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	supervised living homes, as appropriate A) Numerator – Number of cases reviewed where services were provided by a qualified paraprofessional aide. Denominator – Number of cases reviewed during review period.	C) Supervised Living Homes D) Privately Owned Homes 3) Sampling Frequency: Monthly 4) Sample Size: A) Desktop Reviews: Twenty-four reviews (six cases for each setting type) B) On-Site Record Reviews: Twelve reviews (three cases for each setting type)				
	Assurance 5: The state shall determine participants' satisfaction with the quality of care and quality of Individualized Support Services furnished by the agency or home and the direct care staff. 1) Performance Metric: Number and percent of beneficiaries in sample who rate their providers as satisfactory or higher. A) Numerator – Number of participants who rated their provider satisfactory or higher. B) Denominator – Number of Individualized Supports participants completing satisfaction survey during review period.	Data Sources: 1) Satisfaction surveys conducted as part of annual re-assessments. 2) Satisfaction surveys conducted as part of change of status re-assessments. 3) Satisfaction survey conducted with participants who have requested a change of provider. Sampling: 1) Type of Sample: Stratified random sample. 2) Strata: Strata include: A) Participants receiving annual re-assessment. B) Participants receiving change of status re-assessments. C) Participants requesting a	DMA QI Analyst and QI Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst and QI Contractor. Who Addresses Individual Issues: DMA QI Analyst. Who Tracks Remediation: DMA QI Analyst.	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
		change of provider. 3) Sampling Frequency: Monthly 4) Sample Size: Determined each month for previous month for each strata based on the 95% confidence level				
The SMA retains authority and responsibility for program operations and oversight.	Assurance 1: The North Carolina Division of Medical Assistance shall enter into contractual agreements with an independent assessment contract administrator, and IT Support Entity that establishes Medicaid authority over all program components. 1) Performance Metrics: Number and percent of contractors with performance-based agreements establishing DMA authority and responsibility for 1915(i) benefit operations and oversight. A) Numerator: Number of agreements reviewed that fulfill this requirement B) Total reviewed during review period	Data Source: Program files and documents 1) Written performance-based agreements, and 2) Performance reviews Sampling: 1) Sample Type: One hundred percent review of all contracts executed an review period 2) Sampling Frequency: Quarterly 3) Sample Size: All contracts, other agreements, and performance reviews	DMA QI Analyst	Quarterly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Quarterly
	Assurance 2: The North Carolina Division of Medical Assistance shall monitor all clinical policy requirements and 1915(i) benefit administrative functions on an ongoing basis using an automated program management system. 1) Performance Metrics: Total and percent of cases	Data Source: QI Report Sampling: 2) Sample Type: Random 3) Sampling Frequency: Monthly 4) Sample Size: Determined each month for the total 1915(i) benefit enrollment	Program IT Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	meeting program standards for: A) Compliance with Medicaid Clinical Coverage Policy i) Numerator – Cases that meet performance standards for clinical policy requirements ii) Denominator – Total cases reviewed in review period B) Compliance with program administrative requirements i) Numerator – Cases that meet performance standards for program administration ii) Denominator – Total cases reviewed in review period	based on the 95% confidence level.				
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	Assurance 1: The state shall ensure that all claims are paid in accordance with the number of hours of Individualized Support determined by the Independent Eligibility Assessment specified in the service authorization and documented in the beneficiary's plan of care. 1) Performance Metric – Total and percent of claims sample paid in accordance with the approved amount of service. A) Numerator – Number of claims paid in accordance with	Data Sources: 1) QIReport 2) Prior approval records in MMIS; and 3) Paid claims records in MMIS. Sampling: 1) Sample Type: Random sample of paid claims 2) Sample Frequency: Monthly 3) Sample Size: Determined each month for the previous month based on the 95% confidence level.	Program IT Contractor	Monthly	Who Aggregates and Analyzes: Program IT Vendor Who Addresses: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	approved service authorization. B) Denominator – Total number of claims paid in review period.					
	Assurance 2: The state shall ensure that all claims all claims paid are supported by documentation in the beneficiary's service record and provided in accordance with the beneficiary's plan of care. 1) Performance Metric: Total and percent of claims sample paid in accordance with service record and plan of care. A) Numerator – Claims paid in accordance with service record and plan of care. B) Denominator – Total number of claims reviewed in review period.	Data Source: Provider service records. Sampling: 1) Sampling Type: Stratified Random Sample of Cases. 2) Strata Include: A) Adult Care Homes. B) Family Care Homes. C) Supervised Living Homes. D) Privately-Owned Homes. 3) Sampling Frequency: Monthly. 4) Sample Size: A) Desktop Reviews: Twenty-four reviews (six cases per setting type). B) On-Site Record Reviews: Twelve reviews (three cases per setting type).	Providers	Monthly	Who Aggregates and Analyzes: DMA QI Analyst. Who Addresses Individual Issues: PAC QI Manager. Who Tracks Remediation: DMA QI Analyst.	Monthly
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of	Assurance 1: All beneficiaries approved for Individualized Support under the (i) Option shall receive a copy of the Client's Bill of Rights and the 1915(i) HCBS Standards, as applicable to each setting type, and each provider shall ensure that receipt of these documents contains	Data Source: Provider service records. Sampling: 1) Sampling Type: Stratified Random Sample of Cases. 2) Strata Include: A) Adult Care Homes. B) Family Care	Providers	Monthly	Who Aggregates and Analyzes: DMA QI Analyst. Who Addresses Individual Issues: PAC QI Manager. Who Tracks Remediation: DMA QI Analyst.	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
restraints.	information on how to report critical incidents and submit complaints. Receipt of this Bill of Rights shall be documented in the participant's service record. 1) Performance Metric: Number and percent of service records reviewed that contain: i) Information on reporting incidents and submitting complaints; and ii) A signed and dated acknowledgement that beneficiary has received a copy of the Client Bill of Rights. A) Numerator = Number of reviews where performance metric is met. B) Denominator = Number of cases reviewed during review period.	Homes. C) Supervised Living Homes. D) Privately-Owned Homes. 3) Sampling Frequency: Monthly. 4) Sample Size: A) Desktop Reviews: Twenty-four reviews (six cases per setting type). B) On-Site Record Reviews: Twelve reviews (three cases per setting type).				
	Assurance 2: Home care agencies, adult care homes and family care homes shall complete an Internet-based uniform reporting form for all specified critical incidents and submit this form to DMA (and all other agencies specified under applicable licensure rules) within XX business days. 1) Performance Metrics: Number and percent of reportable critical incidents that were reported within the required timeframe. A) Numerator =	Data Source: Provider service records. Sampling: 1) Sampling Type: Stratified Random Sample of Cases. 2) Strata include: A) Adult Care Homes. B) Family Care Homes. C) Privately-Owned Homes. 3) Sampling Frequency: Monthly.	Providers	Monthly	Who Aggregates and Analyzes: DMA QI Analyst. Who Addresses Individual Issues: PAC QI Manager. Who Tracks Remediation: DMA QI Analyst.	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	Number cases reviewed that met reporting requirement B) Denominator – Total number reviewed during review period	4) Sample Size: A) Desktop Reviews: Twenty-four reviews (six cases per setting type) B) On-Site Record Reviews: Twelve reviews (three cases per setting type)				
	Assurance 3: Supervised Living Homes shall report all critical incidents utilizing the North Carolina Incident Response Improvement System (IRIS) for all specified critical incidents within XX business days. 1) Performance Metrics: Number and percent of reportable critical incidents that were reported within the required timeframe A) Numerator – Number cases reviewed that met reporting requirement B) Denominator – Total number reviewed during review period	Data Source: Provider service records Sampling: 1) Sampling Type: Stratified Random Sample of Cases 2) Strata Include: A) Supervised Living Homes 3) Sampling Frequency: Monthly 4) Sample Size: A) Desktop Reviews: Twenty-four reviews (six cases per setting type) B) On-Site Record Reviews: Twelve reviews (three cases per setting type)	Providers	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly
	Assurance 4: Individualized Support assessments completed in the beneficiary's home shall include an inspection of the home and identification of any health or safety risks. 1) Performance Metric: Number and percent of in-home assessments that include a home health and safety inspection	Data Source: QI Report Sampling: 1) Sample Type: Random sample 2) Sampling Frequency: Monthly 3) Sample Size: Sample Size: Determined each month for the previous month based on the 95%	Program / Contractor	Monthly	Who Aggregates and Analyzes: PAC QI Manager Who Addresses Individual Issues: DMA QI Analyst Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*
	A) Numerator = Number of assessments that included a home health and safety inspection B) Denominator = Total number reviewed during review period	confidence level				
Assurance 5: All aide and supervisory staff employed or under contract to the Individualized Support provider must have successfully passed a criminal history records check as required under NCGS 114-19.10, NCGS 131D-40, NCGS 122C-80 and health care personnel registry check as required by NCGS 131E-256 1) Performance Metric: Number and percent of sample of staff personnel records that show the individual staff have passed both the criminal history records check and health care personnel registry check A) Numerator = Number of individuals meeting requirements for criminal and personnel registry checks B) Denominator = Total number reviewed during review period	Data Sources: 1) Desktop reviews of selected cases where providers are asked to confirm that specified aides meet all professional qualification and training requirements 2) On-site review of personnel and training records Sampling: 2) Sampling Type: Stratified Random Sample of Cases 3) Strata Include: A) Adult Care Homes B) Family Care Homes C) Supervised Living Homes D) Privately-Owned Homes 4) Sampling Frequency: Monthly 5) Sample Size: A) Desktop Reviews: Twenty-four reviews (six cases per setting type) B) On-Site Record Reviews: Twelve reviews (three cases per setting type)	DMA QI Analyst and QI Contractor	Monthly	Who Aggregates and Analyzes: DMA QI Analyst Who Addresses Individual Issues: PAC QI Manager Who Tracks Remediation: DMA QI Analyst	Monthly

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** *(Source of Data & sample size)*	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes, aggregates, and reports on remediation activities)*	**Frequency** *of Analysis and Aggregation*

System Improvement:

(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)

Introduction

Federal regulations require that each state program approved under the §1915(i) Option have, at a minimum, systems in place to measure and improve its performance in meeting certain specified assurances that are set forth in 42 CFR §441.301 and §441.302. These assurances, and the methodology designed to measure performances in each of six major assurance areas and associated sub-areas, are described in the state's Quality Improvement Strategy (QIS). This paper provides information to supplement this Plan and further describe the methods the state will employ to ensure that these QIS assurances are monitored and evaluated.

The North Carolina Division of Medical Assistance (DMA), as the state Medicaid Agency, retains full and final responsibility and authority for all operations conducted in this program including services provided by other state and local agencies, contracted entities, and providers. The proposed §1915(i) Individualized Support benefit will be monitored, reviewed, and evaluated on an ongoing basis. The state will employ six different methods to monitor and continuously improve quality and compliance in each of the QIS assurance areas and the various components that pertain to each. These six methods are described below and related to the each of the assurances contained in the state's proposed §1915(i) Combined Individualized Support Quality Improvement Strategy.

Automated Systems

The DMA has developed an automated system to manage the business process of its In-Home Personal Care Services program, including monitoring and evaluating key program administration processes, including:

1. Receiving and processing physician referrals;
2. Scheduling and conducting independent assessments and re-assessments;
3. Authorizing service levels based on assessment results;
4. Producing beneficiary/provider notifications;
5. Supporting provider choice and making provider referrals;
6. Submitting plans of care;
7. Provider reporting; and
8. Supporting requests for mediation and appeal hearings.

This system, called QiRReport, is an automated, Internet-based system that builds an integrated database that captures the information necessary to monitor and evaluate most of the assurance areas addressed in the state's QIS. DMA Quality Improvement staff will have full access to all information contained in this system and utilize this system as the principal means to provide ongoing monitoring and evaluation of all services provided and operations conducted by DMA contractors under the 1915(i) Option benefit. This system is to be expanded to include all the Individualized Support addressed under the §1915(i) Option and eventually to all the state's home and community-based services (HCBS).

QiRePort will be used to monitor the assurance areas summarized in Table 1 below.

Table 1: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing the QiRePort Automated System

QIS Assurance Area	Component	DMA Monitoring
A: Program Assessments and Re-assessments	*Assurance A-1:* New admission assessments	• All assessments are automated and uploaded to QiRePort • DMA will review a random sample of new referrals from the previous month where the referral was complete and, of this number, determine how many received an independent assessment • This review will be conducted every month for new referrals processed in the previous month
	Assurance A-2: Annual re-assessments	• Annual review dates are entered into the QiRePort System • DMA will review a random sample of beneficiaries with a annual review date in the previous month and determine how many received an annual re-assessment prior to the review date • This review will be conducted every month for re-assessments processed in the previous month
	Assurance A-3: Timelines for assessments and reassessments	• DMA will determine, for both samples, how many received assessments or re-assessments as applicable, within the required 15 business days • This review will be conducted every month for samples selected from assessments processed during the previous month
B: Service Plan (Plan of Care)	*Assurance B-1:* Complete a person-centered POC for each participant	• Individualized Support Providers will be required to complete a POC based on the independent assessment and submit to DMA, or its designee, via QiRePort for review and approval • DMA will review a random sample of all POCs submitted in the previous month to determine if all requirements and criteria have been met • This review will be conducted every month for a sample of POC submitted during the previous month
	Assurance B-2: The POC is updated annually	• Providers must submit an updated POC, via QiRePort, following the annual re-assessment • DMA will look at a random sample of re-assessments conducted in the previous month to determine if an updated POC has been submitted within the required timeframe • This review will be conducted every month for a sample of POC submitted during the previous month
	Assurance B-3: Choice of provider	• The assessment protocol includes providing qualified beneficiaries with county list of providers and documenting each beneficiary's choice • No provider referral will be made if this protocol is not properly completed • This will be reviewed every month for a sample of POC submitted during the previous month
D: Recipient Health and Welfare	*Assurance D-4:* Health and safety	• Assessment for Individualized Support in private homes will include a health and safety inspection of the beneficiary's

	inspection of beneficiary's home	home • This assessment will be submitted to DMA via QiRePort • DMA will review a random sample of private in-home assessments conducted in the previous month and determine how many have included the health and safety review • This review will be conducted every month for private in-home assessments processed during the previous month

Table 1: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing the QiRePort Automated System (Continued)

QIS Assurance Area	Component	DMA Monitoring
E: State Administrative Authority	*Assurance E-2:* Monitor compliance with Medicaid Clinical Coverage Policy and program administrative requirements	• Virtually all aspects of Individualized Support administration and operations are addressed by QiRePort • DMA will utilize QiRePort to review a random sample of cases processed in the previous month to determine if all clinical policies and required administrative functions were completed • This review will be conducted every month for cases processed in the previous month

Desktop Reviews and Provider Site Visits

DMA, or its designee, will establish a schedule of provider desktop reviews and site visits to conduct monitoring and review activities that require review of provider service and personnel records. DMA, or its designee, will conduct 24 desktop and 12 on-site reviews each month of provider records to monitor activities related to professional qualifications, beneficiary health and welfare, and provider service documentation.

QIS assurance areas to be addressed through provider desktop and on-site reviews are summarized in Table 2 below.

Table 2: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing Desktop and Provider On-Site Reviews

QIS Assurance Area	Component	DMA Monitoring
C: Professional Qualifications	*Assurance C-4:* Qualifications and training competencies for paraprofessional Individualized Support aides	Review of personnel records to determine if all employed or contracted paraprofessional aides have met the qualifications and training requirements specified in state licensure requirements for home care agencies, adult and family care homes, and supervised living homes, as appropriate
D: Recipient Health and Welfare	*Assurance D-1:* Recipient Bill of Rights	Review of beneficiary service records to determine if all beneficiaries have received a copy of their Bill of Rights that contains all required information and that the service record

		contains a signed acknowledgement by the beneficiary that he/she has receive this document
	Assurance D-2 and Assurance D-3: Incident Reports	Review of provider copies of incident reports to determine if copies were sent to DMA, Division of Health Services Regulation (DHSR) and local Department of Social Service
	Assurance D-5: Criminal background checks	Review of provider personnel records to determine if a criminal background and DHSR Health Care Personnel Registry check had been conducted on all aide and supervisory staff be employment

Table 2: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing Desktop and Provider On-Site Reviews (Continued)

QIS Assurance Area	Component	DMA Monitoring
F: State Financial Accountability	*Assurance F-2:* Claims paid are consistent with the beneficiary's service authorization, POC, and provider service r	Review of provider service records to determine if claims have been paid in accordance with the service authorization, POC, and provider service records

Use of the Medicaid Management Information Systems (MMIS)

DMA will utilize the state fiscal agent's MMIS to ensure that all QIS assurances and program requirements regarding qualified providers and financial accountability are met. QIS assurance areas to be addressed through MMIS are summarized in Table 3 below.

Table 3: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing the Medicaid Managed Information System

QIS Assurance Area	Component	DMA Monitoring
C: Professional Qualifications	*Assurance C-1:* Services provided to beneficiaries in private homes are provided by home care agencies licensed by DHSR and enrolled with Medicaid as a home care provider	Quarterly random samples of paid claims will be reviewed to determine how many claims were denied because the provider was not an enrolled Medicaid provider of home care services
	Assurance C-2: Services provided to beneficiaries in adult and family care homes are provided by adult and family care homes licensed by DHSR and	Quarterly random samples of paid claims will be reviewed to determine how many were denied because the provider was not an enrolled Medicaid provider of adult care home services

	enrolled with Medicaid as an adult or family care home provider	
	Assurance C-3: Services provided to beneficiaries in supervised living homes are provided by facilities licensed by DHSR and Enrolled with Medicaid as a supervised living home	Quarterly random samples of paid claims will be reviewed to determine how many were denied because the provider was not an enrolled Medicaid provider of supervised living services

Contracts and Memorandums of Agreement

DMA will utilize contractual agreements with private entities and Memorandums of Agreements with other state, local, and regional agencies to ensure that the state complies with its QIS assurances and maintains appropriate management oversight of program operations. DMA monitors all contracts and memorandums of agreement according to the State's performance-based contracting requirements.

QIS assurance areas to be addressed through contracts and Memoranda of Agreement are summarized in Table 4 below.

Table 4: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing Contracts and Memorandums of Agreement

QIS Assurance Area	Component	DMA Monitoring
A: Program Assessments and Re-Assessments	*Assurance A-4:* Assessments conducted by qualified professionals	• Contracts with entities providing assessments will be required to meet specified professional qualifications for assessors • Assessor qualifications will be reviewed by DMA • DMA will approve assessor orientation and training programs • DMA will specify and approve contractor or quality assurance procedures for monitoring and evaluating the validity and reliability of assessments
E: State Administrative Authority	*Assurance E-1:* Contractual Agreements	All contracts for services provided under the (i) Option will establish DMA (Medicaid) authority and management oversight over all program services and operations
	Assurance E-1: Memorandums of Agreement	All Memoranda of Agreements with state, regional, and local agencies will establish DMA (Medicaid) authority and management oversight over all program services and operation

Recipient Surveys

DMA will survey Individualized Support beneficiaries on an ongoing basis to determine their satisfaction with the quality of care and quality of service provided to them under this benefit. QIS assurance areas to be addressed through a Recipient Satisfaction Survey are summarized in Table 5

below.

Table 5: Summary of §1915(i) Option Individualized Support Benefit QIS Monitoring Activities Utilizing a Recipient Satisfaction Survey

QIS Assurance Area	Component	DMA Monitoring
C: Qualified Providers	*Assurance C-5:* Determine the level of satisfaction with services furnished by provider agencies and direct care staff	DMA will conduct a program participant satisfactions survey each time an annual re-assessment, change of status re-assessment review, or change of provider request is processed.

Quality Improvement Staff

DMA will develop an operational budget for the §1915(i) Option Individualized Support Benefit that will include funding for a Program Manager and QI Analyst. Contractors will also be required to designate a QI Manager to participate in the QIS and Continuous Quality Improvement Programs conducted under this benefit. The Program Manager and QI Analyst will review all performance metrics on a month-to-month basis and be responsible for initiating any corrective action plans required to remediated identified problems or deficiencies.

Joint House Committee on Appropriations Subcommittee on Health and Human Services
Wednesday, March 6, 2013, at 8:30 a.m.
Room 643

MINUTES

The House Committee on Appropriations Subcommittee on Health and Human Services met at 8:30 am on Wednesday, March 6, 2013 in Room 643. Representatives Avila, Brisson, Farmer-Butterfield, Ford, Fulghum, Hollo, Insko, Lambeth, Martin and Murray attended. Senators Hise, Pate, McKissick, Robinson and Barringer attended.

Senator Ralph Hise, presided.
Senator Hise, gaveled the meeting at 8:30am and introduced the Pages and Sergeants and Arms.
House Pages: Zachary Barr, Benjamin Howie, Gabriel Johnson and Briana Jones.
Senate Pages: Lydia Kuehnert and Brittany Leuth.
Sergeants at Arms – House: Charles Godwin and Fred Hines.
Sergeants at Arms – Senate: Canton Lewis and Steve Wilson.

Senator Hise introduced Ms. Janice Paul, Staff Attorney for the Research Division for the NC General Assembly, presented an Overview of NC Mental Health Reform and Health and Human Services Legislative Oversight Committee, Mental Health Subcommittee Report and Recommendations.

All presentations are attached to these minutes.

The meeting was adjourned at 9:50 am.

Senator Ralph Hise
Presiding

Caroline Stirling, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 28, 2013 12:39 PM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Wednesday, March 06, 2013 at 8:30 AM

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	March 6, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

JOINT APPROPRIATIONS SUBCOMMITTEE HEALTH AND HUMAN SERVICES

AGENDA

March 6, 2013
Legislative Office Building - Room 643
8:30 a.m.

Sen. Ralph Hise, Presiding	Welcome, Opening Remarks
Overview of NC Mental Health Reform	Janice Paul Staff Attorney Research Division
Health and Human Services Legislative Oversight Committee, Mental Health Subcommittee Report and Recommendations	Janice Paul Staff Attorney Research Division
Adjourn	
Next Meeting:	Thursday, March 7th, 8:30 a.m.

NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

SUBCOMMITTEE ON MENTAL HEALTH

FINAL REPORT
TO THE
FULL COMMITTEE

JANUARY 2013

TRANSMITTAL LETTER

The Subcommittee on Mental Health, respectfully submits the following report to the Joint Legislative Oversight Committee on Health and Human Services pursuant to S.L. 2012-142, Sec. 10.11 as amended by S.L. 21012-145, Sec. 3.4.

Representative Justin Burr
Co-Chair

Senator Louis Pate
Co-Chair

SUBCOMMITTEE MEMBERSHIP

THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON
HEALTH AND HUMAN SERVICES
SUBCOMMITTEE ON MENTAL HEALTH

MEMBERSHIP LIST
2011- 2012

Senator Louis Pate – Co-Chair

Senator Doug Berger

Senator Stan Bingham

Senator Fletcher Hartsell, Jr.

Senator Tommy Tucker

Representative Justin Burr – Co-Chair

Representative Marilyn Avila

Representative William Brisson

Representative Hugh Blackwell

Representative Bert Jones

STAFF

Jan Paul, Research

Patsy Pierce, Research

Joyce Jones, Bill Drafting

Joey Stansbury, Committee Clerk

Denise Thomas, Fiscal Research

Barbara Riley, Research

Susan Barham, Research

OVERVIEW OF SUBCOMMITTEE PROCEEDINGS

The Subcommittee on Mental Health Services of the Joint Legislative Oversight Committee on Health and Human Services held four meetings between September 10, 2012, and December 18, 2012.

September 10, 2012

Review of Law Establishing Subcommittee Charge
Denise Thomas, Fiscal Research

Overview of Major Mental Health Reform
History and Major Legislative and Policy Changes 2001 – Present
Jan Paul, Research

Impact on State Facilities and Community Psychiatric Hospitals
Ms. Laura White, Team Leader Psychiatric Hospitals
Division of State-Operated Healthcare Facilities

LME Perspective on Impact of Major Reform/Policy Changes
Pam Shipman, CEO PBH

Impact of Mental Health Policy on Law Enforcement
Sheriff Tony Perry, Camden County, President, NC Sheriffs' Association

October 8, 2012

Community Hospital Panel
Sandhills/Randolph Co. Psychiatry Contracts
Anthony Carraway, M.D., Sandhills LME/MCO
Kenny Burrow, CEO, Therapeutic Alternatives
Tremonteo Crawford, RN, MSN, Chief Nursing Officer, Randolph Hospital, Inc.

Durham Center Access (Facility-based Crisis)
Trish Hussey, Executive Director, Freedom House Recovery Center
Anita A. Daniels, MSW, LCSW, CSI, LCAS, Director, Durham Center Access
Logan Graddy, M.D., Medical Director, Freedom House Recovery Center

Presbyterian Hospital Peer Support Specialist Program
D. Dontae Latson, MSSA, LCSW, Director
Cherene Allen-Caraco, Mecklenburg Promise

Three-Way Contract Hospitals Overview
Denise Thomas, Fiscal Research

Hospitals with Three-way Contracts
Stephanie Greer, MBA, Director, Inpatient and Outpatient Behavioral Health Programs
Charles A. Cannon Jr. Memorial Hospital, Linville, NC
Victor Armstrong, Behavioral Medicine Program Manager
Alamance Regional Medical Center, Burlington, NC

State-Community Hospital-LME/MCO Solution-Based Planning
Dr. Beth Melcher, Chief Deputy Secretary, DHHS
Hugh Tilson, NC Hospital Association
Pam Shipman, Cardinal Innovations LME/MCO

December 10, 2012

Reviewing the Map: History and Process of Determining Facilities' Catchment Areas and How Current Catchment Areas Affect Local Communities
Laura White, Team Leader Psychiatric Hospitals, Division of State-Operated Healthcare Facilities

Overview of the Involuntary Commitment Process
Mark Botts, J.D., UNC School of Government

Telepsychiatry
Shelia Davies, MPA, Project Director, Albemarle Hospital Foundation
Edward Spencer, M.Ed., MSW, Program Manager, DMH Telepsychiatry Program, South Carolina Department of Mental Health

Three-Way Contract Payments
Dr. Beth Melcher, Chief Deputy Secretary, DHHS

Services for Members of the Military and Veterans with PTSD
Kimberly Alexander-Bratcher, Project Director, NCIOM
Harold Kudler, M.D., Mental Health Coordinator, Veterans Integrated Service Network, Durham VA Medical Center
Stephanie Nissen, LPC, LMHC, North Carolina National Guard

Subcommittee Discussion and Review of Draft Subcommittee Report

December 18, 2012

Subcommittee Review of Draft Subcommittee Report

SUMMARY OF SUBCOMMITTEE PROCEEDINGS

This section of the report provides a brief summary of the Subcommittee meetings. It is not intended to be a complete, official record of those meetings. However, there is an official record of the Subcommittee's meetings, including minutes and handouts distributed to the Subcommittee members, in the Legislative Library.

September 10, 2012

Co-Chairmen Senator Pate and Representative Burr welcomed members to the Subcommittee meeting and Denise Thomas, Fiscal Research reviewed the 2012 budgetary provisions establishing the charge of the Subcommittee. Jan Paul, Staff Attorney, Research, reviewed the history of State and county mental health services, focusing on major reform efforts since 2001. Ms. Paul discussed the State's responses to the Olmstead decision and other federal initiatives and mandates over the past decade.

Laura White, Hospital Team Leader for the Division of State-Operated Healthcare Facilities, DHHS, explained the impact of reform on the State facilities and community psychiatric hospitals. Ms. White included the following information during her presentation:

- After the Olmstead decision, DHHS and the Division of MH/DD/SAS developed a plan to expand community capacity and then reduce the size of the state psychiatric hospitals.
- Five hundred beds were closed rather than the seven hundred originally established. Among the beds closed were the adult long term, geriatric long term, and skilled nursing beds.
- $28 million was provided to the Local Management Entities (LMEs) on a one-time and recurring basis in order to support the services established for those being discharged from hospitals into the community as well as those who otherwise would have needed those hospital beds.

Pam Shipman, CEO of Piedmont Behavioral Health, provided a perspective on how major reform and policy changes have affected the LMEs, including the positive aspects of the managed care system which is being expanded via the 1915(b)/(c) waiver throughout the State.

Tony Perry, Sheriff of Camden County and President of the North Carolina Sheriffs' Association, addressed the impact of mental health reform on the law enforcement community. He said that the responsibility of transporting individuals with behavioral health needs to and from facilities is a State mandated law and that an officer could spend as much as 20 to 24 hours in transporting and wait time.

October 8, 2012

Anthony Carraway, Sandhills LME/MCO, Kenny Burrow, Therapeutic Alternatives, and Tremonteo Crawford Randolph Hospital, Inc., described the collaborative process among their agencies to provide psychiatric assessments and consultation to persons coming to the emergency department (ED) at Randolph Hospital. The presenters stated wait time in the ED has been reduced with the implementation of this service.

Trish Hussey, Executive Director, Freedom House Recovery Center, Anita A. Daniels, Director, Durham Center Access, and Logan Graddy, Medical Director, Freedom House Recovery Center, described the services provided by the Durham Access Center. The Durham Access Center is a crisis center providing these services to approximately 200 individuals per month with an average stay of 20 hours. Services include:

- 24-hour crisis facility
- 16 facility-based crisis beds – short-term stabilization for adults – alternative to inpatient hospitalization
- 11 23-hour crisis evaluation observation rooms (one for juveniles) – short-term intensive intervention to stabilize acute or crisis situations
- Telephone and face-to-face screening, triage and referral to community providers

Dontae Latson, MSSA, LCSW, Director, and Cherene Allen-Caraco, Mecklenburg's Promise, explained what "peer support" means and provided examples of different peer support models. They also discussed outcomes research related to providing peer supports to persons with mental health needs.

Denise Thomas, Fiscal Research, explained what a three-way contract between a community hospital, an LME/MCO, and DHHS entails. These contracts support community hospital beds for persons with mental health needs. Three-way contract managers, Stephanie Greer, Director, Inpatient and Outpatient Behavioral Health Programs, Charles A. Cannon Jr. Memorial Hospital, Linville, NC, and Victor Armstrong, Behavioral Medicine Program Manager, Alamance Regional Medical Center, Burlington, NC, described how the contracts are working for their hospitals. The contract managers indicated that the delay in payment from the State was reducing their ability to provide hospital beds to persons with mental illness in their communities.

Dr. Beth Melcher, DHHS, Hugh Tilson, NC Hospital Association, and Pam Shipman, Cardinal Innovations LME/MCO, shared concerns which had been expressed in meetings to address the problems created when persons with mental health needs repeatedly use EDs for all health and mental health needs.

December 10, 2012

Laura White, Hospital Team Leader, Division of State Operated Healthcare Facilities, Department of Health and Human Services, presented on the history of catchment areas/ admissions regions of the state psychiatric facilities. The hospital catchment areas were first

established in the N.C. Administrative Code in 1976, with the last major change to the admission regions coming in 2009, which created three rather than four state hospital regions in preparation for consolidation of Dorothea Dix Hospital and John Umstead Hospital into Central Regional Hospital. She outlined the hospital services subject to admission regions as well as those not subject to admission regions. Ms. White provided a map of the three regions and explained the criteria, including population and geographic proximity, used in determining equitable catchment areas, and described the transition planning process.

Mark Botts, J.D., UNC School of Government, provided an overview of the involuntary commitment process (IVC). His presentation focused on the criteria and procedure for IVC, and specifically what happens after a clinician or a layperson petitions for IVC, what occurs after a magistrate issues a custody and transportation order, and the process for transporting, examining, and affording due process to an individual for whom an involuntary commitment is sought.

Shelia Davies, MPA, Director, Albemarle Hospital Foundation, provided an overview and explained the goals of the North Carolina Hospital Telepsychiatry Network. She explained that the project was created to establish a hospital based two-way, real time, interactive audio and video network to improve the delivery of acute behavioral health care in hospitals and reduce the cost of delivering such care.

Edward Spencer, M.Ed., MSW, Program Manager,Telepsychiatry Program, South Carolina Department of Mental Health, described South Carolina's behavioral health partnership program to provide timely psychiatric assessment and rapid initiation of treatment, increased quality of care, reduced lengths of stay, comprehensive discharge planning, and savings to the hospital and community.

Dr. Beth Melcher, Chief Deputy Secretary, DHHS, addressed concerns previously expressed by Subcommittee members regarding late payments by DHHS to LMEs on three-way contracts designed to increase bed capacity within the community by paying hospitals for short-term care of mental health patients in crisis. She discussed adequacy of the payment rate, billing issues, the proposed payment process, and claims and contract spending.

Kimberly Alexander-Bratcher, Project Director, North Carolina Institute of Medicine, discussed the findings and recommendations of the NCIOM Task Force on Behavioral Health Services for the Military and Their Families. The General Assembly had asked the NCIOM to study the adequacy of mental health, developmental disabilities, and substance abuse services funded with Medicaid and state funds available to active and reserve component members of the military, veterans, and their families and to determine any gaps in services.

Harold Kudler, M.D., Mental Health Coordinator, Veterans Integrated Service Network, Durham VA Medical Center, described selected N.C. military/veteran demographics, various pervasive mental health problems reported among veterans, ongoing N.C. and national initiatives, treatment and provider training, and key steps in building military-friendly practices and health systems.

Stephanie Nissen, LPC, LMHC, North Carolina National Guard, outlined the Integrated Behavioral Health System. Ms. Nissen discussed the most common clinical and non-clinical referrals of service members, and current gaps in services for members of the military seeking treatment and assistance related to Post Traumatic Stress Disorder and other mental health conditions

Following the presentations, there was subcommittee discussion and a review of the subcommittee's draft findings and recommendations. The subcommittee members were informed that the final report would be discussed and voted upon at the next meeting on December 18, 2012.

December 18, 2012

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health met on Tuesday, December 18, 2012, to discuss its final report. Following discussion and the adoption of several amendments, the report was approved.

FINDINGS AND RECOMMENDATIONS

FINDING 1: The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health, heard from the Department of Health and Human Services, Division of State Operated Healthcare Facilities (DSOHF), about the total number of licensed and staffed psychiatric hospital beds in both community and operating state hospitals. DSOHF indicated that the total number of beds has decreased since 2001. The Subcommittee also learned that the average length of stay for individuals presenting to community hospital emergency departments (EDs) with a behavioral health crisis was 15 hours, 52 minutes. Over half of these patients (53%) were discharged to home or self-care. The Subcommittee finds that even though North Carolina's total population continues to increase, the psychiatric hospital bed census has decreased and that the operation of State psychiatric facilities is needed as a part of the continuum of mental health care and to help decrease the length of stay in EDs.

RECOMMENDATION 1: The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services encourage the General Assembly to direct the Department of Health and Human Services to (i) determine the cost of increasing the number of beds in State psychiatric hospitals, (ii) explore the possibility of creating a south central mental health region to include at least Anson, Cabarrus, Davidson, Mecklenburg, Montgomery, Moore, Randolph, Richmond, Rowan, Scotland, Stanly, and Union counties, and (iii) investigate the possibility of placing a new psychiatric facility in this region of the State. The Department shall provide a written report to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2013.

FINDING 2: The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health, heard from several providers about the burdensome and sometimes delayed process by which community hospitals bill and receive payments under the three-way contacts. In addition, the existing rate of $750 per day is insufficient to cover the cost to serve higher-need mental health patients.

RECOMMENDATION 2: The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services, encourage the General Assembly to direct the Department of Health and Human Services to work with community hospitals to develop a plan to (i) address delayed payments and (ii) revise three-way contract payment from a single rate model to a tiered rate structure based upon the patient's acuity level. The Department shall submit the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Chairs of the House and Senate HHS Appropriations Subcommittees no later than October 1, 2013.

FINDING 3: Based on current data shared during presentations, the Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health, understands that there are critical shortages of qualified mental health professionals in many areas across the State. The Subcommittee heard from two presenters that telepsychiatry is an effective option

to address these shortages. The Subcommittee finds that the shortage of qualified professionals adds to hospital ED wait time, involuntary commitments, and local law enforcement involvement in transport of patients who have been involuntarily committed, and that telepsychiatry may be an effective way to address some of these issues, especially in rural and underserved areas.

RECOMMENDATION 3(a): The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services encourage the General Assembly to direct the Department of Health and Human Services to develop a plan for a statewide telepsychiatry program. The Department's plan should include program costs and rates of payment for telepsychiatry services, and address liability issues related to participation in telepsychiatry. The Department shall submit its plan to the Joint Legislative Oversight Committee on Health and Human Services no later than October 1, 2013.

RECOMMENDATION 3(b): The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services encourage the General Assembly to direct the Department of Health and Human Services to investigate incentives and the removal of unnecessary practice barriers in order to increase the overall supply of psychiatrists, psychologists, and other mental health professionals, especially in rural and underserved areas of the State. The Department shall submit a written report to the Joint Legislative Oversight Committee on Health and Human Services no later than October 1, 2013.

FINDING 4: The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health, heard from several presenters about the increasing number of military veterans in North Carolina, and that many of these veterans exhibit behavioral health problems associated with Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD). Many of these veterans living in NC are experiencing homelessness, alcohol and other substance abuse problems, and criminal system involvement. The Subcommittee finds that because North Carolina is a military-friendly State and has a large number of veterans living in the State, and that veterans have specific behavioral health care needs, that the State should continue to link veterans to effective and efficient services.

RECOMMENDATION 4: The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services encourage the General Assembly to require that the Department of Health and Human Services continue to work with the Department of Veterans Affairs and other military groups to (i) increase training for mental health professionals in evidence-based practices designed specifically for individuals who are active or retired military, (ii) increase the numbers of veterans taking advantage of Medicaid and other federally funded assistance programs through targeted outreach through local DSS agencies and identifying veterans in the NCFAST program, and (iii) decrease homelessness among veterans. The Department shall submit a written report to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2013.

APPENDIX

Authorizing Legislation : S.L. 2012-142, Sec. 10.11, as amended by S.L. 21012-145, Sec. 3.4:

EXAMINATION OF THE STATE'S DELIVERY OF MENTAL HEALTH SERVICES

SECTION 10.11.(a) The Joint Legislative Oversight Committee on Health and Human Services shall appoint a subcommittee to examine the State's delivery of mental health services. As part of its examination, the subcommittee shall review all of the following:

(1) The State's progress in reforming the mental health system to deliver mental health services to individuals in the most integrated setting appropriate, without unnecessary institutionalization.

(2) The State's capacity to meet its growing mental health needs with community-based supports.

(3) The process for determining the catchment areas served by the State's psychiatric hospitals, with consideration of both of the following:

a. Factors used in assigning the geographic groupings of local management areas and managed care organizations into catchment areas.

b. Alternatives to the current process for determining the catchment areas served by the State's psychiatric hospitals, including a determination of whether there is a more efficient and equitable manner of assigning hospital catchment areas.

(4) The impact of implementing the 1915(b)/(c) Medicaid waiver and other mental health system reforms on public guardianship services, including at least all of the following:

a. Guardianship roles, responsibilities, and procedures.

b. The effect on existing relationships between guardians and wards.

c. Recommended legislation to support the transition of public guardianship services from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within the Department of Health and Human Services to county departments of social services.

SECTION 10.11.(b) The subcommittee shall report its findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services on or before January 15, 2013, at which time it shall terminate.

HISTORY OF NORTH CAROLINA'S BEHAVIORAL HEALTH DELIVERY SYSTEM

Jan Paul, Research Division
March 6, 2013

1700's, 1800's

County governments permitted to confine persons with mental illness in jails or poorhouses.

Mid-1800's

1849 – formation of North Carolina State Medical Society. Institution authorized for care of mentally ill.

1856 – Opened "State Hospital for the Insane," which became Dorothea Dix.

By 1914

- Two more state hospitals.
- State facility for individuals with mental retardation.

1930's

Local mental health clinics in Charlotte, Winston-Salem.

1946

National Mental Health Act, PL 487.

1950's

- Most individuals needing MHDDSAS services and almost all public funds went to or through state facilities.
- NC's MHDDSAS consisted of 4 state psychiatric hospitals, 4 mental retardation centers, and various other facilities.
- First of three Alcohol Treatment Centers established at Butner.

1963

- Movement towards creating community-based services to provide mental health treatment.
- Community Mental Health Centers Act, H.R. 58.
- NCGA authorized communities to collaborate with state agencies to create and operate mental health clinics.

1970

- Establishment of 42 Area Programs

- Governor established NC Drug Commission and first drug prevention treatment programs in the state.

1977

NCGA required counties to establish "Area Authorities." (Former G.S. 122C-35 et seq.)

1980's

1981 - Congress repealed the Community Mental Health Centers Act.

Responsibility for providing mental health and substance abuse services moved to public behavioral health services, primary care providers, emergency departments, law enforcement/courts.

1990

"Equal Opportunity for Individuals with Disabilities" (Americans with Disabilities Act, or ADA) enacted.
Title 42, U.S.C., Chapter 126

ADA Home Page: www.ada.gov

For text, go to:
www.ada.gov/pubs/ada.htm

Early 2000's – MAJOR MENTAL HEALTH REFORM

- (1) Olmstead v. L.C., 527 U.S. 581 (June 22, 1999).
- www.ada.gov/olmstead/index.htm

- (2) N.C. State Auditor's Report (April 2000).

July 5, 2000

- S.L. 2000-83
  - Established The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.
  - Directed the LOC to develop a plan to reform the state system for MH/DD/SAS.
  - Directed the Secretary of DHHS to overhaul NC's public system of MH/DD/SAS.

2001 – Major Mental Health Reform Legislation

October 2001 – N.C.'s mental health reform legislation was passed:

- Session Law 2001-437 (HB 381):
  An Act to Phase In Implementation Of Mental Health System Reform At The State And Local Level.

  - Primary intent -- deinstitutionalization and privatization of clinical services.

DHHS Plan: LMEs

The Secretary's State Plan 2001: Blueprint for Change, dated November 30, 2001.

http://www.ncdhhs.gov/mhddsas/statspublications/annualrptsstrategicplans/Strategicplan2001/sp01-staffcompetencies11-30.pdf

General Assembly Action

- Identified new funding for hospitalizations for uninsured patients in 3-way contracts between DHHS, LMEs and local hospitals.
- Provided support for mobile crisis and crisis intervention teams.
- Provided funding for local psychiatrists.

Post 2001

- Admissions to the four state hospitals continued to increase.
- Division of MH/DD/SAS instituted waiting lists for state hospital admissions.
- Demands on hospital emergency departments increased.

ValueOptions - 2002

- NC Division of Medical Assistance (DMA) entered into a contract with ValueOptions, Inc., to provide utilization review for Medicaid patients.

2005 - Piedmont Behavioral Health

- The state established Piedmont Behavioral Health (PBH) (now Cardinal Innovations) as a pilot Medicaid managed care vendor through the use of the Medicaid 1915 (b)/(c) Waiver Program.
- Pilot program expanded through S.L. 2008-107.
- S.L. 2010-31 required the designation of two additional expansion sites.

2008-2009 – CABHAs

- DHHS created new provider agencies called Critical Access Behavioral Health Agencies (CABHAs) to provide comprehensive and integrated services.
- By March 2012, more than 200 CABHAs had been certified in NC.

2009 - Medicaid Behavioral Health Managed Care

DHHS selected the 1915 (b)/(c) Medicaid Waiver Program was to control Medicaid-funded services.

1915(b) Waivers

1915(b) Waivers are one of several options available to states that allow the use of a *MANAGED CARE* delivery approach in the Medicaid Program.

1915(c) Waivers

1915(c) Waivers are one of many options available to states to allow the provision of long term care services in *HOME AND COMMUNITY BASED SETTINGS* under the Medicaid Program.

2010 – Affordable Care Act

States have options to:

- analyze financing and organizational structure
- promote care
- coordinate Medicaid behavioral health services with social services
- focus on preventive services and education
- use evidence-based practices in public behavioral health.

2011 – Disability Rights Lawsuit

- Disability Rights NC filed a complaint with the USDOJ based on the *Olmstead* decision, alleging that N.C. inappropriately institutionalizes individuals in adult care homes.
- In August 2012, North Carolina reached a settlement with the USDOJ to develop and implement strategies to transition individuals with mental illness out of adult care homes.

2011 – Waiver Expansion: S.L. 2011-264 (HB 916)

- The General Assembly passed House Bill 916 (S.L. 2011-264), requiring expansion of PBH's model managed behavioral health care program under the 1915(b)/(c) Medicaid Waiver.
  - Rapid statewide expansion of the 1915(b)/(c) Waivers
  - Phased merger of LMEs into Managed Care Organizations (MCOs). Medicaid behavioral health benefits to be carved out from other Medicaid benefits and managed by the LME/MCOs under contract with DHHS's Division of Medical Assistance.
  - County governments not liable for overspending or cost overruns.
  - LMEs failing to meet operational requirements by 1/1/13 to merge, align, or be reassigned.
- Implementation set for completion by July 1, 2013.

2012 – S.L. 2012-151 (S191)

- Amended the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 and other statutes to address identified barriers to the implementation of statewide expansion of the 1915(b)/(c) Medicaid Waiver.

Summary

Joint House Committee on Appropriations Subcommittee on Health and Human Services
Thursday, March 7, 2013, at 8:30 a.m.
Room 643

MINUTES

The House Committee on Appropriations Subcommittee on Health and Human Services met at 8:30 am on Thursday, March 7, 2013 in Room 643. Representatives Avila, Brisson, Farmer-Butterfield, Ford, Fulghum, Hollo, Insko, Lambeth, Martin and Murray attended. Senators Hise, Pate, McKissick, Robinson and Barringer attended.

Representative William Brisson, presided.
Representative Brisson, gaveled the meeting at 8:30am made opening remarks and introduced the Pages and Sergeants and Arms.
House Pages: Briana Jones, Leah Reynolds and Annie Snyder
Senate Pages: Chandler Evans
Sergeants at Arms – House: Charles Godwin and Fred Hines.
Sergeants at Arms – Senate: Ed Kesler and Steve Wilson.

Representative Brisson introduced Ms. Denise Thomas, Staff for the Fiscal Research Division for the NC General Assembly, presented Blue Ribbon Commission Report and Recommendations.

Mental Health Discussion/Wrap Up.

All presentations are attached to these minutes.

The meeting was adjourned at 9:50 am.

Representative William Brisson
Presiding

Caroline Stirling, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 28, 2013 12:42 PM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Thursday, March 07, 2013 at 8:30 AM

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Thursday	March 7, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

March 7, 2013
Legislative Office Building - Room 643
8:30 a.m.

Rep. William Brisson, Presiding	Welcome, Opening Remarks
Blue Ribbon Commission Report and Recommendations	Denise Thomas Staff Fiscal Research Division
Mental Health Discussion/Wrap Up	Committee
Adjourn	
Next Meeting:	Tuesday, March 12th, 8:30 a.m.

Blue Ribbon Commission on Transitions to Community Living

Joint House and Senate HHS Appropriations Subcommittee

March 7, 2013

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Presentation Outline

- Origin of Commission
- Proceedings
- Report and Recommendations

"The Perfect Storm"

- CMS concerns about different eligibility criteria for Medicaid-funded personal care services in private residences versus adult care homes
- Federal law classifies facilities with more than 16 mentally ill residents—ages 21-64—as Institutions for Mental Disease (IMD)
  - IMDs are ineligible to receive Medicaid reimbursement
  - Some NC adult care homes housed 10+ mentally ill residents
- U.S. Department of Justice investigation of possible violations of the Americans with Disabilities Act and the Olmstead Decision concerning the housing of mentally ill persons in the least restrictive setting

S.L. 2012-142, Sec.10.23A
Transitions to Community Living Initiative

The General Assembly finds that the State's long-term care industry plays a vital role in ensuring that citizens are afforded opportunities for safe housing and adequate client-centered supports in order to live as independently as possible in their homes and communities across the State.

This role is consistent with citizens of the State having the opportunity to live in the most appropriate, integrated settings of their choice.

The General Assembly also is committed to the development of a plan that continues to advance the State's current system into a statewide system of person-centered, affordable services and supports that emphasize an individual's dignity, choice, and independence and provides new opportunities and increased capacity for community housing and community supports.

BR Commission Charge

(i) examine the State's system of community housing and community supports for people with severe mental illness, severe and persistent mental illness, and intellectual and developmental disabilities and

(ii) develop a plan that continues to advance the State's current system into a statewide system of person-centered, affordable services and supports that emphasize an individual's dignity, choice, and independence.

BR Commission – 32 Members

- House and Senate Members
- DHHS Secretary
- DMH/DD/SAS Director
- DMA Director
- Housing Finance Agency Director
- Mental Health and DD Services Consumer
- Banking/Financial Institution
- LME/MCO
- County Government
- NC Association of Long-Term Care Facilities
- NC Assisted Living Association
- Family Care Homes
- Group Homes
- Supported Housing Service Provider

Commission Proceedings

- Commission consisted of two subcommittees:
  - Adult Care Homes
  - Housing
- Each Subcommittee met four times
- Each submitted a report on findings and recommendations to the Full Commission
- Report from the Blue Ribbon Commission on Transitions to Community Living submitted to the 2013 General Assembly

Blue Ribbon Commission
Adult Care Home Subcommittee
Findings and Recommendations

#1 Explore Alternatives for Large Adult Care Homes

- Directs DHHS to work with the adult care home industry to explore business and service delivery alternatives for repurposing large (16+ bed) adult care homes

- Report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, on or before September 1, 2013.

#2 Mitigate the Loss of Medicaid Eligibility by Those Exiting an Adult Care Home

- Directs DHHS to consider all options to mitigate the loss of Medicaid eligibility by those exiting an adult care home and no longer receiving State-County Special Assistance as an adult care home resident for this specific population for a set period of time.
- DHHS shall report findings and recommendations to the Senate and House HHS Appropriations Subcommittees on or before March 1, 2013.

#3: Establish a Long-Term Care Continuum Workgroup

- Directs DHHS to establish a workgroup including stakeholders, Departmental personnel, and unbiased experts, to explore changes to North Carolina's long-term care continuum, including, but not limited to: expansion of waiver options and potential new licensure structure, and assuring that individuals are not unduly offered more restrictive placements than needed and are assured of receiving skilled nursing care as designated through assessment.
- Interim report due on or before April 1, 2013, and a final report of findings and recommendations on or before October 1, 2013, to the Senate and House Appropriations HHS Subcommittees

#4 Explore a Supplement to be Paid on Behalf of an ACH Resident

- Directs DHHS to explore establishing a process to allow payment by an individual or family member on behalf of a recipient of State-County Special Assistance when that recipient has lost their eligibility for Medicaid Personal Care Services (PCS), and those Medicaid PCS services are not covered under a Medicaid appeal process.
- DHHS shall report findings and recommendations to the Senate and House HHS Appropriations Committee on or before March 1, 2013.

#5 Study Tiered Personal Care Services

- Directs DHHS investigate tiered Medicaid Personal Care Services with eligibility criteria and a related rate structure based on assessed intensity of need. The Department shall consider coverage for medication management and for those individuals that have Alzheimer's disease or related dementias
- Report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, on or before October 1, 2013.

#6 Study State-County Special Assistance Rate Structure

- Directs DHHS to study State-County Special Assistance to:

  1) develop alternative cost methodology options for determining rates, and

  2) to investigate the feasibility of a tiered rate structure to address assessed resident needs based on the intensity of need, including medication management.

- Report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, and to the Senate Appropriations Committee on Health and Human Services and House Appropriations Subcommittee on Health and Human Services, on or before October 1, 2013.

#7 Habilitation Services for Adults with Intellectual/Developmental Disabilities (I/DD)

Directs DHHS to prepare a 1915 (i) option application with a narrow focus on habilitation services for adults with intellectual and other developmental disabilities. Eligibility for this 1915(i) option must be carefully constructed to consider assessed needs of the individual and to assure that these needs do not meet the criteria and intensity of need for ICF-IDD level of care. This 1915(i) option should be incorporated into the support needs process and the management and capitation of the LME/MCOs.

Additionally, cost containment and comparability must be addressed, and projections for costs and number of eligible recipients must be provided when the application draft is submitted for review to the Senate Appropriations Committee on Health and Human Services, and House Appropriations Subcommittee on Health and Human Services, on or before February 1, 2013.

The Department shall not take further action on the application until there is approval by the NC General Assembly.

#8 Explore Service Delivery Options for Individuals with Mental Illness

- Directs DHHS to expand upon and develop new service definitions and delivery options to meet the needs of individuals with a primary diagnosis of mental illness by: (1) considering an addition and expansion of 1915(b)(3) services, and (2) review of State Plan services and making clinical and rate recommendations to amend the 1915(b) waiver upon approval of the NC General Assembly.

- DHHS shall report findings, anticipated costs, and recommendations to the Senate and House HHS Appropriations Committees on or before March 1, 2013.

#9 CAP-IDD (Innovations) Medicaid Waiver Slots

Directs DHHS to expand the number of available CAP-IDD (Innovations) Medicaid Waiver slots within current funding and to unfreeze current slots within current funding constraints.

Report on the status of the CAP-IDD (Innovations) waiver slots to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

Blue Ribbon Commission
Housing Subcommittee
Findings and Recommendations

Increase Number of Permanent Housing Units

- Direct that future State, federal or other sources of expansion funding provided to the NC Housing Trust Fund, the Key Program, and other state housing assistance programs be designated specifically to increase the number of permanent housing units, in addition to existing temporary or transitory housing

- In the absence of increased funding for this purpose, the State should consider targeting some portion of existing funding toward projects that increase supportive housing availability

Transitions to Community Living Fund

- Encourage that, of the $10.3 million appropriated in S.L. 2012-142, Section 10.23A.(e), any unspent funds remaining on June 30, 2013 and any future funding provided for this purpose, shall not revert but shall be transferred to, and deposited into, a special reserve account within the Housing Trust Fund
- These funds shall be used only for the purpose of providing supportive housing to persons with mental disabilities and shall remain in a special reserve account until appropriated by an act of the General Assembly
- The special reserve account shall be terminated on June 30, 2020, and any funds remaining in the account on that date shall revert to the General Fund

Increase Availability of Rental Housing for Persons with Mental Illness

- Direct DHHS to evaluate the capacity of the automated databases used by state agencies to monitor the inventory of available rental housing and take the necessary actions to expand landlords' access to and use of these data systems.
- Directs North Carolina Housing Finance Agency and the Department of Health and Human Services to explore the possibility of increasing the percentage of targeted units in new developments from 10% to a greater percentage.

Tenant-Based Rental Assistance Program

- Directs DHHS and the NC Housing Finance Agency to develop a plan to establish a state funded and administered tenant-based rental assistance program (TBRA) specifically designated for the 3,000 persons who must be transitioned to community-based housing as required by the U.S. DOJ settlement agreement.

- The TBRA plan shall identify the housing needs within each MCO catchment area. No later than March 1, 2013, DHHS shall submit a preliminary plan, including budgetary and other resource needs, to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services Appropriations Subcommittees, and the House and Senate General Government Appropriations Subcommittees.

LME/MCO Community Partnerships

- Encourage LMEs to form partnerships with existing non-profit and other agencies that currently provide supportive housing assistance and other services to persons with qualifying disabilities in home and community-based settings.

Availability of Home and Community-Based Services

Directs DHHS and the LMEs/MCOs to determine the additional services and resources needed to support the transition of 3,000 mentally ill persons from adult care homes to community-based settings by June 30, 2020.

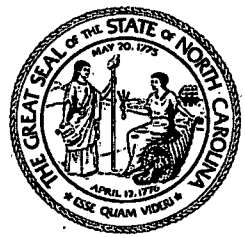
No later than March 1, 2013, DHHS shall submit a written report to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services Appropriations Subcommittees and the House and Senate General Government Appropriations Subcommittees.

Maximize Use of Assistive Technology

Directs DHHS and the LMEs/MCOs to identify specific assistive technology that can be used to divert or transition persons with mental disabilities from institutional settings.

DHHS shall develop a plan to maximize the use of assistive technology in the implementation of the U.S. DOJ settlement agreement.

No later than March 1, 2013, DHHS shall submit an assistive technology plan to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services



NORTH CAROLINA GENERAL ASSEMBLY

BLUE RIBBON COMMISSION ON TRANSITIONS TO COMMUNITY LIVING

Co-chairs:
Representative Nelson Dollar
Senator Ralph Hise

FINAL REPORT TO THE 2013 GENERAL ASSEMBLY

DECEMBER 19, 2012

COPIES OF THIS REPORT MAY BE OBTAINED FROM:

The Legislative Library
Legislative Office Building – Room 500
919-733-9390

COMMISSION
TRANSMITTAL LETTER

To: 2013 General Assembly

Date: December 19, 2012

The Blue Ribbon Commission on Transitions to Community Living was created by Session Law 2012-142, Section 10.23A, as amended by Session Law 2012-145, Section 3.6. In accordance with the authorizing legislation, the Commission was composed of 32 members and consisted of a Subcommittee on Adult Care Homes and a Subcommittee on Housing. The Blue Ribbon Commission on Transitions to Community Living met on September 5, 2012, and on December 19, 2012.

The Subcommittee on Adult Care Homes and the Subcommittee on Housing each met four times between September 12, 2012, and December 12, 2012. During their respective meetings on December 12th, each Subcommittee approved a report for submission to the Blue Ribbon Commission on Transitions to Community Living. This report incorporates the Proceedings, Findings, and Recommendations as amended, from the two Subcommittees.

The findings and recommendations, as amended, from the Subcommittee on Adult Care Homes and the Subcommittee on Housing were adopted by the full Commission and are reported as the findings and recommendations of the Blue Ribbon Commission on Transitions to Community Living. This report from the Blue Ribbon Commission on Transitions to Community Living is respectfully submitted to the 2013 General Assembly.

Representative Nelson Dollar
Co-Chair

Senator Ralph Hise
Co-Chair

TABLE OF CONTENTS

COMMISSION MEMBERSHIP

The Blue Ribbon Commission on Transitions to Community Living, created by Session Law 2012-142, Section 10.23A, as amended by Session Law 2012-145, Section 3.6, was composed of the 32 members provided below.

Representative Nelson Dollar - Co-Chair	Senator Ralph Hise, Jr. - Co-Chair
Representative Marilyn Avila	Senator Stan Bingham
Representative William Brisson	Senator Andrew Brock
Representative Justin Burr	Senator Peter Brunstetter
Representative Mark Hollo	Senator Ellie Kinnaird
Representative Fred F. Steen, II	Senator Louis Pate, Jr.
Mr. Albert Delia	Mr. James Jarrard
Mr. Michael Watson	Mr. Robert Kucab
Mr. John Bocciardi	Mr. Hugh Campbell
Mr. Connie Cochran	Mr. Floyd Davis
Ms. Jeanne Duncan	Mr. Sam Hooker
Mr. Ken Jones	Mr. Steve Keen
Mr. Paul Kennedy	Ms. Leigh Ann Kingsbury
Mr. Mark Long	Ms. Ann Medlin
Ms. Pam Shipman	Ms. Regina Stavredes
Dr. Peggy Terhune	Ms. Rosemary Weaver

SUBCOMMITTEE ON ADULT CARE HOMES MEMBERSHIP

The Blue Ribbon Commission on Transitions to Community Living consisted of a Subcommittee on Adult Care Homes composed of the members provided below.

Representative Nelson Dollar, Co-Chair

Representative William Brisson

Representative Mark Hollo

Mr. Hugh Campbell

Mr. Connie Cochran

Mr. Sam Hooker

Ms. Leigh Ann Kingsbury

Mr. Michael Watson, Director
Division of Medical Assistance, DHHS

Mr. Jim Jarrard, Director,
Division Mental Health, Developmental Disabilities and Substance Abuse Services, DHHS

Senator Stan Bingham, Co-Chair

Senator Peter Brunstetter

Senator Louis Pate, Jr.

Mr. Mark Long

Dr. Peggy Terhune

Ms. Ann Medlin

Ms. Pam Shipman

Mr. Dennis Streets, Director
Division of Aging & Adult Services, DHHS

Staff

Dr. Patricia Porter, Consultant

Ms. Maria Kinnaird, Committee Assistant

Ms. Theresa Matula, Research Division

Ms. Amy Jo Johnson, Research Division

Mr. Donnie Charleston, Fiscal Research Division

Ms. Joyce Jones, Bill Drafting Division

Ms. Candace Slate, Committee Assistant

Ms. Sara Kamprath, Research Division

Dr. Patsy Pierce, Research Division

SUBCOMMITTEE ON HOUSING MEMBERSHIP

The Blue Ribbon Commission on Transitions to Community Living consisted of a Subcommittee on Housing composed of the members provided below.

Representative Justin Burr, Co-Chair	Senator Ralph Hise, Jr., Co-Chair
Representative Marilyn Avila	Senator Andrew Brock
Representative Fred Steen, II	Senator Ellie Kinnaird
Mr. John Bocciardi	Mr. Floyd Davis
Ms. Jeanne Duncan	Mr. Ken Jones
Mr. Steve Keen	Mr. Paul Kennedy
Mr. Bob Kucab	Ms. Regina Stavredes
Ms. Rosemary Weaver	
Ms. Martha Are, Division of Aging & Adult Services, DHHS	Dr. Beth Melcher, Deputy Secretary, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS

Staff

Ms. Dina Long, Committee Assistant	Ms. Shelly Carver, Committee Assistant
Ms. Janice Paul, Research Division	Ms. Susan Barham, Research Division
Mr. Brad Krehely, Research Division	Ms. Barbara Riley, Research Division
Ms. Denise Thomas, Fiscal Research Division	Mr. Mark Bondo, Fiscal Research Division

EXECUTIVE SUMMARY

Provided below are the recommendations, as amended, from the Subcommittee on Adult Care Homes and the Subcommittee on Housing. Findings for these recommendations may be found in the Findings and Recommendations section of this report for each Subcommittee. On December 19, 2012, the Blue Ribbon Commission adopted these recommendations.

RECOMMENDATIONS FROM THE SUBCOMMITTEE ON ADULT CARE HOMES

RECOMMENDATION 1: EXPLORE ALTERNATIVES FOR LARGE ADULT CARE HOMES

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services to work with the adult care home industry to explore business and service delivery alternatives for repurposing large (16+ bed) adult care homes. The Department must explore, but is not limited to, the following options: a Request for Proposal (RFP) process and funding to transition adult care homes to alternative service options; expansion and/or transition to address the needs of special populations (e.g. traumatic brain injury); options tied to any changes in restructuring of the skilled nursing facility and adult care home continuum; and all methods for reducing the number and costs of large adult care home facilities. The Department shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, on or before September 1, 2013.

RECOMMENDATION 2: MITIGATE THE LOSS OF MEDICAID ELIGIBILITY BY THOSE EXITING AN ADULT CARE HOME

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services to consider all options to mitigate the loss of Medicaid eligibility by those exiting an adult care home and no longer receiving State-County Special Assistance as an adult care home resident for this specific population for a set period of time. The Department must explore, but is not limited to, the following options: the implications of tying the receipt of SA In-Home to Medicaid eligibility as is the current practice for SA-ACH recipients; acquiring a federal disregard for residents moving from a facility to a home to allow a waiver of their deductible; and investigating the Medicaid Health Insurance Premium Payment Program provision to determine whether Medicaid can pay the "premium" for these individuals so they remain Medicaid eligible. The Department shall report findings and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

RECOMMENDATION 3: ESTABLISH A LONG-TERM CARE CONTINUUM WORKGROUP

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services to establish a workgroup including stakeholders, Departmental personnel, and unbiased experts, to explore changes to North Carolina's long-term care continuum, including, but not limited to: expansion of waiver options and potential new licensure structure, and assuring that individuals are not unduly offered more restrictive placements than needed and are assured of receiving skilled nursing care as designated through assessment. The Department must make an interim report on or before April 1, 2013, and a final report of findings and recommendations on or before October 1, 2013, to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Health and Human Services.

RECOMMENDATION 4: EXPLORE A SUPPLEMENT TO BE PAID ON BEHALF OF AN ACH RESIDENT

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services to explore establishing a process to allow payment by an individual or family member on behalf of a recipient of State-County Special Assistance when that recipient has lost their eligibility for Medicaid Personal Care Services (PCS), and those Medicaid PCS services are not covered under a Medicaid appeal process. The Department shall report findings and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

RECOMMENDATION 5: STUDY TIERED PERSONAL CARE SERVICES

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services to investigate tiered Medicaid Personal Care Services with eligibility criteria and a related rate structure based on assessed intensity of need. The Department shall consider coverage for medication management and for those individuals that have Alzheimer's disease or related dementias, and shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, on or before October 1, 2013.

RECOMMENDATION 6: STUDY STATE-COUNTY SPECIAL ASSISTANCE RATE STRUCTURE

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services to study State-County Special Assistance to: 1) develop alternative cost methodology options for determining rates, and 2) to investigate the feasibility of a tiered rate structure to address assessed resident needs based on the intensity of need, including medication management. The Department shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, and to the Senate Appropriations Committee on Health and Human Services and House Appropriations Subcommittee on Health and Human Services, on or before October 1, 2013.

RECOMMENDATION 7: HABILITATION SERVICES FOR IDD ADULTS

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services to prepare a 1915(i) option application with a narrow focus on habilitation services for adults with intellectual and other developmental disabilities. Eligibility for this 1915(i) option must be carefully constructed to consider assessed needs of the individual and to assure that these needs do not meet the criteria and intensity of need for ICF-IDD level of care. This 1915(i) option should be incorporated into the support needs process and the management and capitation of the LME/MCOs. Additionally, cost containment and comparability must be addressed, and projections for costs and number of eligible recipients must be provided when the application draft is submitted for review to the Senate Appropriations Committee on Health and Human Services, and House Appropriations Subcommittee on Health and Human Services, on or before February 1, 2013. The Department shall not take further action on the application until there is approval by the NC General Assembly.

RECOMMENDATION 8: EXPLORE SERVICE DELIVERY OPTIONS FOR INDIVIDUALS WITH MENTAL ILLNESS

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services to expand upon and develop new service definitions and delivery options to meet the needs of individuals with a primary diagnosis of mental illness by: (1) considering an addition and expansion of 1915(b)(3) services, and (2) review of State Plan services and making clinical and rate recommendations to amend the 1915(b) waiver upon approval of the NC General Assembly. The Department shall present findings, anticipated costs, and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

RECOMMENDATION 9: CAP-IDD (INNOVATIONS) MEDICAID WAIVER SLOTS

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services to expand the number of available CAP-IDD (Innovations) Medicaid-waiver slots within current funding and to unfreeze current slots within current funding constraints. The Department shall report on the status of the CAP-IDD (Innovations) waiver slots to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

RECOMMENDATIONS FROM THE SUBCOMMITTEE ON HOUSING

RECOMMENDATION #1:

The Blue Ribbon Commission on Transitions to Community Living directs that future State, federal or other sources of expansion funding provided to the NC Housing Trust Fund, the Key Program, and other State housing assistance programs be designated specifically to increase the number of permanent housing units, in addition to existing temporary or transitory housing. In the absence of increased funding for this purpose, the State should consider targeting some portion of existing funding toward projects that increase supportive housing availability.

RECOMMENDATION #2:

The Blue Ribbon Commission on Transitions to Community Living encourages that, of the $10.3 million appropriated in S.L. 2012-142, Section 10.23A.(e), any unspent funds remaining on June 30, 2013 and any future funding provided for this purpose, shall not revert but shall be transferred to, and deposited into, a special reserve account within the Housing Trust Fund. These funds shall be used only for the purpose of providing supportive housing to persons with mental disabilities and shall remain in a special reserve account until appropriated by an act of the General Assembly. The special reserve account shall be terminated on June 30, 2020, and any funds remaining in the account on that date shall revert to the General Fund.

RECOMMENDATION #3:

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services to evaluate the capacity of the automated databases used by State agencies to monitor the inventory of available rental housing and take the necessary actions to expand landlords' access to and use of these data systems.

RECOMMENDATION #4:

The Blue Ribbon Commission on Transitions to Community Living directs the North Carolina Housing Finance Agency and the Department of Health and Human Services to explore the possibility of increasing the percentage of targeted units in new developments from 10% to a greater percentage.

RECOMMENDATION #5:

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services and the NC Housing Finance Agency to develop a plan to establish a State funded and administered tenant-based rental assistance program (TBRA) specifically designated for the 3,000 persons who must be transitioned to community-based housing as required by the U.S. DOJ settlement agreement. The TBRA plan shall identify

the housing needs within each MCO catchment area. No later than March 1, 2013, DHHS shall submit a preliminary plan, including budgetary and other resource needs, to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services Appropriations Subcommittees, and the House and Senate General Government Appropriations Subcommittees.

RECOMMENDATION #6:

The Blue Ribbon Commission on Transitions to Community Living encourages LMEs to form partnerships with existing non-profit and other agencies that currently provide supportive housing assistance and other services to persons with qualifying disabilities in home and community-based settings.

RECOMMENDATION #7:

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services (DHHS) and the LMEs/MCOs to determine the additional services and resources needed to support the transition of 3,000 mentally ill persons from adult care homes to community-based settings by June 30, 2020. No later than March 1, 2013, DHHS shall submit a written report to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services Appropriations Subcommittees and the House and Senate General Government Appropriations Subcommittees.

RECOMMENDATION #8:

The Blue Ribbon Commission on Transitions to Community Living directs the Department of Health and Human Services and the LMEs/MCOs to identify specific assistive technology that can be used to divert or transition persons with mental disabilities from institutional settings. DHHS shall develop a plan to maximize the use of assistive technology in the implementation of the U.S. DOJ settlement agreement. No later than March 1, 2013, DHHS shall submit an assistive technology plan to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services Appropriations Subcommittees, and the House and Senate General Government Appropriations Subcommittees.

FINDINGS AND RECOMMENDATIONS BY SUBCOMMITTEE

FINDINGS AND RECOMMENDATIONS ADULT CARE HOMES SUBCOMMITTEE

The findings and recommendations below, as amended, are based on information provided to the Blue Ribbon Commission on Transitions to Community Living, Subcommittee on Adult Care Homes, during its regularly-scheduled meetings. Many of the issues explored by this Subcommittee continue to evolve. The recommendations included in this report request the Blue Ribbon Commission on Transitions to Community Living to direct the Department of Health and Human Services to explore specific issues that may need further study or action in the near future. The recommendations require reports to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Health and Human Services. These Committees should follow-up on the recommendations contained in the report as they deem necessary and appropriate to their work.

FINDING 1:

During the Blue Ribbon Commission meeting on September 5, 2012, the Commission, which included members of the Adult Care Homes Subcommittee, heard a presentation on the Americans with Disabilities Act (ADA) and the *Olmstead* Decision. The Commission also heard a presentation on the Settlement Agreement between the United States Department of Justice and the State of North Carolina. One of the substantive provisions provided in the US DOJ Settlement Agreement is as follows:

> "The State agrees to develop and implement effective measures to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports identified through person centered planning in the most integrated setting appropriate to meet the needs of individuals with SMI [Serious Mental Illness], who are in or at risk of entry to an adult care home, pursuant to the details and timelines set forth below."

During the Subcommittee meeting on September 11, 2012, members heard presentations on adult care homes and the challenges they face. Theresa Matula, Subcommittee staff, provided information on adult care homes and their residents which was based on data provided by the Division of Health Service Regulation. Ms. Matula's presentation included a breakdown of the numbers of beds and facilities by county and in the State as a whole. A panel of Commission members representing various types of facilities provided information on residents; funding sources; and the combined impact of the requirements of the US DOJ Settlement Agreement, the designation of some facilities as Institutions of Mental Disease, and the potential impact of the Medicaid Personal Care Services eligibility criteria and independent assessments. The panel was also provided an opportunity to suggest possible solutions for the people who reside in the facilities and for the industry. Suggestions from representatives of the adult care home industry included the following: alternative funding streams that are not Activities of Daily Living

(ADL) driven to serve the individuals residing in Adult Care Homes (ACH) who do not need ADL assistance but do require ACH level of care; Secure the I-Option for Adult Care Home Special Care Units (SCU); explore adding Fair Rental Value type incentive program to encourage providers to reinvest in the physical plant; and allow ACH beds approved under Certificate of Need (CON) rules to provide alternative housing options – such as 16-bed conversions for Mental Health services.

During the November 12th meeting, the Subcommittee heard a presentation by Dr. Janet O'Keeffe, Senior Researcher and Policy Analyst, RTI International. Dr. O'Keeffe questioned whether North Carolina should examine its continuum of care and perhaps evaluate adjustment of the admission criteria for nursing homes, licensed under Chapter 131E of the General Statutes. She suggested that if such an evaluation resulted in a need for more nursing homes, a conversion of some adult care homes to nursing homes could be an option.

The Subcommittee is concerned for individuals who depend on services, and the responsibility of the State to ensure that a range of services is provided to meet the needs and preferences of consumers. Therefore, the Subcommittee makes Recommendation 1 to direct the Department of Health and Human Services to explore alternatives for large adult care homes.

RECOMMENDATION 1: EXPLORE ALTERNATIVES FOR LARGE ADULT CARE HOMES

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living recommends the Blue Ribbon Commission direct the Department of Health and Human Services to work with the adult care home industry to explore business and service delivery alternatives for repurposing large (16+ bed) adult care homes. The Department must explore, but is not limited to, the following options: a Request for Proposal (RFP) process and funding to transition adult care homes to alternative service options; expansion and/or transition to address the needs of special populations (e.g. traumatic brain injury); options tied to any changes in restructuring of the skilled nursing facility and adult care home continuum; and all methods for reducing the number and costs of large adult care home facilities. The Department shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, on or before September 1, 2013.

FINDING 2:

On November 14, 2012, the Subcommittee heard a presentation on State-County Special Assistance by Suzanne Merrill, DAAS, DHHS. Ms. Merrill reported that the State-County Special Assistance for Adult Care Homes (SA-ACH) program is an Optional State Supplement (OSS) program to the Social Security Income (SSI) program. In North Carolina, Medicaid is automatic for SSI recipients under an agreement with the Social Security Administration. Therefore, recipients eligible for SA-ACH are automatically eligible for Medicaid. SA-ACH is available to eligible residents of adult care homes licensed under Chapter 131D of the General Statutes, and residents of supervised living

facilities, licensed under Chapter 122C of the General Statutes, and as defined in accordance with 10A NCAC 27G.5601, that serve adults whose primary diagnosis is mental illness but may also have other diagnoses, and that serve adults whose primary diagnosis is a developmental disability but may also have other diagnoses.

By contrast, the State-County Special Assistance In-Home program (SA In-Home) was established by the North Carolina General Assembly and is not part of the OSS program. Individuals receiving SA In-Home must qualify for Medicaid separately. Due to varying requirements, residents living in adult care homes end up having lower income eligibility requirements for Medicaid than the individuals receiving SA In-Home. If SA-ACH residents are discharged from facilities and end up in a non-facility setting, the individual loses the automatic eligibility for Medicaid that accompanied their SA-ACH. These individuals may qualify for SA In-Home, but Medicaid would no longer be automatic and they would be required to apply for Medicaid. The DHHS estimates that 27% of all SA-ACH recipients would not qualify for Medicaid if transitioned to SA In-Home and required to meet the higher income eligibility criteria. As such, the Subcommittee makes Recommendation 2 to mitigate the loss of Medicaid eligibility by those exiting an adult care home.

RECOMMENDATION 2: MITIGATE THE LOSS OF MEDICAID ELIGIBILITY BY THOSE EXITING AN ADULT CARE HOME

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to consider all options to mitigate the loss of Medicaid eligibility by those exiting an adult care home and no longer receiving State-County Special Assistance as an adult care home resident for this specific population for a set period of time. The Department must explore, but is not limited to, the following options: the implications of tying the receipt of SA In-Home to Medicaid eligibility as is the current practice for SA-ACH recipients; acquiring a federal disregard for residents moving from a facility to a home to allow a waiver of their deductible; and investigating the Medicaid Health Insurance Premium Payment Program provision to determine whether Medicaid can pay the "premium" for these individuals so they remain Medicaid eligible. The Department shall report findings and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

FINDING 3:

Long-term care service options, the range of services, and the corresponding admission or eligibility criteria was a common theme throughout the Subcommittee's meetings. During the September 12th panel discussion, a representative of the adult care home industry provided that, "There needs to some type of acuity-based reimbursement system. If not, individuals with the lowest needs will end up in the most expensive service settings. Conversely, residents with some of the greatest needs will end up remaining in ACHs." During the November 12th presentation by Dr. Janet O'Keeffe, Senior Researcher and Policy Analyst, RTI International, she questioned whether North Carolina

should examine its continuum of care and she gave examples of how some other states are structured. Dr. O'Keeffe discussed North Carolina's nursing bed admission criteria, the amount of State-County Special Assistance provided to facilities, and adjustment of the eligibility criteria for nursing homes licensed under Chapter 131E of the General Statutes. Dr. O'Keeffe suggested that more stringent admission standards for nursing homes may prevent North Carolina from applying for more waivers to cover certain individuals. One of the states mentioned by Dr. O'Keeffe was Florida which has three levels of care. As a result of the information shared by all, the Subcommittee makes Recommendation 3 to establish a long-term care continuum workgroup.

RECOMMENDATION 3: ESTABLISH A LONG-TERM CARE CONTINUUM WORKGROUP

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to establish a workgroup including stakeholders, Departmental personnel, and unbiased experts, to explore changes to North Carolina's long-term care continuum, including, but not limited to: expansion of waiver options and potential new licensure structure, and assuring that individuals are not unduly offered more restrictive placements than needed and are assured of receiving skilled nursing care as designated through assessment. The Department must make an interim report on or before April 1, 2013, and a final report of findings and recommendations on or before October 1, 2013, to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Health and Human Services.

FINDING 4:

The Subcommittee heard numerous presentations on the Medicaid Personal Care Services (PCS) changes for residents of licensed facilities and the status of the independent assessment process. The Subcommittee received information during the November 14th meeting on the numbers and percentages of individuals that will not qualify for Medicaid PCS on January 1, 2013. Also during the November 14th meeting, the DHHS provided responses to questions about care and supplementing care in an adult care home. The Department provided the following, "The licensed adult care home is responsible for care and services planned and provided to the resident. If the facility does not employ their own staff to provide scheduled personal care services they could contract for services through a licensed home care agency, but they would remain responsible for the quality and delivery of those services." The DHHS was asked specifically if family members could contribute to the cost of care for a family member who is a resident of an adult care home and not jeopardize Special Assistance. The response was, "The question has been researched in terms of SSI's and NC's Optional State Supplement Program (SA) and continued Medicaid eligibility and a family's voluntary payment to a facility for personal care would not be counted as income for SSI and our State Supplement Program (SA) nor would it be counted as income for Medicaid." Consistent with these findings, the Subcommittee provides Recommendation 4 to direct DHHS to explore establishing a

process to allow a supplement to be paid by an individual or family member on behalf of an adult care home resident for a recipient that has lost eligibility for Medicaid Personal Care Services.

RECOMMENDATION 4: EXPLORE A SUPPLEMENT TO BE PAID ON BEHALF OF AN ACH RESIDENT

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to explore establishing a process to allow payment by an individual or family member on behalf of a recipient of State-County Special Assistance when that recipient has lost their eligibility for Medicaid Personal Care Services (PCS), and those Medicaid PCS services are not covered under a Medicaid appeal process. The Department shall report findings and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

FINDING 5 AND 6:

During the course of its existence, the Subcommittee monitored the Medicaid Personal Care Services (PCS) independent assessment process for licensed facility residents. On November 14th, the Subcommittee received a report of independent assessments completed as of October 26, 2012. The data provided the number of assessments processed by setting, and the number and percentage of individuals qualifying for the new PCS criteria and those not qualifying. Additionally, this data provided: the age distribution of non-qualified beneficiaries; a diagnosis summary with percentages reflecting the diagnosis category selected by attesting practitioners; the average number of activities of daily living (ADLs) needed for those that qualified and those that do not; the numbers of hands-on ADL needs for those that qualify and those that do not; and the personal care needs of PCS non-qualified beneficiaries. For those not qualifying for PCS, the information indicated what percentage of residents in a particular care setting needed supervision/cueing, or hands-on assistance, for the following needs: bathing, dressing, mobility, toileting, eating, and medication management. The changes to PCS for facilities enacted in S.L. 2012-142, Section 10.9F, as amended, are effective January 1, 2013. Should the State decide to add a layer of service at a later date, the independent assessment data and the information requested in Recommendations 5 and 6 would facilitate such an option. Recommendation 5 directs the DHHS to investigate tiered PCS with eligibility criteria and a related rate structure tied to the assessed intensity of need and to explore coverage for medication management and for those individuals with Alzheimer's disease or related dementias. The second part of Recommendation 6 requires the DHHS to investigate the feasibility of a tiered State-County SA rate structure to address assessed resident needs based on the intensity of need, including medication management. Exploring both alternatives would provide the State with the ability to determine the best course of action, if any further action were desired.

The Subcommittee explored the interrelationship between the different funding streams for long term care (Medicaid and State revenue). Presentations by staff and outside

experts examined the State-County SA program and its cost methodology, as well as the history of Medicaid PCS. The presentations showed that North Carolina stands out as having a high level of SA expenditures relative to other States with similar adult care home structures. North Carolina is responsible for approximately 20% of the nation's Medicaid funded ACH residents and has a high level of PCS expenditures. The historic funding overview provided during the meeting on November 14th, depicted how the nature of the two programs have changed relative to their original scope and intent. As contained in Recommendation 6, the Subcommittee recommends the Department of Health and Human Services study State-County Special Assistance to develop alternative cost methodology options for determining rates.

RECOMMENDATION 5: STUDY TIERED PERSONAL CARE SERVICES

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services investigate tiered Medicaid Personal Care Services with eligibility criteria and a related rate structure based on assessed intensity of need. The Department shall consider coverage for medication management and for those individuals that have Alzheimer's disease or related dementias, and shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, on or before October 1, 2013.

RECOMMENDATION 6: STUDY STATE-COUNTY SPECIAL ASSISTANCE RATE STRUCTURE

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services study State-County Special Assistance to: 1) develop alternative cost methodology options for determining rates, and 2) to investigate the feasibility of a tiered rate structure to address assessed resident needs based on the intensity of need, including medication management. The Department shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, and to the Senate Appropriations Committee on Health and Human Services and House Appropriations Subcommittee on Health and Human Services, on or before October 1, 2013.

FINDING 7:

On November 14, 2012, the Subcommittee heard Ms. Tara Larson, DMA, DHHS, explain that planning continues on the Medicaid 1915(i) option application for adults with Intellectual and Developmental Disabilities (IDD). A draft submission by the Department to CMS will address a target population and eligibility criteria to capture those individuals not meeting the eligibility criteria for the regular Medicaid State Plan PCS services. The first service to be included on the 1915(i) option will be a personal assistance definition focusing on habilitation (training, cueing, prompting) of ADLs, or hands on assistance to complete the ADLs. Additionally, the service definition will

include instrumental activities of daily living (IADLs) associated with completion of the ADLs such as: meal preparation, setting up supplies for bathing, or cleaning up the bathroom once the bath is completed. In order to reduce the duplication of assessment on recipients and to reduce the burden on providers, the data from the assessments used to assess recipients for Medicaid PCS will be used to determine eligibility under the new 1915(i) option.

Ms. Larson told the Subcommittee that the draft outline will be submitted to the Centers for Medicare & Medicaid Services (CMS) by November 30, 2012. Once the initial 1915(i) option is approved and implemented by the target date of July 1, 2013, simultaneous planning will continue for an additional two services under the option: meaningful day activity and respite. The Committee heard Ms. Larson say that the January 1, 2013 through July 1, 2013 planning period will allow for: (1) more accurate cost modeling, (2) more accurate predictability of the number of people to be served to ensure cost neutrality of Medicaid funding, and (3) leveraging of State funds. She said that DHHS would like to include the 1915(i) option under the 1915(b)(c) waiver so that all funding sources for IDD would be under the managed care option and overall cost data for services to people with IDD could be provided.

Additionally, Ms. Larson informed the Subcommittee that legislative authorization will be required for submission of the 1915(i) option for IDD. She said that draft submissions may be sent to CMS in order to receive feedback, but that official submission to CMS means that the State has the required funding in place and legislative authority to proceed. She said that no planning for submission of a 1915(i) option has begun for any other population and reiterated that legislative authority would be required for submission of a 1915(i) option for any other population.

RECOMMENDATION 7: HABILITATION SERVICES FOR IDD ADULTS

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to prepare a 1915 (i) option application with a narrow focus on habilitation services for adults with intellectual and other developmental disabilities. Eligibility for this 1915(i) option must be carefully constructed to consider assessed needs of the individual and to assure that these needs do not meet the criteria and intensity of need for ICF-IDD level of care. This 1915(i) option should be incorporated into the support needs process and the management and capitation of the LME/MCOs. Additionally, cost containment and comparability must be addressed, and projections for costs and number of eligible recipients must be provided when the application draft is submitted for review to the Senate Appropriations Committee on Health and Human Services, and House Appropriations Subcommittee on Health and Human Services, on or before February 1, 2013. The Department shall not take further action on the application until there is approval by the NC General Assembly.

FINDING 8:

During the October 10, 2012 meeting, the Subcommittee heard from Pam Shipman, Cardinal Innovations' LME/MCO about their use of 1915(b)(3) waiver funding options. She explained that additional habilitative services, such as supported employment, can be provided to persons with mental illness and/or intellectual/developmental disabilities by using monies saved through managed care implementation. Ms. Shipman provided detailed handouts describing services that may be funded through 1915(b)(3) waiver authority.

On November 14, 2012, the Committee heard from Tara Larson that the 1915(b)(c) waiver is in process on the regular renewal schedule. All MCOs will have the 1915 (b)(3) waiver services of respite, peer support specialist, and community guide. Piedmont Behavioral Healthcare/Cardinal Innovations will have the following additional 1915(b)(3) waiver services: in-home skill building for people with IDD, comprehensive services for women with substance abuse, and transitional living for children.

Ms. Larson indicated that supported employment will begin as a State-funded service limited to three sites that will meet the fidelity model identified in the US DOJ Settlement Agreement. Once start-up is completed and fidelity is met, then supported employment will be added as a 1915(b)(3) waiver service for implementation in July 2014. The Subcommittee also learned from Ms. Larson that DMA is reviewing the possibility of adding one-time transitional cost as a 1915(b)(3) waiver service. She stated that these transitional costs would be limited to a specific dollar amount and could be used to assist with deposits and needed furniture purchases to enable the person to move into a supported housing arrangement. The Subcommittee provides Recommendation 8 to direct the Department to explore service delivery options for individuals with mental illness to include expansion and addition of 1915(b)(3) waiver services, and review of State Plan services and making clinical and rate recommendations to amend the 1915(b) waiver upon approval of the NC General Assembly.

RECOMMENDATION 8: EXPLORE SERVICE DELIVERY OPTIONS FOR INDIVIDUALS WITH MENTAL ILLNESS

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to expand upon and develop new service definitions and delivery options to meet the needs of individuals with a primary diagnosis of mental illness by: (1) considering an addition and expansion of 1915(b)(3) services, and (2) review of State Plan services and making clinical and rate recommendations to amend the 1915(b) waiver upon approval of the NC General Assembly. The Department shall present findings, anticipated costs, and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

FINDING 9:

During the November 14th meeting, the Subcommittee heard from Tara Larson that the Innovations waiver expansion has been submitted to CMS for approval. An additional

250 slots have been submitted for approval as allowed in the certified Medicaid budget for this Fiscal Year. Slots that were already in the system but were "frozen" have been unfrozen and are available for use. Consistent with this information, the Subcommittee provides Recommendation 9 regarding CAP-IDD (Innovations) Medicaid waiver slots.

RECOMMENDATION 9: CAP-IDD (INNOVATIONS) MEDICAID WAIVER SLOTS

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to expand the number of available CAP-IDD (Innovations) Medicaid Waiver slots within current funding and to unfreeze current slots within current funding constraints. The Department shall report on the status of the CAP-IDD (Innovations) waiver slots to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

FINDINGS AND RECOMMENDATIONS HOUSING SUBCOMMITTEE

The settlement agreement between the State and U.S. Department of Justice requires the Department of Health and Human Services (DHHS) to secure 3,000 community-based supportive housing units for persons with persistent and severe mental illness by July 1, 2020.

FINDING:

There exists in the State an inadequate supply of community-based housing options for persons with disabilities. While the shortage is statewide, the impact is particularly significant in rural areas. Persons with mental illnesses should have access to decent, safe, affordable, and permanent community-based housing options.

RECOMMENDATION #1:

The Subcommittee on Housing, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct that future State, federal or other sources of expansion funding provided to the NC Housing Trust Fund, the Key Program, and other state housing assistance programs be designated specifically to increase the number of permanent housing units, in addition to existing temporary or transitory housing. In the absence of increased funding for this purpose, the State should consider targeting some portion of existing funding toward projects that increase supportive housing availability.

RECOMMENDATION #2:

The Subcommittee on Housing, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission to encourage that, of the $10.3 million appropriated in S.L. 2012-142, Section 10.23A.(e), any unspent funds remaining on June 30, 2013 and any future funding provided for this purpose, shall not revert but shall be transferred to, and deposited into, a special reserve account within the Housing Trust Fund. These funds shall be used only for the purpose of providing supportive housing to persons with mental disabilities and shall remain in a special reserve account until appropriated by an act of the General Assembly. The special reserve account shall be terminated on June 30, 2020, and any funds remaining in the account on that date shall revert to the General Fund.

FINDING:

NC Housing Search.com and the Key Program are valuable resources for identifying and increasing the supply of private, community-based housing units available to persons with mental illness.

RECOMMENDATION #3:

The Subcommittee on Housing, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to evaluate the capacity of the automated databases used by state agencies to monitor the inventory of available rental housing and take the necessary actions to expand landlords' access to and use of these data systems.

RECOMMENDATION #4:

The Subcommittee on Housing, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the North Carolina Housing Finance Agency and the Department of Health and Human Services explore the possibility of increasing the percentage of targeted units in new developments from 10% to a greater percentage.

FINDING:

A tenant-based rental assistance program is the most geographically flexible option to provide affordable housing for persons with disabilities.

RECOMMENDATION #5:

The Subcommittee on Housing, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services and the NC Housing Finance Agency to develop a plan to establish a state funded and administered tenant-based rental assistance program (TBRA) specifically designated for the 3,000 persons who must be transitioned to community-based housing as required by the U.S. DOJ settlement agreement. The TBRA plan shall identify the housing needs within each MCO catchment area. No later than March 1, 2013, DHHS shall submit a preliminary plan, including budgetary and other resource needs, to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services Appropriations Subcommittees, and the House and Senate General Government Appropriations Subcommittees.

FINDING:

Non-profits and other agencies are currently providing supportive housing assistance and other services to persons with mental disabilities in home- and community-based settings.

RECOMMENDATION #6:

The Subcommittee on Housing, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission encourage LMEs to form partnerships with existing non-profit and other agencies that currently provide supportive housing assistance and other services to persons with qualifying disabilities in home and community-based settings.

FINDING:

Persons with mental disabilities should be housed in the least restrictive setting possible. Settings should meet the characteristics of home and community-based standards, including, but not limited to, the freedom to choose roommates, service providers, community outings, meal and bed times, to have access to visitors, to have privacy, and to exercise personal choice.

FINDING:

Persons with mental illnesses should have access to the services necessary to allow them to live in home and community-based settings, including case management, counseling, transportation, supported employment. However, in many counties, particularly those in rural areas, the availability of such services is inadequate or non-existent.

RECOMMENDATION #7:

The Subcommittee on Housing, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct DHHS and the LMEs/MCOs to determine the additional services and resources needed to support the transition of 3,000 mentally ill persons from adult care homes to community-based settings by June 30, 2020. No later than March 1, 2013, DHHS shall submit a written report to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services Appropriations Subcommittees and the House and Senate General Government Appropriations Subcommittees.

FINDING:

Assistive technology can help persons with mental illnesses and other disabilities cope with the challenges of living in community-based settings. Assistive devices can include computers and tablets, telephones, video cameras, medication aids, and safety devices such as GPS locator systems. Some examples include electronic/digital planners and reminders which can be used to help with keeping appointments, medication schedules, and getting to work on time or devices such as sound machines that can soothe and help persons cope with anxiety and stress or block disruptive noise.

RECOMMENDATION #8:

The Subcommittee on Housing, Blue Ribbon Commission on Transitions to Community Living recommends the Blue Ribbon Commission direct the Department of Health and Human Services and the LMEs/MCOs to identify specific assistive technology that can be used to divert or transition persons with mental disabilities from institutional settings. DHHS shall develop a plan to maximize the use of assistive technology in the implementation of the U.S. DOJ settlement agreement. No later than March 1, 2013, DHHS shall submit an assistive technology plan to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services

Appropriations Subcommittees, and the House and Senate General Government Appropriations Subcommittees.

COMMISSION PROCEEDINGS

The Blue Ribbon Commission on Transitions to Community Living met two times: September 5, 2012 and December 19, 2012. This section of the report provides a brief overview and a summary of the Commission proceedings. Detailed minutes and copies of handouts from each meeting are on file in the legislative library or at the following link: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=203

Overview of Topics and Presenters

September 5, 2012

- **Organization and Glossary Discussion**
  Dr. Pat Porter, HHS Consultant
  Amy Jo Johnson, Research Division
- **Background and Purpose of the BRC to Include Limited Focus and Outcomes Expected**
  Chairman Dollar

Background Presentations

- **ADA and the *Olmstead* Decision (Including DOJ findings letter)**
  Emery Milliken, General Counsel, DHHS
- **Overview of DOJ Settlement**
  Emery Milliken, General Counsel, DHHS
- **Description of Personal Care Services Program, with emphasis on how PCS is paid in ACHs and how this was different for PCS in-home; Budget changes to PCS in this year's budget; Status of SPA; Update on projected number of people impacted**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance (DMA), DHHS
- **PCS Independent assessments of individuals living in facilities and DHHS' projected number of people that will be impacted by PSC change**
  Tara Larson, Chief Clinical Operating Officer, DMA, DHHS
- **IMD & Assessment Process Update**
  Tara Larson, Chief Clinical Operating Officer, DMA, DHHS
- **Overview of current community housing options for people with MI or IDD to include housing stock and funding options (DOJ constraints)**
  Dr. Beth Melcher, Chief Deputy Secretary for Health Services, DHHS

- **Overview of Adult Care Homes, Special Care Units, Assisted Living, Group Homes for people with MI or IDD, Family Care Homes**
  Theresa Matula, Research Division, General Assembly
- **Description of the State County Special Assistance Program, Eligibility, Differences in SA program in ACH vs. the community, number of people in each setting, projected impact of SA change in February 2013, alternatives**
  Suzanne Merrill, Adult Services Section Chief, Division of Aging and Adult Services, DHHS
- **Discussion of current service array for adults with MI and IDD**
  Jim Jarrard, Director of MH/DD/SA, DHHS
- **Q&A/Discussion with BRC Members**
- **Division of Tasks for two Subcommittees (including Member assignments) and notice of future dates, times and places for meetings**
  Chairman Dollar
  Chairman Hise

Summary of Blue Ribbon Commission Proceedings

September 5, 2012

Amy Jo Johnson, Commission staff, reviewed Session Law 2012-142, Sections 10.23A(b),(c), and (h) that authorized creation of the Blue Ribbon Commission on Transitions to Community Living. The purpose of the Commission is twofold: "(i) examine the State's system of community housing and community supports for people with severe mental illness, severe and persistent mental illness, and intellectual and developmental disabilities and (ii) develop a plan that continues to advance the State's current system into a statewide system of person-centered, affordable services and supports that emphasize an individual's dignity, choice, and independence." Session Law 2012-142 also required the Commission to appoint a Subcommittee on Housing and a Subcommittee on Adult Care Homes.

Dr. Pat Porter, Consultant to the Commission, gave an overview of how the work of the Commission would be done through the Subcommittees in four meetings. The full Commission would meet one final time after completion of the work of the subcommittees. Dr. Porter also provided the Commission members with a list of acronyms to serve as a reference tool in future meetings.

Chairman Dollar gave an overview of the primary focus and expected outcomes of the Commission's work. Chairman Dollar also explained that North Carolina faces a "perfect storm" of three issues that have the potential to have an impact on and cause the possible relocation of board and care residents: changes in Medicaid Personal Care Services (PCS) eligibility, identification of a facility as an Institution of Mental Disease (IMD), and the United States Department of Justice (US DOJ) Settlement Agreement.

Emery Milliken, General Counsel, Department of Health and Human Services (DHHS) briefly reviewed the requirements of the Americans with Disabilities Act of 1990 (ADA) and the Olmstead decision. She explained that the US DOJ investigated North Carolina's mental health system in 2011 and issued a findings letter on July 28, 2011, to Attorney General Roy Cooper. The investigation concluded that in the opinion of the US DOJ, North Carolina has failed to provide services to persons with mental illness in the most integrated setting appropriate to their needs and many individuals with mental illness in adult care homes could be served in alternative community-based placements. The State has entered into a private Settlement Agreement with the US DOJ that will require the State to provide 3,000 supported housing slots over eight years.

Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance (DMA), DHHS, provided updates on two of the three major issues facing the State relating to housing and services for elderly adults and adults with mental illness and/or intellectual or developmental disabilities. First, Ms. Larson addressed the status of the new eligibility requirements for PCS slated to begin January 1, 2013, and the progress of the Independent Assessments (IAs) used to determine eligibility for the new PCS program. She reported that based on 66% of the IAs completed by August 30, 2012, 46% of those assessed would no longer qualify for PCS under the new eligibility requirements.

Second, Ms. Larson provided information on the IMD determination issue. During Phase I activities, one facility was identified as an IMD on June 7, 2012. A Temporary Restraining Order (TRO) was filed on June 15, 2012, and the facility identified as an IMD on June 7th was reinstated on June 25th. DMA rescinded the IMD designation of twelve other facilities due to the TRO. Ms. Larson advised the Commission that DMA has moved on to Phase II activities, involving all occupied beds in adult care homes, group homes and family care homes. Phase II activities indicate that the preliminary number of facilities, at the time of the meeting, which might possibly meet the definition of an IMD is 135. She concluded her remarks with a detailed description of the discharge process for individuals residing in an adult care home in case that the ACH is found to be an IMD.

Dr. Beth Melcher, Chief Deputy Secretary for Health Services, DHHS, presented information about the number of facilities and number of beds in community housing options, including adult care homes, supervised living facilities, and specialized community residential centers for individuals with developmental disabilities. She also explained the different supported housing programs that offer community-based housing that are available in the State. She concluded her remarks with information about the 3,000 "housing slots" that are to be provided under the US DOJ Settlement Agreement. She reiterated that these "housing slots" cannot be in adult care homes, family care homes, group homes, nursing facilities, boarding homes, assisted living residences, supervised living settings, or any setting required to be licensed.

Ms. Theresa Matula, Commission staff, provided statutory references for the various residential care alternatives for adults: supervised living facilities (group homes), assisted living, multiunit assisted housing with services (MAHS), adult care homes, family care homes, and adult care homes that only serve elderly persons (includes special care units). She also provided a breakdown of licensed adult care homes and special care units based on information from the Division of Health Service Regulation, DHHS.

Suzanne Merrill, Adult Services Section Chief, Division of Aging and Adult Services, DHHS, described the State-County Special Assistance (SA) Program. SA is further broken down into the adult care home program and the in-home program. Payments to recipients are 50% State funds and 50% county funds that can be used to either (i) supplement a person's own income to pay the cost of room and board in certain licensed facilities through the SA ACH program or (ii) provide cash payment to address identified needs of a person living at home through the SA In-Home (IH) program. In August 2012, 53% of SA recipients were residing in adult care homes. Ninety-one counties currently participate in the SA IH Program. The General Assembly enacted S.L. 2012-142, Section 10.23 that requires the remaining nine counties to participate in the SA IH program and requires that payments for SA IH recipients are equal to the payments for SA ACH recipients.

Jim Jarrard, Acting Director, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, DHHS presented the most utilized services, total dollars of services used, and the total number of persons served by service for the following groups:

- Adults with IDD

- Children with IDD
- Adults with mental illness
- Children and adolescents with mental illness
- Adults with substance abuse issues
- Children and adolescents with substance abuse issues.

Chairman Dollar assigned the Commission members to one of the Subcommittees.

December 19, 2012

The Blue Ribbon Commission on Transitions to Community Living met on Wednesday, December 19, 2012, to discuss a report to the 2013 General Assembly. Recommendations from the Subcommittee on Adult Care Homes and from the Subcommittee on Housing were presented to the Commission. The recommendations from the two Subcommittees were adopted by the Commission and the Commission approved a report to the 2013 General Assembly.

SUBCOMMITTEE ON ADULT CARE HOMES PROCEEDINGS

The Blue Ribbon Commission on Transitions to Community Living, Subcommittee on Adult Care Homes, was created by S.L. 2012-142. S.L. 2012-142, Section 10.23A, subsections (a)-(c) and (h) are provided in the Appendix.

The Subcommittee met four times between September 12, 2012, and December 12, 2012. This section of the report provides a brief overview and a summary of the Subcommittee proceedings. Detailed minutes and copies of handouts from each meeting are on file in the legislative library and at the following link:
http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=203

Overview of Adult Care Home Subcommittee Topics and Presenters

September 12, 2012

- **Purpose and Anticipated Outcomes for Subcommittee**
  Chairman Dollar
- **Getting a Clear Picture of Adult Care Homes and Their Residents**
  Theresa Matula, Research Division
- **Challenges through the Industry Lens**
  Connie Cochran, CEO, Easter Seals UCP NC & VA
  Hugh Campbell, President, NC Association of Long Term Care Facilities
  Sam Hooker, Board Member, NC Assisted Living Association
  Peggy Terhune, CEO, Monarch NC
- **Update on Institutions of Mental Disease (IMD)**
  Sandy Terrell, Assistant Director, Clinical Policy & Programs, Division of Medical Assistance, DHHS
- **Directed Discussion by Subcommittee Members**
  Chairman Dollar

October 10, 2012

- **Summary of Responses to Questions Posed to Subcommittee**
  Pat Porter, HHS Consultant
  Patsy Pierce, Research Division
- **Institutions of Mental Disease (IMD): Update**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS
- **Status of Personal Care Service (PCS) Eligibility and Independent Assessment Process**

Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS

- **Adult Care Home Discharge Planning Process and Timeline**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS
- **Presentation of Current and Potential Funding Options for Intellectual/Developmental Disability (IDD) and Mental Health Supervised Living Facilities (Group Homes)**
  Pam Shipman, CEO, Cardinal Innovations Healthcare Solutions
  Karen Adams-Gilchrist, Chief Program Officer, Easter Seals UCP NC & VA

November 14, 2012

- **Restatement of Subcommittee's Purpose, Review of Information Covered, and Summary of Current Situation**
  Chairman Dollar
- **Brief Update on IMD Determinations**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS
- **PCS Assessments: Status of Notification, Breakdown of Data**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS
- **Potential New and Expanded Service Options by Setting, Facility Size and Population: Licensed and Unlicensed for SPMI/SMI/IDD**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS
- **State-County Special Assistance: Overview of Program and Medicaid Eligibility Criteria Issue**
  Suzanne Merrill, Division of Aging and Adult Services, DHHS
- **A Comparison of Adult Care Home Funding Strategies**
  Donnie Charleston, Fiscal Research
- **Trends in Funding Adult Care Homes and Multi-Unit Assisted Housing with Services**
  Janet O'Keefe, DrPH, Senior Researcher and Policy Analyst, RTI International

December 12, 2012

- **Presentation of Report**
  Chairman Dollar
- **Committee Discussion of Draft Report**

Summary of Adult Care Home Subcommittee Proceedings

September 12, 2012

Chairman Dollar gave an overview of the purposes of the Subcommittee. Those purposes included: (1) review of the current status of adult care homes (ACHs), (2) determination of impact of designation of a facility as an Institution of Mental Disease (IMD) and changes in Medicaid Personal Care Services (PCS) eligibility, (3) delineation of a clear and coordinated process for discharge and community placement for individuals no longer appropriately served by ACHs, (4) review of service and support funding options, and (5) identification of possible alternative best practice models of services for ACHs that cannot be sustained in their current operation. He also informed the members that later they would hear from a panel of Subcommittee members representing the adult care homes and group homes industries.

Theresa Matula, Subcommittee staff, Research Division, North Carolina General Assembly (NCGA), explained that North Carolina faces the possibility of board and care residents being impacted, and possibly relocated, based on three issues: PCS eligibility changes, identification of IMDs, and the United States Department of Justice (US DOJ) Settlement Agreement. In an effort to assist the Subcommittee in defining the range and depth of facilities involved in these issues, Ms. Matula provided the Subcommittee with an overview of the various licensed facilities. She provided statutory references and descriptions of the following: Supervised Living Facilities (Group Homes) and Adult Care Homes (including Family Care Homes, 55+ licensed facilities, Special Care Units, and Combination Homes). Utilizing data supplied by the Division of Health Service Regulation, Department of Health and Human Services (DHHS), Ms. Matula provided the Subcommittee with the numbers of licensed facilities and beds in these categories.

Connie Cochran, CEO, Easter Seals UCP NC & VA; Hugh Campbell, President, NC Association of Long Term Care Facilities, Sam Hooker, board member NC Assisted Living Association, and Dr. Peggy Terhune, CEO, Monarch NC, each described the specific populations being served, funding sources used, and types of facilities under their organization's purview. They each discussed the impact of issues relating to PCS, IMD determination and the recent US DOJ Settlement Agreement. Finally, they each provided possible solutions for residents in their facilities who may be at risk for losing services and housing due to these issues.

At the request of Sen. Brunstetter, Emory Milliken, General Counsel, DHHS, was asked to provide comments from a legal perspective on the IMD issue as well as the US DOJ settlement issue. Ms. Milliken stated that the US DOJ investigation of our mental health system found that North Carolina, in their opinion, had an institutional bias towards keeping people in institutional settings rather than in communities. She also said that the process the Division of Medical Assistance (DMA), DHHS is following is consistent with the law and if we did anything differently this could impact the US DOJ Settlement Agreement.

Ms. Sandy Terrell, Assistant Director, Clinical Policy & Programs, DMA, DHHS, provided an update on shared ownership, the IMD process, and the status of the group

homes. She described the screening process and analysis of data required to make a final determination of whether a facility is determined to be an IMD. The process involves looking at the occupied beds as well as the overall characteristics of the facility. Ms. Terrell indicated that the corrective action plan originally was supposed to be completed by August 31, but due to the methodology change directed by the Centers for Medicare & Medicaid Services (CMS) to review the occupied beds versus the licensed beds, a new date for completion is still under negotiation with CMS.

Ms. Terrell gave an update on the facilities potentially at risk in Phase II of the IMD investigation: 84 adult care homes, 52 family care homes, 47 group homes.

October 10, 2012

Ms. Tara Larson, Chief Clinical Operating Officer, DMA, DHHS provided updates on two of the three major issues facing the State in relation to housing and services for elderly adults and for adults with mental illness and/or intellectual or developmental disabilities. First, Ms. Larson addressed the IMD determination issue and indicated that, at the time of this presentation, 151 facilities had been identified as possibly meeting the definition of an IMD. The proposed timelines for IMD determination completion must be approved by CMS and include:

- Adult Care Homes: 11/30/12
- Family Care Homes: 2/28/13
- 122C Group Homes/Supervised Living Facilities: 6/30/13
- Family Care Homes or 122C Group Homes on the same property by 11/30/12

Ms. Larson continued with her presentation on the IMD determination by outlining how DMA determines if multiple facilities fall under "shared ownership," including components such as licensure, ownership, governance/administration, and medical responsibility. Ms. Larson concluded her presentation on IMD determination by discussing the preliminary injunction the Office of Administrative Hearings had enjoined against DHHS/DMA.

Second, Ms. Larson provided a detailed description of the PCS eligibility Independent Assessment (IA) process. She indicated that to date, 13,171 IAs had been completed, and of the 8,781 that had been analyzed and entered into the system, 48% of those assessed would no longer qualify for PCS under the new eligibility criteria scheduled to begin January 1, 2013.

Ms. Larson concluded her remarks with a description of the discharge process for individuals currently residing in Adult Care Homes in case the ACH is found to be an IMD.

Ms. Pam Shipman, CEO, Cardinal Innovations Healthcare Solutions, and Ms. Karen Adams-Gilchrist, Chief Program Officer, Easter Seals UCP NC and VA, presented possible solutions for how persons with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI) may be able to live more independently. Ms. Shipman's ideas included continuing Geriatric Adult Specialty Teams but using them in admissions, discharge, and transition processes. She also indicated a need for new service definitions including: supported employment, peer support, assistive devices, and residential

supports. Additionally, Ms. Shipman suggested that a funding source for these new services could be utilizing funds currently being used for group homes for persons with mental illness as a state match either as a 1915(b)(3) waiver or State Plan service. Ms. Adams-Gilchrist suggested stabilizing current funding and submitting a request for a 1915(i) option for the Intellectually/Developmentally Disabled (IDD) target population to fund transition services.

Public members of the Subcommittee were previously asked to respond to a set of discussion questions. Dr. Pat Porter summarized the responses which indicated needs and solutions for housing and services; and supports and funding for the frail elderly and for adults with disabilities who may be affected by the PCS, IMD, and DOJ issues.

November 14, 2012

Chairman Dollar began the meeting by reiterating the purposes and goals of the Subcommittee.

Ms. Tara Larson, Chief Clinical Operating Officer, DMA, DHHS, provided an update on the IMD determination process indicating that there are 46 ACH facilities that still need to be reviewed by November 30, 2012. Of the facilities reviewed thus far, several have converted to Special Care Units, four remain under preliminary injunction, and several others have been determined not to be IMDs.

Ms. Larson also provided an update on PCS independent assessments. She indicated that persons who no longer qualify for PCS can use private funds, if available, to cover the needed assistance. She also outlined options for ACHs to use to continue to provide room, board and services such as converting to multiunit assisted housing with services (MAHS). Ms. Larson continued her presentation by providing the detailed results of IAs completed at this time. Approximately 9,322 persons across all types of facilities appear to no longer qualify for PCS. She provided a handout including summary and specific facility data. Ms. Larson indicated that DMA has been providing PCS and IMD data to local department of social services (DSS) agencies. She also provided specifics on different State funding sources and possible Medicaid State Plan amendments for additional funding for needed services.

Ms. Suzanne Merrill, Adult Services Section Chief, Division of Aging and Adult Services, DHHS, provided details about the State-County Special Assistance-Adult Care Home (SA-ACH) program. State-County Special Assistance provides a cash payment to supplement an individual's income to live in adult care homes licensed under Chapter 131D of the General Statues, and Supervised Living Facilities (Group Homes) licensed under Chapter 122C of the General Statutes and defined in 10A NCAC 27G.5601 to serve adults whose primary diagnosis is mental illness but may also have other diagnoses (5600a) and to serve adults whose primary diagnosis is a developmental disability but may also have other diagnoses (5600c). SA-ACH covers expenditures not related to PCS (e.g salaries and benefits for non-PCS staff, housekeeping, food, supplies, depreciation or rent, repairs, insurance, equipment, linens, etc.). Medication administration is not covered by SA.

Ms. Merrill also described the SA In-Home program which covers expenses to support a person living safely at home. Needs are determined by a local DSS case manager and may include expenditures such as rent, utilities, and personal assistance in the home. Ms. Merrill's presentation included an overview of recent changes (S.L. 2012-142, Section 10.23) to SA In-Home. The changes include equalization of SA In-Home payments with SA-ACH. Previously SA In-Home payments were 75% of SA-ACH, effective July 1, 2012 the payments are 100%. Additionally, she highlighted how counties pay for the administrative costs for SA In-Home and she provided a breakdown of SA cases by setting: ACH (52%); Family Care Home (9%); Special Care Unit (12%); Supervised Living Facility/Group Home – for the mentally ill (8%); Supervised Living Facility/Group Home – for the developmentally disabled (10%); and SA In-Home (6%).

Finally, Ms. Merrill provided information on the relationship between SA and Medicaid. She explained that SA-ACH is an Optional State Supplement (OSS) to the Social Security's Supplemental Security Income (SSI) program. Since Medicaid is automatic for SSI recipients, SA-ACH residents receive Medicaid. However, SA In-Home was established by the NC General Assembly and is not part of the OSS program. As a result, SA In-Home residents must qualify for full private living Medicaid. The DHHS estimates that approximately 27% of all SA recipients in licensed facilities have income above the federal poverty level and will not qualify for Medicaid in a private living setting. Ms. Merrill provided information on how North Carolina compares with other states on implementation of the OSS program: six (6) states provide supplements only to individuals in private living settings; 16 states provide supplements only to individuals in residential care settings (includes NC), 22 states provide supplements to individuals in both residential care settings and private living settings, and six (6) states do not participate in the OSS program.

Donnie Charleston, Subcommittee staff, Fiscal Research Division, NCGA, provided an overview of ACH funding used in other states, as compared to those used in NC. Comparison states were chosen based upon similar domiciliary requirements. He indicated that the comparison states use five options to fund ACHs: (1) Medicaid State Plan Services, (2) 1915(c) waiver, (3) 1115 Demonstration Programs, (3) 1915(i) option, and (5) State revenue. He indicated NC had a significantly larger number of ACH residents compared to the other states used in the study. Mr. Charleston also gave rankings on the amounts spent on PCS by a number of states, including NC, and indicated that NC's PCS expenditures had risen more than those of the comparison states since 1999. He outlined State and federal legislation and audit activity to try to meet, limit, and control PCS funding needs. Mr. Charleston also provided comparative information on the amount of state funds (Special Assistance) provided to ACHs. He concluded his remarks by explaining "cost modeling rate methodology" to determine Special Assistance rates.

Dr. Janet O'Keefe, Senior Researcher and Policy Analyst, RTI International, shared her opinion on some of the reasons NC is in the current situation with CMS regarding PCS, IMDs, and the US DOJ Settlement Agreement. She indicated that NC's definition of "nursing facility" is more stringent than in other states. She recommended that NC consider an (i) option to help address the needs of adults with Severe Mental Illness,

especially now that, under the Affordable Care Act, the (i) option can serve those with lesser levels of impairment. Dr. O'Keefe also recommended that NC lower nursing home eligibility criteria in an effort to serve additional people and receive additional federal funding in those facilities. She suggested that NC pay a higher PCS In-Home rate, and that NC use licensing rules to address varying levels of need. Overall, Dr. O'Keefe said that NC needs to rethink how the adult care system is structured, especially with the growing aging population having long-term care needs.

The Subcommittee members commented and discussed various issues.

December 12, 2012

The Subcommittee met on December 12, 2012, to discuss and approve a report. The final meeting of the Blue Ribbon Commission on Transitions to Community Living is scheduled for December 19, 2012.

SUBCOMMITTEE ON HOUSING PROCEEDINGS

The Blue Ribbon Commission on Transitions to Community Living, Subcommittee on Housing, was created by S.L. 2012-142. S.L. 2012-142, Section 10.23A, subsections (a)-(c) and (h) are provided in the Appendix.

The Blue Ribbon Commission on Transitions to Community Living, Subcommittee on Housing, met 4 times from September 12, 2012, until December 12, 2012.

Overview of Housing Subcommittee Topics and Presenters

September 12, 2012

- **Housing Options under the DOJ Settlement**
  Dr. Beth Melcher, Deputy Secretary, DHHS
- **Tenant-Based Residential Assistance and Key Program**
  Martha Are, DHHS Homeless Programs Coordinator
- **Access to Housing for Persons with Disabilities**
  Ken Edminster, DHHS Housing Specialist
- **Housing in North Carolina:**
  The Final Report of the Plan for the Efficient and Effective Use of State Resources in the Financing and Development of Independent and Supportive Living Apartments for Persons with Disabilities
  Bob Kucab, Executive Director, NC Housing Finance Agency

October 10, 2012

- **Supportive Housing Overview**
  Jonathan Wilkins, Director, Resources for Human Development
- **Innovations in Supportive Housing**
  Thava Mahadevan, UNC Center for Excellence in Community Mental Health
- **CASA**
  Debra King, CEO
- **Mecklenburg's Promise**
  Cherene Allen-Caraco
- **DOJ Slot Requirements and Wraparound Services**
  Dr. Beth Melcher, Deputy Secretary, DHHS
- **Service Delivery by LMEs**
  Leza Wainwright, ECBH

- **TBRA Under DOJ**
  Martha Are, DHHS
- **Challenges in Administering TBRA Statewide**
  Bob Kucab, Executive Director, NC Housing Finance Agency
- **Collaboration with the Private Sector**
  Ken Szymanski, AICP, Executive Director, Greater Charlotte Apartment Association & Apartment Association of North Carolina

November 14, 2012

- **Review of Subcommittee Purpose and Goals**
  Senator Hise
- **Explanation of DHHS Draft Plan and Budget Estimates**
  Dr. Beth Melcher and Steve Owen, DHHS
- **LME Response to DHHS Draft Plan/Summary of LME Survey**
  Brian Ingram, Smoky Mountain Center
  Pam Shipman, Cardinal Innovations
- **Recommendations from Housing Advocacy Community**
  Carley Ruff, Policy and Outreach Coordinator, NC Housing Coalition
- **Committee Discussion and Recommendations/ Results of Survey of Committee Members**

December 12, 2012

- **Assistive Technology - Overview**
  Tammy Koger, Director, Assistive Technology Project, DHHS Division of Vocational Rehabilitation
- **Technology for Independent Living**
  Allen Ray, President/CEO, SimplyHome-CMI
- **Committee Discussion of Draft Report**

Summary of Housing Subcommittee Proceedings

September 12, 2012

The Housing Subcommittee of the Blue Ribbon Commission on Transitions to Community Living met on September 14, 2012, at 10:00 AM in Room 415 of the Legislative Office Building.

Senator Hise explained the Housing Subcommittee's charge. He said the primary focus of the subcommittee, as directed by the budget provision, would be to:

- Review the current community-based housing options in North Carolina.
- Develop a plan for the expansion of low-cost, community-based housing options for individuals with severe mental illness or intellectual or other developmental disabilities available throughout the state.
- Ensure that individuals in community-based housing options have access to the services they need.

Senator Hise recognized Mr. Bob Kucab, Executive Director of the NC Housing Finance Agency, for the first presentation on the current housing needs in North Carolina and the inventory of affordable rental housing stock. In addition, Mr. Kucab discussed the NC Housing Search website, which offers information about affordable housing and matches clients with units; as well as the Housing 400 program, a program that provides capital and operating subsidies.

Senator Hise then recognized Dr. Beth Melcher, Deputy Secretary for Health Services at the Department of Health & Human Services, for the next presentation on housing options under the Department of Justice (DOJ) Settlement. Ms. Melcher discussed the challenges now faced by the state: (1) how to create a stock of integrated housing and (2) how to provide support services to assist persons with disabilities in maintaining this housing.

Next, Ms. Martha Are, Homeless Programs Coordinator for the Department of Health & Human Services, gave a presentation on tenant-based residential assistance and the Key Program. Ms. Are provided an overview of the inventory of housing available to persons with disabilities and persons with mental illness. Ms. Are also explained how the interplay between various funding sources often makes housing inventory difficult to count. Ms. Are then provided an explanation of the Key Program, a rental assistance program which provides bridge funding between what a tenant can pay and the cost to operate the unit. She explained the Key rental assistance is only given to individuals who are referred by a service provider. Lastly, Ms. Are discussed the development of a Tenant Based Rental Assistance (TBRA) program, which she described as a core feature of the DOJ agreement and the most geographically flexible housing option.

Senator Hise then recognized Mr. Ken Edminster, Housing Specialist for the Department of Health & Human Services, for the final presentation on best practices for supportive housing, a model consisting of permanent housing for individuals alongside wraparound support services that ensure the best chance of success for those individuals. Mr. Edminster outlined strategies for expanding supportive housing, which include increasing

the number of affordable options, ensuring community supports, and separating housing from support services.

Before adjourning the meeting, Chairman Hise asked for additional comments and questions from Subcommittee members.

October 10, 2012

The Housing Subcommittee of the Blue Ribbon Commission on Transitions to Community Living met on October 10, 2012, at 10 A.M. in Room 643 of the Legislative Office Building. The first presentation on supportive housing was given by Mr. Jonathan Wilkins, Unit Director for Resources for Human Development (RHD) and Mr. Bernard Glavin, Corporate Associate Director, Resources for Human Development, Central Office. Their presentation focused on twelve key elements of supportive housing and RHD's enhanced program designed to offer independent living through subleasing programs, as well as several different variations of programs tailored to meet the needs of individuals.

Mr. Thava Mahadevan, M.S., LCAS-A, Director of Operations at UNC Center for Excellence in Community Mental Health, discussed innovations in supportive housing through research, training, technical assistance and clinical care in the community. Next Ms. Debra King, CASA Chief Executive Officer, gave examples of the rental housing built and managed by CASA and explained CASA's guiding principles and the importance of upfront and ongoing funding. Lastly Ms. Cherene Allen-Caraco, Director of Mecklenburg's Promise, presented consumer-operated program solutions for recovery and national reform.

After a period of question and answer, Chairman Burr moved to the next section of the agenda on Supporting DOJ-Required Housing Slots. The first to present was Dr. Beth Melcher, Deputy Secretary of DHHS. Dr. Melcher emphasized the need for rental subsidy, support of LMEs, and linking support services with housing. The next presenter was Ms. Leza Wainwright, Executive Director of East Carolina Behavioral Health (ECBH), a LME/MCO managing care functions, serving 19 counties in a rural and economically challenged area. Ms. Wainwright presented information on the challenges of local implementation issues and care coordination functions.

After lunch, Chairman Burr reconvened the meeting with the Exploring Tenant-Based Rental Assistance (TBRA) section by calling Mr. Bob Kucab, Executive Director of NC Housing Finance Agency, to speak about challenges in administering TBRA statewide. Mr. Kucab gave an overview of TBRA, including discussion on the challenges that are ahead and an outline of the five main TBRA components. Ms. Martha Are, DHHS Division of Aging and Adult Services, described TBRA under the DOJ – Community Living Voucher Program. Lastly, Mr. Ken Szymanski, AICP, Executive Director of Apartment Association of North Carolina (AANC), discussed collaboration with the private sector.

After a lengthy question and answer session, Chairman Burr thanked everyone for their participation and adjourned the meeting.

November 14, 2012

The Housing Subcommittee of the Blue Ribbon Commission on Transitions to Community Living met on November 14, 2012, at 1 PM. in Room 643 of the Legislative Office Building.

At the outset of the meeting, Senator Hise reviewed the purpose and goals of the Subcommittee for the members. The first speaker, Dr. Beth Melcher, Deputy Secretary of DHHS, presented the DHHS draft plan for implementation of the United States DOJ settlement along with the Department's initial cost estimates to implement the plan. Next, Subcommittee staff reviewed the results of a survey of LME's on local housing availability. The survey responses showed that housing availability meeting the DOJ settlement agreement criteria is minimal, especially in the near term.

The Subcommittee then heard from three LME CEO's responding to the DHHS draft plan. Ellen Holliman, CEO of Alliance Behavioral Healthcare, stated that housing is the cornerstone for persons with mental illness to remain in the community and be successful. She noted the need for adequate funding to carry out implementation of the settlement. Brian Ingraham, CEO of Smoky Mountain Center, thought the DHHS plan was a well thought out approach and consistent with the role of the LME's. He agreed that sufficient funding will be needed to support the LME's increased responsibilities. Mr. Ingraham also expressed concern about the lack of available housing in western North Carolina. Pam Shipman, CEO of Cardinal Innovations, noted that the plan focused on the important areas of housing, access to clinical treatment, and supportive work. There will be challenges in implementation.

The next presenter was Carley Ruff of the North Carolina Housing Coalition. Ms. Ruff provided a number of recommendations for expanding available housing to meet the terms of the DOJ settlement agreement including supporting and expanding the State's existing State housing resources and creating a Tenant Based Rental Assistance program.

Staff made the final presentation of the day providing the Subcommittee with a chart summarizing the recommendations made by the members of the Subcommittee to address the Subcommittee's charge.

The meeting concluded with a discussion by Subcommittee members. Senator Hise reminded the members that the Subcommittee would be considering recommendations to submit to the full Blue Ribbon Commission on Transitions to Community Living at the next meeting scheduled for December 12, 2012.

December 12, 2012

The Housing Subcommittee of the Blue Ribbon Commission on Transitions to Community Living met on December 12, 2012, at 10:00 a.m. in Room 643 of the Legislative Office Building.

The first speaker, Tammy Koger, Director, Assistive Technology Project, Division of Vocational Rehabilitation, DHHS, gave an overview of assistive technology and explained how the technology enabled persons with mental illness to live more independently. The next speaker, Allen Ray, President/CEO of SimplyHome, explained

how assistive technology can reduce costs while providing options for independent living.

Finally, the Subcommittee reviewed the draft report. Following a period of discussion, the amended report was approved and adopted. The Subcommittee report will be transmitted to the Blue Ribbon Commission on Transitions to Community Living. The final meeting of the Blue Ribbon Commission on Transitions to Community Living is scheduled for December 19, 2012.

APPENDICES

APPENDIX 1

Authorizing Legislation

S.L. 2012-142
Section 10.23A, Subsections (a)-(c) and (h)

TRANSITIONS TO COMMUNITY LIVING INITIATIVE

SECTION 10.23A.(a) The General Assembly finds that the State's long-term care industry plays a vital role in ensuring that citizens are afforded opportunities for safe housing and adequate client-centered supports in order to live as independently as possible in their homes and communities across the State. This role is consistent with citizens of the State having the opportunity to live in the most appropriate, integrated settings of their choice. The General Assembly also is committed to the development of a plan that continues to advance the State's current system into a statewide system of person-centered, affordable services and supports that emphasize an individual's dignity, choice, and independence and provides new opportunities and increased capacity for community housing and community supports.

SECTION 10.23A.(b) Blue Ribbon Commission on Transitions to Community Living. – There is established the Blue Ribbon Commission on Transitions to Community Living (Commission). The Commission shall (i) examine the State's system of community housing and community supports for people with severe mental illness, severe and persistent mental illness, and intellectual and developmental disabilities and (ii) develop a plan that continues to advance the State's current system into a statewide system of person-centered, affordable services and supports that emphasize an individual's dignity, choice, and independence. In the execution of its duties, the Commission shall consider the following:

(1) Policies that alter the State's current practices with respect to institutionally based services to community-based services delivered as close to an individual's home and family as possible.

(2) Best practices in both the public and private sectors in managing and administering long-term care to individuals with disabilities.

(3) An array of services and supports for people with severe mental illness and severe and persistent mental illness, such as respite, community-based supported housing and community-based mental health services, to include evidence-based, person-centered recovery supports and crisis services and supported employment.

(4) For adults with intellectual and other developmental disabilities, expansion of community-based services and supports, housing options, and supported work. Maximize the use of habilitation services that may be available via the Medicaid "I" option for individuals who do not meet the ICF-MR level of need.

(5) Methods to responsibly manage the growth in long-term care spending, including use of Medicaid waivers.

(6) Options for repurposing existing resources while considering the diverse economic challenges in communities across the State.

(7) Opportunities for systemic change and maximization of housing, and service and supports funding streams, including State-County Special Assistance and the State's Medicaid program.

(8) The appropriate role of adult care homes and other residential settings in the State.
(9) Other resources that might be leveraged to enhance reform efforts.

SECTION 10.23A.(c) The Commission shall be composed of 32 members as follows:

(1) Six members of the House of Representatives appointed by the Speaker of the House of Representatives.
(2) Six members of the Senate appointed by the President Pro Tempore of the Senate.
(3) Secretary of the Department of Health and Human Services (DHHS) or the Secretary's designee.
(4) Director of the Housing Finance Agency or the Director's designee.
(5) Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of DHHS or the Director's designee.
(6) Director of the Division of Medical Assistance of DHHS or the Director's designee.
(7) Two mental health consumers or their family representatives.
(8) Two developmental disabilities consumers or their family representatives.
(9) Two persons in the field of banking or representing a financial institution with housing finance expertise.
(10) Two representatives of local management entities/managed care organizations.
(11) A county government representative.
(12) A North Carolina Association, Long Term Care Facilities representative.
(13) A North Carolina Assisted Living Association representative.
(14) A family care home representative.
(15) A representative of group homes for adults with developmental disabilities.
(16) A representative of group homes for individuals with mental illness.
(17) Two representatives of service providers with proven experience in innovated housing and support services in the State.

The Secretary of the Department of Health and Human Services shall ensure adequate staff representation and support from the following: Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Division of Aging and Adult Services, Division of Health Services Regulations, Division of Social Services, and other areas as needed.

The Commission shall appoint a Subcommittee on Housing composed of 15 members and a Subcommittee on Adult Care Homes.

The chairs shall jointly appoint members described in subdivisions (7) through (17) of this subsection and shall fill vacancies in those positions. The Commission shall meet at the call of the chairs. Members of the Commission shall receive per diem, subsistence, and travel expenses as provided in G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Commission may contract for consultant services as provided in G.S. 120-32.02. Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Commission in its work. Clerical staff shall be furnished to the Commission through the offices of the House of Representatives and Senate Directors of Legislative Assistants. The Commission may meet in the Legislative Building or the Legislative Office Building. The Commission may exercise all of the powers provided under G.S. 120-19 through G.S. 120-19.4 while in the discharge of its official duties. The funds needed to support the cost of the

Commission's work shall be transferred from the Department of Health and Human Services upon request of the Legislative Services Director.

...

SECTION 10.23A.(h) The Commission shall issue an interim report by October 1, 2012, and a final plan to the 2013 General Assembly no later than February 1, 2013, at which time the Commission shall expire.

...

DHHS STATUS REPORTS
BLUE RIBBON COMMISSION ON TRANSITIONS TO COMMUNITY LIVING RECOMMENDATIONS
S.L. 2012-142, Section 10.23A

State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

March 2013

SUMMARY

This report will provide Department of Health and Human Services (DHHS) status updates on recommendations 2, 8, and 9 from the Subcommittee on Adult Care Homes of the Blue Ribbon Commission on Transitions to Community Living, and Recommendation 7 from the Subcommittee on Housing.

SUBCOMMITEE ON ADULT CARE HOMES RECOMMENDATION 2: MITIGATE THE LOSS OF MEDICAID ELIGIBILITY BY THOSE EXITING AN ADULT CARE HOME

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to consider all options to mitigate the loss of Medicaid eligibility by those exiting an adult care home and no longer receiving State-County Special Assistance as an adult care home resident for this specific population for a set period of time. The Department must explore, but is not limited to, the following options: the implications of tying the receipt of SA In-Home to Medicaid eligibility as is the current practice for SA-ACH recipients; acquiring a federal disregard for residents moving from a facility to a home to allow a waiver of their deductible; and investigating the Medicaid Health Insurance Premium Payment Program provision to determine whether Medicaid can pay the "premium" for these individuals so they remain Medicaid eligible. The Department shall report findings and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE:

State-County Special Assistance for Adults (SA) provides a cash supplement to help low-income individuals residing in adult care homes (such as rest homes) pay for their care. Adult care homes (ACHs) are unlike nursing homes in that medical care is not provided by home staff. Designated staff may administer medications and provide personal care services such as assistance with bathing, eating, and dressing. ACH residents with diagnosed with Alzheimer's or a related disorder may reside within a licensed Special Care Unit (SCU) in an ACH.

The State/County Special Assistance In-Home Program for Adults (SA/IH) provides cash supplements to help low-income individuals who are at risk of entering a residential facility such as an ACH or supervised living group home, and would like to remain at home. SA/IH provides an alternative to placement in this type of residential setting for individuals who could live at home safely with additional support services and income. However, unlike the SA program for residents of ACHs (SA-ACH), individuals must be determined eligible for Medicaid in the Aged, Blind, and Disabled Medicaid (ABD) program categories before being evaluated for an SA/IH payment. This means that to be eligible for the SA/IH payment an individual first must have income that does not exceed the Medicaid income limit for the ABD population of 100 percent of the federal poverty level (FPL). Individuals currently eligible for SA-ACH may have a higher income level than 100 percent FPL.

Implications of tying the receipt of Special Assistance In-Home to Medicaid eligibility, as is the current practice for SA-ACH

It is possible to set aside a fixed percentage of income so that it is not considered when determining eligibility, also known as an income disregard. Medicaid income disregards for the aged, blind, and disabled are governed by the Supplemental Security Income (SSI) program, as required under 42 C.F.R. 435.601(a). By using an income methodology that is "less restrictive" than SSI, the Medicaid program can apply an income disregard to raise the Medicaid income limit to the SA/IH payment eligibility amount. However, as required under 42 C.F.R. 435.602(d)(2), such a disregard would have to apply to ALL Medicaid aged, blind, and disabled eligibility groups and would result in an expanded ABD population.

Currently, the income limit for ABD is 100 percent of the federal poverty level (FPL). Any disregard would raise the income limit for all individuals in those programs. The SA-ACH income threshold is higher than the ABD income limit, at 132 percent FPL, or $1,228 per month. To equalize the SA/IH income limit to the SA-ACH limit would require a disregard of $297 to bring the maximum income allowed under the 100 percent FPL limit of $931 for an individual. Such an income disregard would have to apply to all ABD beneficiaries living in the community, not only to SA/IH beneficiaries, and would result in more individuals becoming eligible for Medicaid.

Alternatively, the increased income limit could be limited to the income threshold for the SA program for individuals residing in Special Care Units (SCUs), which is $1,561 per month (approximately 168 percent of FPL). Individuals may exit to the community from the SCU and will need the protection of the disregard. To equalize the SA/IH income limit to the SA-SCU limit would require a disregard of $630 to bring the maximum income allowed under the 100 percent FPL limit of $931 for an individual. However, under 42 C.F.R. 435.602 a disregard must apply to all in the eligibility group, in this case everyone in the ACH, not just those residing in SCUs.

It is difficult to determine the number of individuals who would potentially become eligible for the SA/IH program under either of these options, as these populations are not currently enrolled in Medicaid. However, it would represent an expansion of Medicaid to a traditionally high-cost population.

Any disregard would require submission of a State Plan Amendment (SPA) along with the fiscal impact and funding source to CMS, development of Administrative Procedures Act rules, revisions to the SA and ABD program manuals, as well as programming eligibility rules changes in NCFAST. Because of implementation deadlines for NCFAST, new program rules cannot be accommodated at this time. Completion of these tasks and training of eligibility workers at the county departments of social services would normally be a 6 to 8 month process. However, the programming changes required in NCFAST could not be accomplished until 2014 at the earliest.

Changing Special Assistance (SA) In-Home Program into part of the State/County Special Assistance Program

As a State statutory program, SA/IH has limits on the number of individuals who are eligible for the program. These limits may be increased or decreased by legislation. Incorporating SA/IH into the Special/County Special Assistance Program, which would be allowed in 42 C.F.R. 435.232, would make eligibility an entitlement without limits on the number of potential enrollees. Eligibility for Medicaid would be based on the receipt of an SA payment rather than policy of the ABD programs, therefore potentially increasing the number of individuals receiving Medicaid at higher incomes. However, as part of the federally-defined SA program, the higher income limit, or a corresponding income disregard, need not be applied to all ABD beneficiaries, just those receiving SA either in homes or in ACHs or SCUs.

SUBCOMMITTEE ON ADULT CARE HOMES RECOMMENDATION 8: EXPLORE SERVICE DELIVERY OPTIONS FOR INDIVIDUALS WITH MENTAL ILLNESS

The Blue Ribbon Commission on Transitions to Community Living directed the Department of Health and Human Services to expand upon and develop new service definitions and delivery options to meet the needs of individuals with a primary diagnosis of mental illness by: (1) considering an addition and expansion of 1915(b)(3) services, and (2) review of State Plan services and making clinical and rate recommendations to amend the 1915 (b) waiver upon approval of the NC General Assembly. The Department shall present findings, anticipated costs, and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Service, on or before March 1, 2013.

This recommendation dovetails with the following Blue Ribbon Commission Recommendation:

SUBCOMMITTEE ON HOUSING RECOMMENDATION 7

The Subcommittee on Housing, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct DHHS and the LMEs/MCOs to determine the additional services and resources needed to support the transition of 3,000 mentally ill persons from adult care homes to community-based settings by June 30, 2020. No later than March 1, 2013, DHHS shall submit a written report to the Chairs of the House and Senate Appropriations Committees, the House and Senate Health and Human Services Appropriations Subcommittees and the House and Senate General Government Appropriations Subcommittees.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE:

In response to the Blue Ribbon Commission recommendations, this report details findings of internal and external reviews of the North Carolina mental health service array, summarizes

existing mental health and substance abuse services, and presents recommendations for enhancement of the current Medicaid behavioral health services

Reviews of Current Mental Health and Substance Abuse Adult Service

DHHS divisions, paid external consultants, and consumer advocacy organizations have conducted numerous qualitative and quantitative gap analyses of the current North Carolina mental health service array. This report synthesizes the results from all available gap analyses in order to identify any need for expansion of Medicaid State Plan or 1915(b)(3) services.

1. **US Department of Justice letter to North Carolina**

In a letter dated July 28, 2011, the US Department of Justice (DOJ) concluded that:

> North Carolina failed to "...develop a sufficient quantity of community-based alternatives..." and "[t]he types of services needed to support people with mental illness in community-based settings already exist in North Carolina's community-based mental health service system. These services include ACT teams, Community Support Teams, case management services, peer support services, supported employment services, and crisis services..." ... "Given the array of services...providing services to people with mental illness can be reasonably accommodated."

The report went on to recommend that "the State should ensure that its quality management systems are sufficient to assure that all mental health services funded by the State are of good quality and are sufficient to help individuals achieve positive outcomes...".

2. **Analysis of Service Gaps in the Mental Health, Developmental Disabilities, and Substance Abuse Services (April 1, 2010)**

This report was in response to Session Law 2008-107, Section 10.15(f), which directed DHHS to perform a services gap analysis of the Mental Health, Developmental Disabilities, and Substance Abuse Services System, involving local management entities (LMEs).

The report synthesized gap analyses and recommendations from consumers, LMEs, and other stakeholders. The report finds that long-term supports for independence and recovery are necessary but insufficient in North Carolina, leading to recommendations for the following:

- Safe and affordable housing
- Employment opportunities and supports
- Emergency respite
- Timely access to affordable medications
- Primary healthcare
- Transportation
- Post-secondary education opportunities
- Opportunities for recreation and community involvement

The report also noted that the following opportunities exist to enhance the mental health and substance abuse service quality and accountability:

- Consistent, high quality assessments and services
- Evidence-based practices
- Sharing of information through efficient data systems

3. Mercer Report

In 2012, Mercer Human Services Consulting (Mercer) performed an analysis of the behavioral health service array available to NC Medicaid beneficiaries. Mercer reviewed existing reports and Local Management Entity-Managed Care Organization (LME-MCO) service gap analyses. Mercer concluded that DHHS does offer a complete array of mental health and substance abuse services. However, these services need to be revised to require evidence-based practices. Mercer recommended that current services funded only through State dollars of Money Follows the Person (MFP) should be expanded as Medicaid 1915(b)(3) services available statewide. These services include Transition Year Supports, Peer Support, and Supported Employment.

4. Money Follows the Person (MFP) Demonstration: Overview of State Grantee Progress, July-December 2010 by Mathematic Policy Research, Inc. (May 2011)

A Mathematica Policy Research report reviewed North Carolina's Money Follows the Person transitional program that transitions individuals in institutional settings to a community-based living situation. It suggested that a lack of robust case management services destabilized the community support structure for individuals transitioning into community settings.

5. Trapped in a Fractured System: People with Mental Illness in Adult Care Homes, Special Report: Disability Rights North Carolina (August 2010)

Disability Rights North Carolina (DRNC) issued a special report due to concerns about adults with mental illness living in Adult Care Homes with little reported integration into the community. With respect to services, DRNC recommended that North Carolina develop long term care services and supports in the community for adults with severe and persistent mental illness (SPMI), including but not limited to the clubhouse model of day programming, personal care services, and peer support. The report also recommended development of a robust supported employment initiative for adults with mental illness.

Summary of Findings

- While a complete service array does exist, services are not focused on evidence-based practices which improve the chances of beneficial outcomes.
- Specialized case management protocols have not focused on the needs of individuals transitioning into community settings.

- The current statewide service array is restricted to rehabilitative services. Some supports, such as peer support, supported employment, and one-time transitional funds, are necessary to facilitate successful community living.

Current North Carolina Medicaid Mental Health Service Array for Adults

Eligible Medicaid beneficiaries may access a broad array of mental health services. These services include: Partial Hospitalization, Assertive Community Treatment (ACT), Community Support Team (CST), Psychosocial Rehabilitation (PSR), Facility-Based Crisis (FBC), Mobile Crisis Unit (MCU), Diagnostic Assessment, and Outpatient Therapy and Medication Management. Peer Support is also currently available as a State-funded service and as a 1915(b)(3) service through LME-MCOs. The following is a summary of these services.

Assertive Community Treatment (ACT)

ACT is a wrap-around, team approach to community-based mental health care for individuals with severe mental illness who might otherwise need hospitalization The ACT Team service is provided by an interdisciplinary team that ensures service availability 24 hours a day, 7 days per week, and is prepared to carry out a full range of treatment functions wherever and whenever needed. Structured, face-to-face scheduled therapeutic interventions provide rehabilitative support and guidance in the adaptive, communication, personal care, employment, domestic, psychosocial, and problem solving function domains. The service prevents, overcomes, or manages the beneficiary's level of functioning and enhances his/her ability to remain in the community. The ACT Team also addresses substance abuse, housing, medical needs, and employment issues. While ACT is considered an evidenced-based treatment, NC has no system for monitoring fidelity to the evidence-based practices.

Community Support Team (CST)

Community Support Team (CST) services consist of community-based mental health and substance abuse rehabilitation services and supports to assist adults in achieving rehabilitative and recovery goals. Individualized treatment by the team may include therapy, behavioral intervention, substance abuse treatment, relapse prevention strategies, psychoeducation, symptom self-management, intensive case management, and crisis management.

Psychosocial Rehabilitation (PSR)

PSR focuses on skill and resource development to increase the beneficiary's ability to live as independently as possible, to manage their illness and their life with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational and vocational goals. These interventions are focused on promoting recovery, symptom stability, increased coping skills and achievement of the highest level of functioning in the community.

Peer Support (PS)

Peer Support services (PS) is a community-based service for adults who have a mental illness or a substance abuse disorder, provided by a North Carolina Certified Peer Support Specialist. Peer support is a Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based practice.

Mobile Crisis Management (MCM)

Mobile Crisis Management involves all support, services, and treatments necessary to provide integrated crisis response, stabilization interventions, and prevention activities. Mobile Crisis Management services are available 24 hours a day, 7 days a week, 365 days a year. Crisis response provides an immediate evaluation, triage, and access to acute mental health, developmental disabilities, and/or substance abuse services, treatment, and supports reduce symptoms or harm, and/or safely transition beneficiaries in acute crises to appropriate crisis stabilization and detoxification supports and services.

Facility-Based Crisis

Facility Based Crisis services provide an alternative to hospitalization for adults who have a mental illness or substance abuse disorder. Provided in a 24-hour residential facility with 16 beds or less, it provides support and crisis services in a community setting and can be provided in a non-hospital setting for recipients in crisis who need short-term intensive evaluation, treatment intervention, or behavioral management to stabilize acute or crisis situations.

Recommendations for Medicaid State Plan and 1915 (b)(3) Services

In order to support individuals in community based settings, DHHS recommends the following additions or enhancements to the current mental health service array. It should be noted that any costs have been accounted for in SFY 2012 and subsequent budgets related to the US DOJ Settlement Agreement.

1. **Assertive Community Treatment (ACT):** Modify ACT policy by requiring fidelity to an evidence-based treatment model that includes employment and housing supports. ACT is an existing Medicaid State Plan service.
    - *Clinical Revision:* The ACT policy is in the process of being re-defined according to the Tool for Measurement of ACT (TMACT), an evidence-based ACT model that is expected to result in decreased hospital utilization, more independent living and housing stability, retention in treatment, and beneficiary satisfaction. ACT teams must be monitored to ensure fidelity to the TMACT model and, thus, ensure high quality and positive outcomes.
    - *Training and Fidelity Monitoring:* DHHS will contract with the UNC Center for Excellence in Community Mental Health ACT Technical Assistance Center (TAC) for development, implementation, and support for a long-term ACT program fidelity implementation plan. This will ensure that an adequate number of high fidelity ACT teams are available throughout the State. ACT TAC will be responsible for program evaluation, training, and consultation, as well as directly

evaluating ACT teams and supervising TMACT reports that are submitted by evaluators.

Proposed Year 1 Scope of Work:

- *Oversee ACT Program Fidelity Implementation and Quality Improvement Efforts in NC* (train fidelity evaluators, train ACT teams in TMACT model, conduct TMACT fidelity evaluations, supervise fidelity process to ensure reliable and valid ratings, provide ongoing education and training to stakeholders, including MCOs and providers, develop TA website)
- *Directly provide consultation and technical assistance to ACT teams* (provide initial, time-limited consultation to ACT providers following TMACT evaluation to offer coaching and consultation).
- *Collaborate with ACT Stakeholders to Facilitate Best Practices* (consult with DMHDDSAS and DMA on ACT policy and assist with outcome tracking)

Cost Implications: The five-year DOJ Settlement budget includes costs for fidelity training and monitoring as well as rate increases to support the new service requirements.

	SFY 12-13	SFY 13-14	SFY 14-15	SFY 15-16	SFY 16-17	SFY 17-18	SFY 18-19	SFY 19-20
Training & Fidelity	$66,863	$62,500	$62,500	$62,500	$62,500	$62,500	$62,500	$62,500
Increased Rates	$799, 155	$1,718,245	$1,847,101	$1,985,374	$2,134,549	$2,294,628	$2,478,000	$2,478,000

2. **Supported Employment (SE):** Initially, SE will be developed as a State-funded service, and then transition to a Medicaid-funded 1915(b)(3) service by January 2014. SE offers real-time supports focused on obtaining and maintaining long-term, competitive employment for individuals in recovery from mental illness and substance abuse. The service definition should specify an evidence-based model that involves measured outcomes.
    - *Clinical Revisions:* The previous SE policy has been revised to be consistent with evidence-based models of supported employment and ensure improved quality.
    - *Training:* Contract with NC Employment First Technical Assistance Center to develop training, build provider capacity, and educate stakeholders and target audiences. The TAC will develop and deploy training plans and help the state and LME-MCOs build provider capacity. Evaluation and outcome data will be gathered and used to inform future trainings.
    - *Cost:* As a (b)(3) service, the cost of SE is offset by savings realized under the 1915(b)(c) waiver. SE is currently State-funded, but will be implemented as a Medicaid service in the next year

Cost Implications: The DOJ budget includes funding Supported Employment technical assistance and training through SFY 14-15 ($46,508 through July 2013, then $90,000 for

each of SFY 13-14 and SFY 14-15). As of January 2014, SE will also be a 1915 (b)(3) services funded through savings realized by the LME-MCO waivers.

It is not yet clear whether more Technical Assistance funding will be needed after the initial start-up year to continue with training and fidelity monitoring. The evidence-based practices for SE are still being reviewed and the service definition is still under revision.

3. **Transition Year Stability Funds:** Following Money Follows the Person, one-time transition funds of $2,000 were made available to high priority individuals transitioning to independent living. This cost is included in the DOJ Settlement budget.

4. **Peer Support (PS):** PS is currently a 1915(b)(3) service as well as a State-funded. PS involves the use of trained individuals who have experienced mental health and substance abuse issues to aid in recovery from mental illness and substance abuse. PS provides individuals with a validating community that builds interdependence and mutual responsibility. *Clinical Revision:* PS is currently being revised with attention to evidence-based models of practice.

   Cost Implications: Peer Support Services PSS will also be a 1915 (b)(3) services funded through savings realized by the LME-MCO waivers, requiring no additional service dollar allocation.

   Some Technical Assistance funding will likely be needed to help with training and fidelity monitoring. However, the service definition is currently under revision and promising practices/evidence is being reviewed to determine the best model of Peer Support for our consumers.

5. **Personal Care/Individual Support:** This is a proposed service currently only available in the Cardinal Innovations catchment area. Personal Care (Individual Support) is a "hands-on" service for persons with severe and persistent mental illness (SPMI). The intent of the service is to teach and assist individuals in carrying out instrumental activities of daily living (IADLs), such as preparing meals, managing medicines, grocery shopping and managing money, so they can live independently in the community. The supports will include skills training, social skills training to develop positive relationships and stronger support networks, communication, self-advocacy, informed choice, community integration, pre-employment readiness, recovery education, and change readiness. The individual need for the service is expected to "fade" or decrease over time as the individual becomes capable of performing some of these activities more independently.

   At this time, Personal Care/Individual Support is considered a 'pilot' service. This 1915 (b)(3) service could be expanded to the other LME-MCOs over time upon realizing any additional savings under the waivers.

SUBCOMMITTEE ON ADULT CARE HOMES RECOMMENDATION 9: CAP-IDD (INNOVATIONS) MEDICAID WAIVER SLOTS

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to expand the number of available CAP-IDD (Innovations) Medicaid Waiver slots within current funding and to unfreeze current slots within current funding constraints. The Department shall report on the status of the CAP-IDD (Innovations) waiver slots to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) RESPONSE:

The Division of Medical Assistance (DMA) operates a 1915(c) waiver for individuals with intellectual and developmental disabilities. The 1915(c) waiver allows individuals to live in community settings with services and supports instead of receiving care in institutional settings. Historically, the waiver was called the Community Alternatives Program (CAP) waiver. The waiver is now called the "NC Innovations" waiver. In SFY 2013, DMA created 250 new 1915(c) waiver slots and an estimated 500 current slots were unfrozen. DMA currently funds 12,448 slots.

In order to distribute these slots to new beneficiaries, DMA submitted a Technical Amendment (TA) to the NC Innovations waiver to the Centers for Medicare and Medicaid Services (CMS) for approval. CMS approved the TA on December 10, 2012.

DMA worked with Mercer Human Services Consulting (Mercer) to develop an allocation method for distribution of the slots based on the historical slot allocation process for the CAP waiver. Slots are allocated to LME-MCOs who distribute them to individuals on their wavier wait lists. Mercer allocated the slots to LME-MCOs on a per capita basis.

DMA distributed slot allocation letters to the LME-MCOs on January 14, 2013 and held a technical assistance call to answer any questions. A Special Medicaid Bulletin was published in January 2013 informing providers and beneficiaries that slots were distributed to the LME-MCOs.

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

March 12, 2013
Legislative Office Building - Room 643
8:30 a.m.

Senator Louis Pate, Presiding	Welcome, Opening Remarks
Medicaid Presentation Schedule	Susan Jacobs Committee Staff Fiscal Research Division
Medicaid Budget Overview	Susan Jacobs Committee Staff Fiscal Research Division
Current Budget Status	Carol Steckle, Director Division of Medical Assistance
Adjourn	
Next Meeting:	Thursday, March 14th, 8:30 a.m.

Senate Committee on Appropriations on Health and Human Services
Tuesday, March 12, 2013 at 8:30 a.m.
Room 643

MINUTES

The Senate Committee on Appropriations on Health and Human Services met at 8:30 a.m. on March 12, 2013 in Room 643. Four Senate members were present along with Representatives Marilyn Avila, Bill Brisson, Mark Hollo, Carl Ford, Jim Fulghum, Susan Martin, Donny Lambeth, Tom Murry, Beverly Earle and Jean Farmer-Butterfield.

Senator Louis Pate presided.

Senator Pate recognized the following House Sergeants-at-Arms: Fred Hines and Charles Godwin; Senate Sergeants-at-arms were Leslsie Wright and Billy Fritscher. He then recognized Pages for the House: Mayah Haynes and Taylor Morin, both of Wake County. Senate Pages were: Kianna Brower of Rural Hall and Milizha Mills of Winston-Salem.

Senator Pate welcomed everyone and called on Susan Jacobs of the Research Division to speak regarding the Medicaid Presentation Schedule (attachment 1), and to give an overview of the Medicaid Budget (attachment 2). After a brief question and answer session, Ms. Jacobs recognized Ms. Carol Steckle, Director of the Division of Medical Assistance to give an update on the current budget status and request for information process (attachment 3). Ms. Steckle answered all questions asked by members.

Senator Pate informed the Committee that there would not be any Joint Appropriations Sub-Committee Meetings on Health and Human Services on Wednesdays for the foreseeable future. The next meeting would be held on Thursday, March 14, 2013.

The meeting adjourned at 9:45 a.m.

Senator Louis Pate
Presiding

Edna Pearce, Committee Clerk

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Tuesday	March 12, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

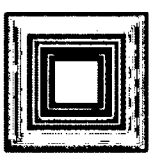
Attachment 1

Department of Health and Human Services
Division of Medical Assistance

Presentation Schedule

Susan Jacobs
Fiscal Research Division

March 12, 2013



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

What are the Long-Term Goals for Medicaid?

- *What* does the General Assembly want in a Medicaid Program?
- Is the current program *designed* to meet legislative expectations and achieve long-term goals?
- Should the state, providers, and recipients share in the *financial risk*?
- Paying for Value: Are current payment policies designed to *reward better outcomes*?

Balancing Act: Access/Quality/Cost

Presentation Schedule: March 12 & 15, 2013

➢ Medicaid Overview

- ❑ Budget Overview
- ❑ Significant Legislative Actions
- ❑ Current Budget Status/Request for Information Process – Carol Steckel, State Medicaid Director

➢ Medicaid Information Technology - Thursday

- ❑ Medicaid Management Information System(MMIS)
- ❑ North Carolina Families Accessing Services Through Technology (NC FAST)

Presentation Schedule: March 19 & 21, 2013

Prescription Drugs

- Historical Expenditures
- Policies in Other States
- North Carolina Policies – Carol Steckel, State Medicaid Director

Payment Reform?

- Is there a direct relationship between costs and outcomes?
- Alternatives to Fee-For Service
- North Carolina Medicaid Provider Payment Policies – Carol Steckel, State Medicaid Director

Presentation Schedule: March 26 & 28, 2013

➢ Community Care of North Carolina (CCNC)

- ❑ Budget History
- ❑ Future Strategies for Coordinated Care

Carol Steckel, State Medicaid Director

➢ Department of Health and Human Services:

Carol Steckel, State Medicaid Director

- ❑ Response/Status of State Auditor Report Findings
- ❑ Budget Recommendations

➢ Report on Medicaid Organization

Carol Shaw, Legislative Staff, Performance Evaluation Division

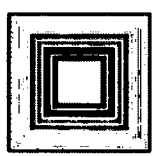
- ❑ Session Law 2012-142 Section 10.9B –Study Medicaid Organization

Attachment 2

Department of Health and Human Services
Division of Medical Assistance
Overview

Susan Jacobs
Fiscal Research Division

March 12, 2013



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Presentation Outline

- Budget Overview
- Historical Budget Issues
- Current Budget Status

Medicaid Program

- ***What*** **is Medicaid?**
- ***Who*** **receives Medicaid?**

Division of Medical Assistance

Mission Statement

"The mission of the Division of Medical Assistance (DMA) is to provide access to high quality, medically necessary health care for eligible North Carolina residents through cost-effective purchasing of health care services and products."

Source: Division of Medical Assistance http://www.ncdhhs.gov/dma/whoweare.htm

Medicaid Program
What is Medicaid?

Medicaid is an ***entitlement*** program designed to pay for medical care for low-income children and working families, people with disabilities and the elderly. Costs for the program are shared by states and the federal government. Eligibility is determined by income, assets, age, and medical need.

Source: TITLE XIX of the Social Security Act—Grants to States for Medical Assistance Programs.

Medicaid Program

What is Medicaid?

Medicaid is a federal entitlement program. Entitlement means individuals found eligible for Medicaid have legal rights to receive services under the Medicaid Program and cannot be denied coverage. Federal guidelines require that children receive comprehensive services.

Implications:

- **All Medicaid recipients must be served.**
- **Their medical bills must be paid.**
- **If appropriations for the Medicaid Program are inadequate, funding must come from other areas of State government.**

Medicaid Program
What is Medicaid?

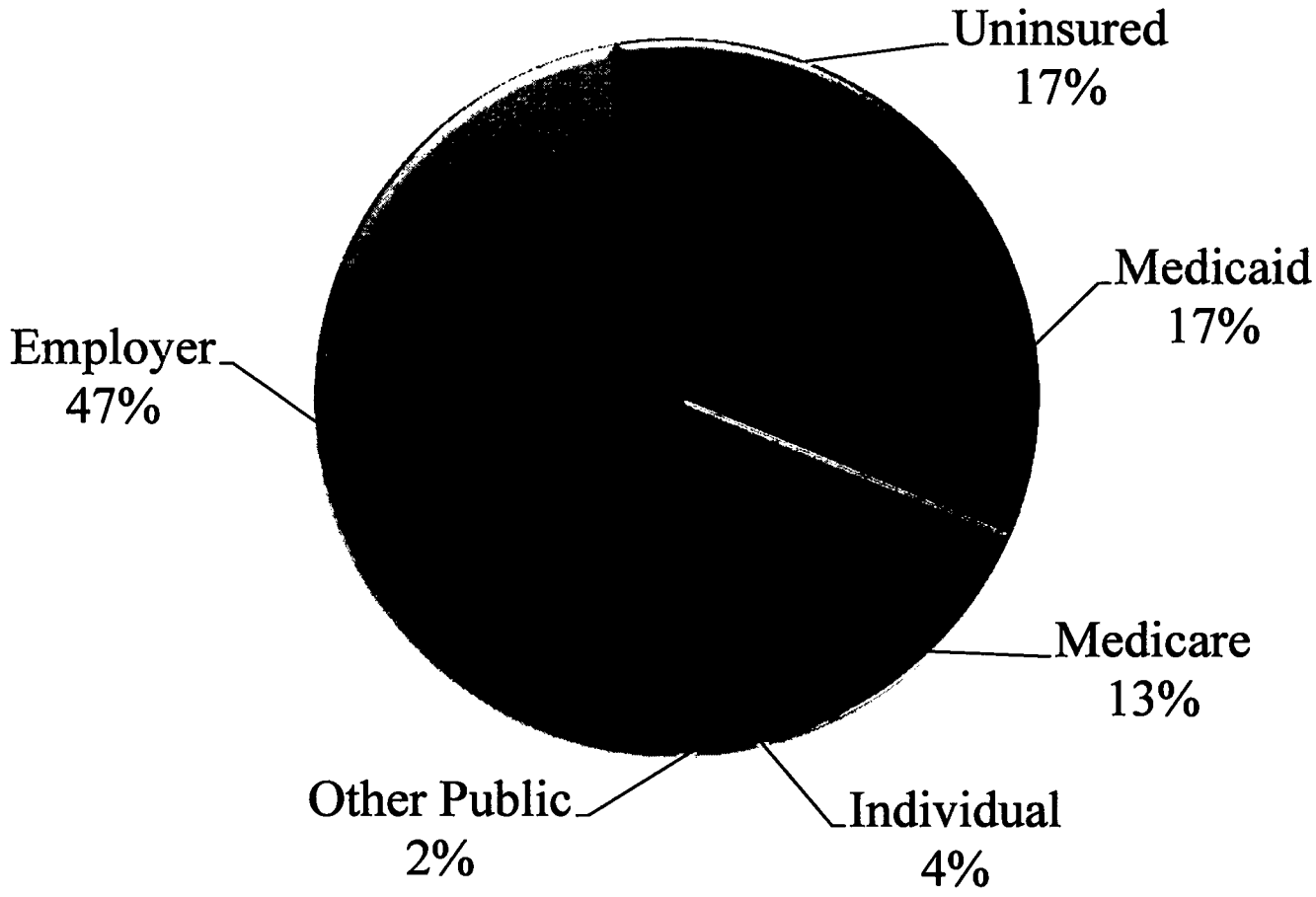
Within broad federal guidelines set by the Centers for Medicare and Medicaid Services (CMS), each state has the authority to:

1. ***Establish*** its own eligibility standards (currently restricted by the Affordable Care Act);
2. ***Determine*** the type, amount, duration, and scope of covered services;
3. ***Set*** the payment rate for services; and
4. ***Administer*** its own program, in accordance with the state plan (changes to the state plan have to be approved by CMS).

The Division of Medicaid Assistance (DMA) and local Departments of Social Services administer NC's program.

Medicaid Program
What is Medicaid?

NC INSURANCE STATUS, 2010-11



Source: Kaiser Family Foundation, statehealthfacts.org

Medicaid Program

Who Receives Medicaid?

2013 Federal Poverty Guidelines

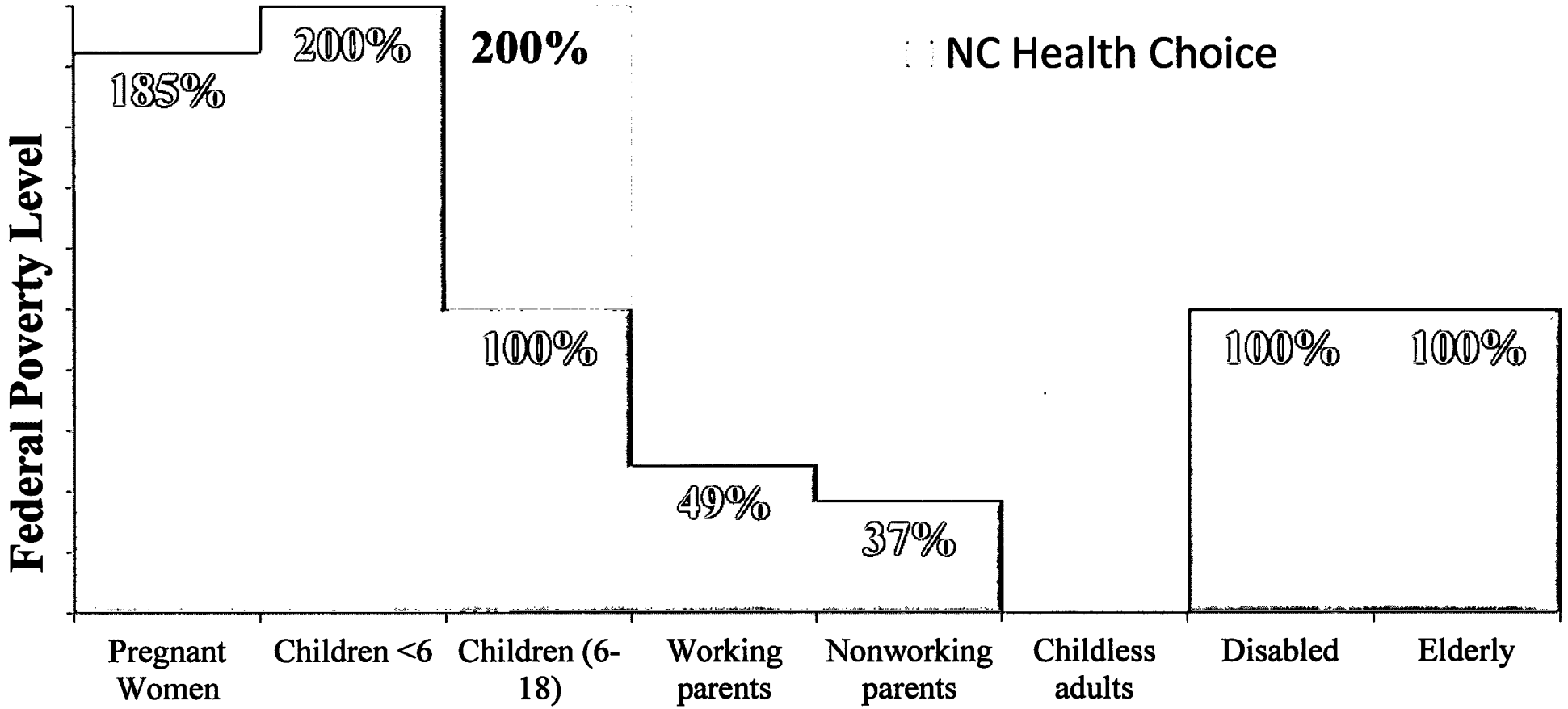
Persons in family/household	Poverty Guideline
1	$11,490
2	15,510
3	19,530
4	23,550
5	27,570
6	31,590
7	35,610
8	39,630

For families/households with more than 8 persons,
add $4,020 for each additional person.

Source: Federal Register, Department of Health and Human Services, Effective January 24, 2013

Medicaid Program

Who Receives Medicaid?

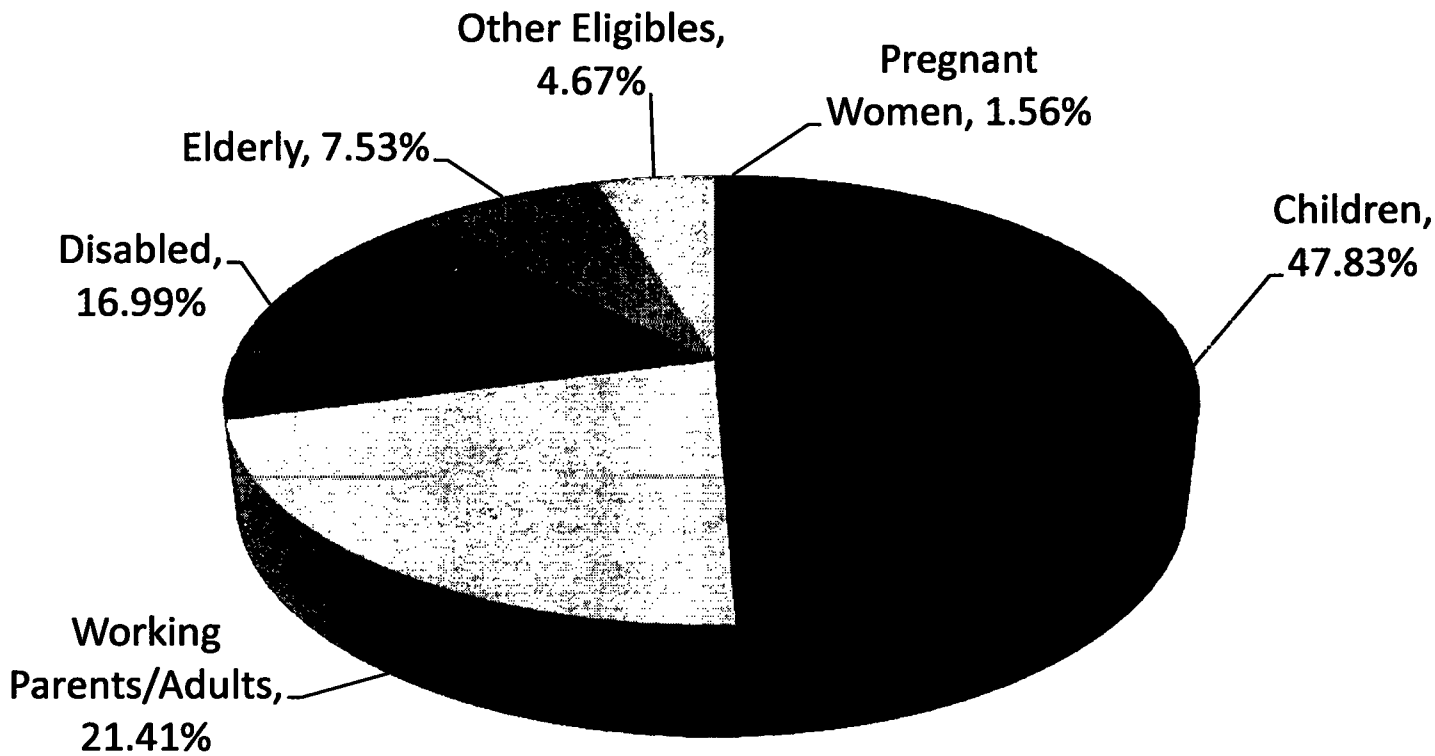


Source: NC Institute of Medicine - Eligibility based on % of the Federal Poverty Guideline.

Medicaid Program

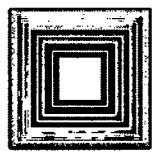
Who Receives Medicaid?

Total: 1,580,198 People



Source: DMA Annual Unduplicated Medicaid Eligibles

Significant Legislative Actions (2011-2013)



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Significant Legislative Actions:

2011 Session	FY 2011-12*	FY 2012-13*
Provider Assessments	($60,183,120)	($62,798,614)
Program Integrity Efforts	($19,200,000)	($28,000,000)
Pharmacy Services	($10,845,441)	($14,436,600)
Modify Generic Prescription Dispensing Fees	($15,000,000)	($24,000,000)
1915 B/C Waiver (Mental Health)	($10,537,931)	($52,551,082)
Community Care of North Carolina	($90,000,000)	($90,000,000)
Modify Optional and Mandatory Services	($16,508,903)	($22,072,343)
Eliminate Inflationary Increases	($62,853,775)	($130,874,505)
Adjust Provider Rates	($46,420,718)	($46,458,260)
Medicaid Rebase	0	$109,693,468

***Represents General Funds only.**

Significant Legislative Actions:

2012 Session (Additional Adjustments)	FY 2012-13*
Medicaid Rebase	$212,476,461
Repayment of Federal Overdraw	$31,300,776
Federal Drug Repayment	$24,606,148
Additional Community Care of NC Savings	($59,000,000)
Reduce Personal Care Services	($6,000,000)
Additional Pharmacy Improvements	($6,671,507)

***Represents General Funds only.**

Significant Legislative Actions:

Session Law 2012-142:

- Section 10.9A – State Audit of Medicaid
- Section 10.9B – Performance Evaluation and Fiscal Research Division Study Medicaid Organization

Session Law 2012-2:

- Provided $205,000,000 in transfers to the Division to cover a budget shortfall in FY 11/12.

Session Law 2012-57:

- Allowed up to $94,000,000 in repair and renovation funds to be transferred to help cover a budget shortfall in FY 2011/12.

Medicaid Budget

- **Source of Funds**
- **Historical Expenditures**

Medicaid Budget

What drives Medicaid Costs?

***Caseload*:** Number of people enrolled.

Case Mix: Type of people served. (Example: Elderly and Disabled populations are more expensive than families and children.)

Utilization and mix of services.

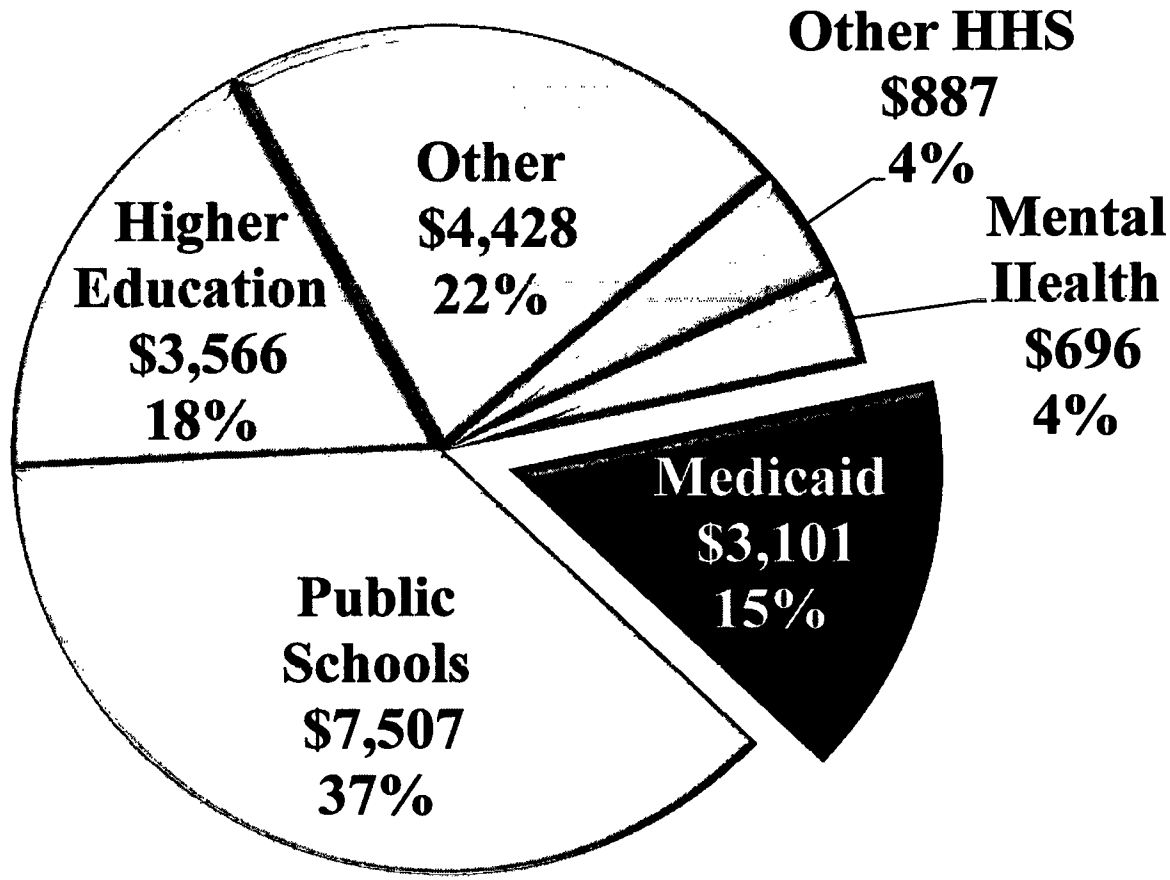
Price of services.

Some costs are controllable at the state level, other impacts on cost occur due to changes outside the state's control.

Medicaid Budget
General Fund Appropriations

General Fund Appropriations for All Agencies FY 2012-13

Total: $20,184.2 million



Medicaid Budget

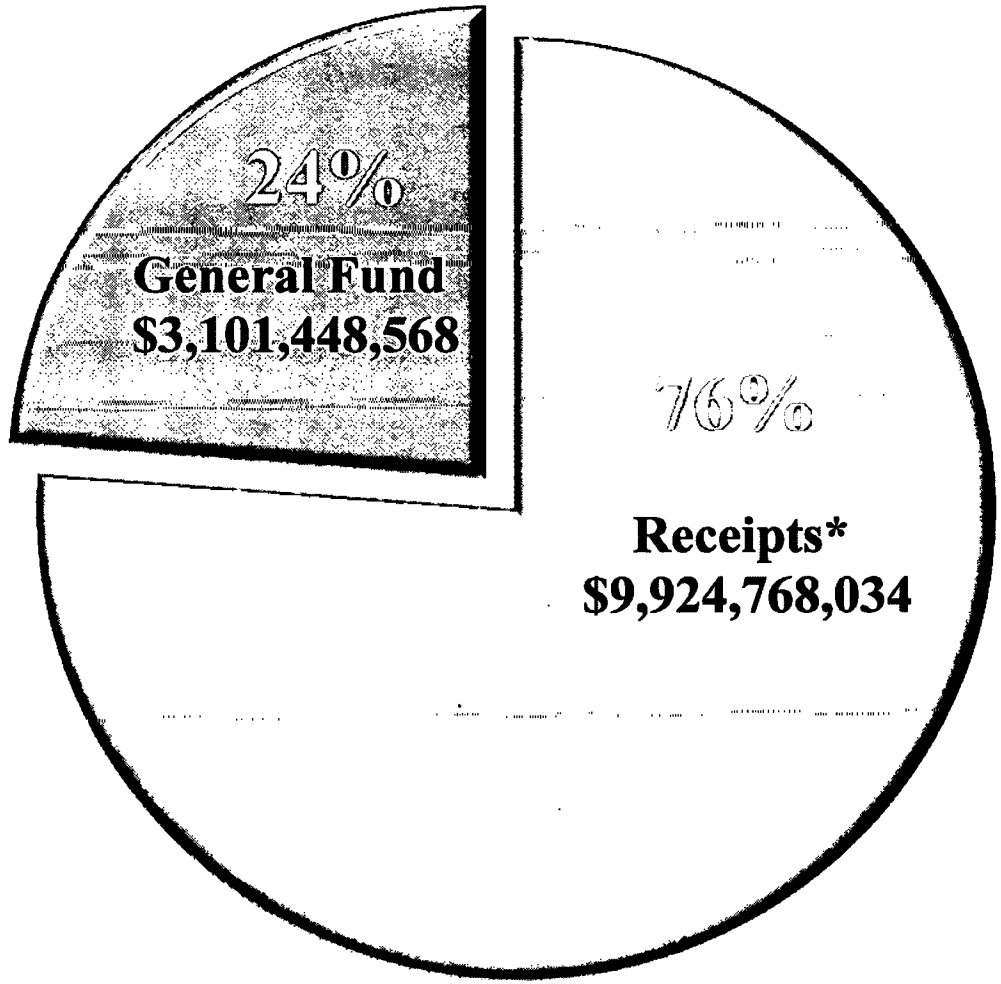
General Fund Appropriations

2012-13 General Fund Budget

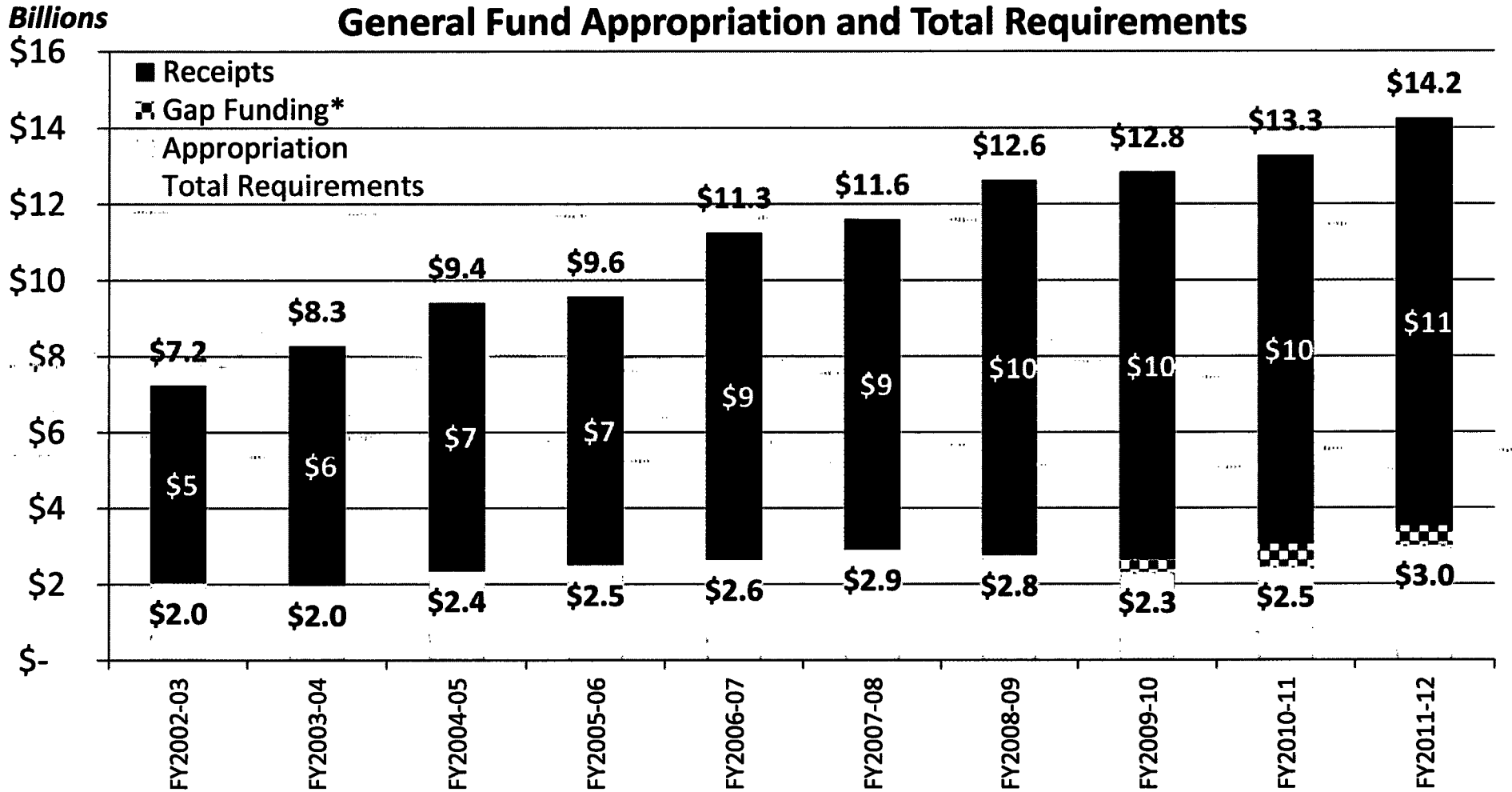
DHHS Agency	2012-13	% of Total
Blind and Deaf / Hard of Hearing Services	8,204,550	0.18%
Health Service Regulation	17,925,590	0.38%
Vocational Rehabilitation	37,528,128	0.80%
Central Management and Support	45,885,628	0.98%
NC Health Choice	81,710,435	1.74%
Aging and Adult Services	87,019,667	1.86%
Public Health	168,923,612	3.61%
Social Services	177,103,952	3.78%
Child Development	262,602,933	5.61%
Mental Health, Dev. Disabilities and Sub. Abuse	695,515,251	14.85%
Medical Assistance	**3,101,448,568**	**66.22%**
Total Health and Human Services	**$4,683,868,314**	**100.00%**

Medicaid Budget
Total Funds From All Sources

FY 2012-13 Certified Medicaid Budget from All Sources: $13 Billion



Medicaid Expenditures



*Shortfall reported and/or managed by the Department of Health and Human Services and the Office of State Budget and Management.

Medicaid Expenditures
Historical Expenditures and FY 2012-13 Certified Budget

Fund/Purpose	FY 09/10 Actual	FY10/11 Actual	FY11/12 Actual	FY12/13 Certified Budget
Administration	$ 36,089,709	$ 37,086,654	$ 89,988,710	$ 35,785,249
Contracts and Agreements	126,539,892	165,733,934	178,388,097	158,409,985
County Administration	2,093,105	1,928,231	1,319,151	1,574,377
Medical Payments	**10,178,992,817**	**10,097,489,827**	**12,044,418,138**	**9,840,661,009**
Provider Cost Settlements	2,060,314,620	2,003,108,804	1,206,450,788	2,690,454,063
Adjustments and Refunds	-424,712,239	-538,511,432	-497,198,930	-501,070,032
Disproportionate Share Payments	683,708,671	1,286,046,250	974,412,001	687,664,883
Undispositioned Receipts	18,001,043	5,139,529	-1,741,046	0
Miscellaneous Periodic Payments	1,043,318	158,948	-20,000	0
Reserves and Transfers	124,995,157	135,000,034	115,000,049	115,000,000
Prior Year Earned Revenue	18,392,003	14,200,000	11,833,330	14,200,000
Other Prior Year Audits and Adjustments	4,653,151	40,421,439	118,600,183	53,018,353
American Recovery and Reinvestment Act	8,010,353	22,548,286	0	0
TOTAL EXPENDITURES	**$12,838,121,598**	**$13,270,350,502**	**$14,241,450,471**	**$13,095,697,887**

Source: Office of the State Controller North Carolina Accounting System

Medicaid Expenditures

Year-To-Date Expenditures and FY 2012-13 Certified Budget

Fund/Purpose	FY11/12 Actual	FY12/13 Budgeted	FY 12/13 Year-To-Date
Administration	$ 89,988,710	$ 35,785,249	$ 83,921,450
Contracts and Agreements	178,388,097	158,409,985	105,776,083
County Administration	1,319,151	1,574,377	85,034
Medical Payments	12,044,418,138	9,840,661,009	7,652,066,007
Provider Cost Settlements	1,206,450,788	2,690,454,063	210,626,676
Adjustments and Refunds	-497,198,930	-501,070,032	-311,925,609
Disproportionate Share Payments	974,412,001	687,664,883	268,043,146
Undispositioned Receipts	-1,741,046	0	-19,956,357
Miscellaneous Periodic Payments	-20,000	0	206,283
Reserves and Transfers	115,000,049	115,000,000	95,000,002
Prior Year Earned Revenue	11,833,330	14,200,000	9,466,664
Other Prior Year Audits and Adjustments	118,600,183	53,018,353	42,249,742
TOTAL EXPENDITURES	**$14,241,450,471**	**$13,095,697,887**	**$8,135,601,217**

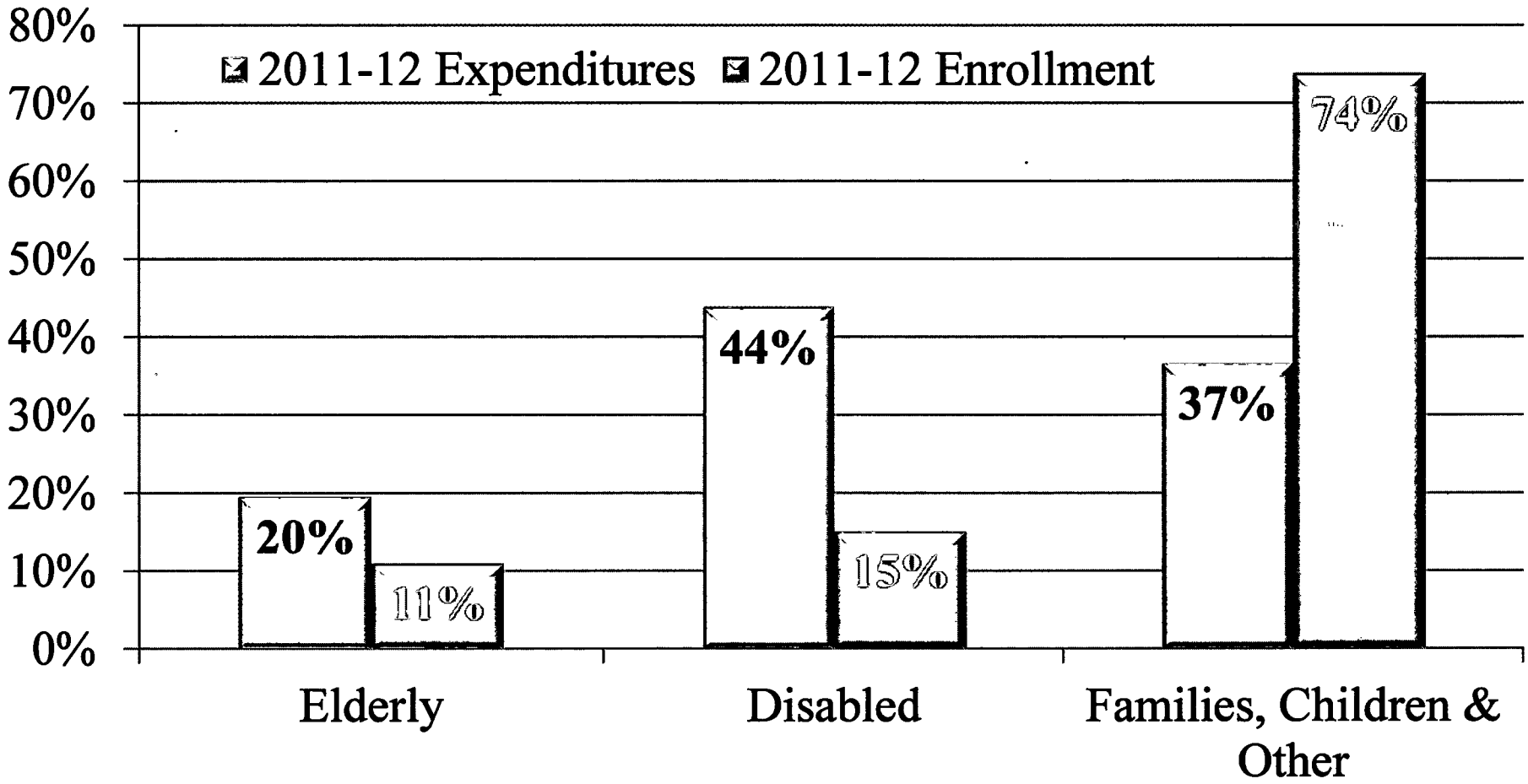
Source: Office of the State Controller North Carolina Accounting System

Medicaid Expenditures
"Top 10" Major Service Expenditure Categories

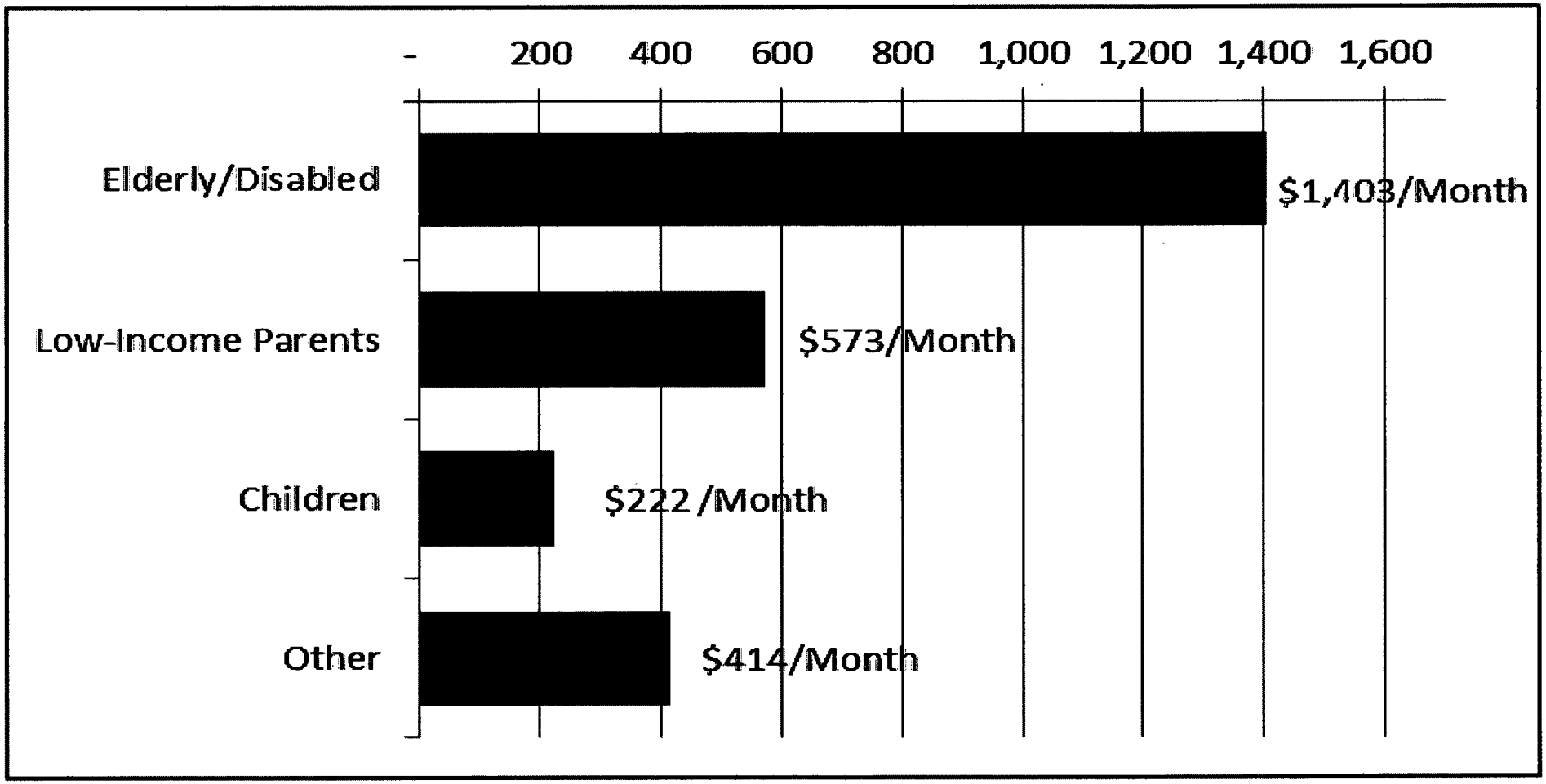
Type of Service	Total Expenditures FY 2012	% of Total
Nursing Facility	1,201,472,054	11.79%
Prescribed Drugs	1,189,415,120	11.67%
Physician	1,188,147,670	11.66%
Inpatient Hospital	1,034,266,583	10.15%
Outpatient Hospital	860,935,862	8.45%
Practitioner-Non Physician	733,345,892	7.20%
Community Alternatives (Mentally Retarded)	486,503,365	4.77%
Intermediate Care Facility (Mentally Retarded)	473,310,216	4.64%
Health Maintenance Organization Premiums	443,213,411	4.35%
Medicare, Part B Premiums	389,246,784	3.82%

Source: Office of State Budget and Management, Division of Medical Assistance Annual Report.

Medicaid Expenditures
Expenditures and Enrollment

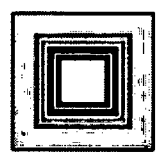


Medicaid Budget
2012 Average Payment Per Eligible Per Month



Source: DHHS, DMA Report to Legislative Oversight Committee on Health & Human Services, December 2012

Historical Budget Issues and Current Budget Status



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Recent Budget Shortfalls
General Fund Appropriations

Fiscal Year	Size of Funding Gap	Management
2010	*$335 Million*	Covered by the Department of Health and Human Services, however $271 million liability carried into next fiscal year.
2011	*$601 Million*	Funded through legislative contingency plan due to unknown federal match rate, and other state budget actions.
2012	$375 Million + $132 Million = *$507 Million*	$375 million managed by Office of State Budget and Management, plus drug rebate liability. General Assembly enacted legislation to cover the budget shortfall.
2013	*Range: $70-$134 Million*	Ongoing

Source: Office of State Budget and Management.

Medicaid Budget Comparison
General Fund Appropriation

	2011-12 (Actual)	2012-13 (Certified)	Difference[1]
Certified Appropriation	$2,958,388,184	$3,101,448,568	
Office of State Budget and Management Gap	*$375,369,958*		
FY11-12 drug rebate liability[2]	*$132,696,266*		
Subtotal: Gap & Liability	**$508,066,224**		
Total	$3,466,454,408	$3,101,448,568	**$(365,005,840)**

[1]Difference reported is not an estimated shortfall for the current year, but a comparison of the current budget to the previous year's actual expenditures.

[2]Drug rebates received in June and due to the federal government were repaid in July rather than June.

Questions

Fiscal Research Division

Room 619, LOB

919-733-4910

www.ncleg.net/fiscalresearch/

N.C. Department of Health and Human Services

MEDICAID BUDGET STATUS 2013

MARCH 12, 2013

Carol H. Steckel, Director

PROJECTED OPERATING SHORTFALL FOR 2013

INCLUDES THE IMPACT OF EXPENDITURES FOR CLAIMS, ADMINISTRATION, CONTRACTS, SETTLEMENTS AND PROGRAM INTEGITY

	Low	High
Volume	$ (47,400,000)	$ (47,400,000)
Program Aid Category Mix	46,600,000	46,600,000
Utilization	(12,000,000)	42,400,000
CCNC	19,800,000	21,700,000
Delay in MCO	16,800,000	20,100,000
Pharmacy Pricing	11,000,000	11,000,000
Flu	8,400,000	8,400,000
TOTAL Claims	43,200,000	102,800,000
Settlements/DSH/Other	25,200,000	27,700,000
Contracts	800,000	900,000
Administration	1,100,000	1,200,000
TOTAL	$ 70,300,000	$ 132,600,000

DOES NOT INCLUDE PAYMENT OF DRUG REBATES AT YEAR END or HEALTH CHOICE SHORTFALL

N.C. Department of Health and Human Services

COMPONENTS OF 2013 OPERATING SHORTFALL

• Volume	• *Impact of variances in overall enrollment*	• Average 20,000 less enrollees
• Program Aid Category Mix	• *Impact of variances in enrollment between 15 different aid categories*	• Greater than expected in higher cost categories
• Utilization *(excluding CCNC, MCO, Pharmacy Pricing and Flu)*	• *Impact of variances in the rate, type or amount of services utilized*	

N.C. Department of Health and Human Services

COMPONENTS OF 2013 OPERATING SHORTFALL

• CCNC	• *Impact of actual savings achieved compared to budgeted amount*	• 1/3 of reduced savings attributable to DMA assignment process – balance reflected in various initiatives included in budget
• Delay in MCO	• *Impact on savings of the revision to the budgeted schedule for implementation*	• Budget assumed all MCO's operational in October – Last MCO's implemented March
• Pharmacy Pricing	• *Impact of the variance in budgeted increases in drug costs and actual increases*	• Budget assumed 8% increase for drug prices, actual brand up 9% and generics up 15%

N.C. Department of Health and Human Services

COMPONENTS OF 2013 OPERATING SHORTFALL

• Flu	• *Impact of a more severe flu season in 2013 than budgeted*	• Physician and ER visits up 300% to 400% from 2012
• Settlements/DSH/ Program Integrity/Other		• Provider settlement payments and program integrity
• Contracts	• *All outsourced services*	• Prior authorization and PI support
• Administration	• *Salaries, supplies, space, postage and other expenses*	• Audit services, software purchases and postage

N.C. Department of Health and Human Services

KEY FEBRUARY UTILIZATION VARIANCES

- Inpatient admissions increased by 8%, shift in admissions for lower cost maternity to higher costs diagnoses and increased proportion of admissions in higher cost facilities
- Hospital outpatient visits increased in surgery, cancer treatment, respiratory and imaging. Also increases larger in higher cost facilities
- 1% overall increase in physician office visits, increase in average cost per recipient reflects mix of services and physician specialty

N.C. Department of Health and Human Services

QUESTIONS

Carol H. Steckel, Director

Carol.Steckel@dhhs.nc.gov

Committee Sergeants at Arms

NAME OF COMMITTEE Joint Comm. on HHS

DATE: 3/12/13 Room: 643

House Sgt-At Arms:

1. Name: Fred Hines
2. Name: Charles Godwin
3. Name: _____
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: Leslie Wright
2. Name: Billy Fritscher
3. Name: _____
4. Name: _____
5. Name: _____

Pages - House

Tuesday, March 12	**Room**	**Time**
JOINT APPROPRIATIONS HEALTH & HUMAN SERVICES	643	8:30 am

Name	County	Sponsor
Mayah Haynes	Wake	Holley
Taylor Morin	Wake	Hastings

Senate/
House

PAGES ATTENDING

COMMITTEE: Joint: Health & Hum. Services ROOM: 643

DATE: 3-12 TIME: 8:30

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!

Key-anna

	Page Name	Hometown	Sponsoring Senator
1	Kianna Brower	Rural Hall	Parman.
2	Milizhia Mills	Winston-Salem	Parman
3			
4	Ma-li-zha		
5			
6			
7			
8			
9			
10			

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

VISITOR REGISTRATION SHEET

Joint Comm. on HHS — 3/12/13

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tracy Colvard	AHHC
Dan Coughlin	NC - Council Com Progr.
Ashley Perkinson	Perkinson Law
Louise Fisher	Advocate for Mentally Ill
Annaliese Dolph	Dolph Law
Jessica Herrmann	Governor's Institute 1121 Situs Ct. Raleigh, NC 27606
Dean Plunkett	PS
Dirk Alston	[illegible]
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

Joint Comm. on HHS — 3/12/13

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fred Wolff	East Seal UCP
Jennifer Mahan	ASNC
DAVID STONE	The Carolinas Center for Hearing and ECA Corp
JAY PETERS	CSS
LAURA BULLOCK	Office of State Auditor
Evelyn Henderson	DHHR
Keara Bowen	LCA
John Hamlin	NFIS
Jimmy Broughton	Womble Carlyle
Matt Wolfe	Parker Poe
Chuck Stone	SEANC

VISITOR REGISTRATION SHEET

Joint Comm. on HHS — 3/12/13

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Towres Maxwell	PSG
Mac Boxley	NC Forest & Pattle
Alex Mullinax	Coo Ment Health
Sam Hansen	
Peggy Mayer	
Heidi Tiger	
Amy Whited	NCMS
Sarah Rothacker	Builders Assoc.
Chip Bigelow	NCMS
	NCDS
Caroline Cobb	The Policy Group
Wendy Kelly	The Policy Group

VISITOR REGISTRATION SHEET

Joint Comm. on HHS — 3/12/13

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Madison Mackenzie	DOJ
Matt Gross	NCPC
Kay Paksoy	NASW-NC
Sarah Wolff	MWCLLC
George Smith	NP
Mari Wilder	Novant
Bob Hedrick	NCPC
Breeden Blackwell	Cape Fear Valley
DANA HAITHCOCK	Private citizen
	NLEMA
Daniel Amborn	NCEMA

VISITOR REGISTRATION SHEET

Joint Comm. ON HHS — 3/12/13

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Ashburn	NCPHA
James Bond	NHG
Thom Mc	FWC
Julia Adams	The Arc of NC / NCARF
Rob Lamm	TEA
Cory Hamm	NCHA
Ken Melton	K.M.A.
J Rode	BCS
Lan Nich	NCALTCF
Mary Bethune	AARP - NC
Allison Waller	Nelson Mullins

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

March 14, 2013
Legislative Office Building - Room 643
8:30 a.m.

Representative Marilyn Avila, Presiding	Welcome, Opening Remarks
Department of Health and Human Services Information Technology Overview	Joe Cooper, Chief Information Officer
Medicaid Management Information System	Paul Guthery, Senior Program Manager Ed Riley, Contract Administrator
North Carolina Families Accessing Services Through Technology	Anthony Vellucci, Program Director
Adjourn	
Next Meeting:	Tuesday, March 19th, 8:30 a.m.

Senate Committee on Appropriations on Health and Human Services
Thursday, March 14, 2013 at 8:30 a.m.
Room 643

MINUTES

The Senate Committee on Appropriations on Health and Human Services met at 8:30 a.m. on Thursday, March 14, 2013 in Room 643. Five Senate members were present along with Representatives Marilyn Avila, Mark Hollo, Carl Ford, Jim Fulghum, Verla Insco and Jean Farmer-Butterfield.

Representative Avila presided.

Representative Avila recognized the following House Sergeants-at-Arms: Fred Hines and Charles Godwin; Senate Sergeants-at-Arms were Charles Harper, Ed Kesler and Charles Marsalis. She then recognized Pages for the House: Emily Hedrick of Alamance County, Jeffrey Manchester of Mecklenburg County and Jake Parrish of Carteret County. Senate Pages were: Emma Burri from Mecklenburg County and Milizhia Mills from Forsyth County.

Representative Avila welcomed everyone and called on Mr. Joe Cooper, Chief Information Officer for the Department of Health and Human Services to give an overview of the Department's Information Technology (attachment 1). After completing his presentation, Mr. Cooper recognized Mr. Paul Guthery, Senior Program Manager to speak on the Medicaid Management Information System; Mr. Ed riley, Contract Administrator also spoke regarding the MMIS (attachment 2). Mr. Anthony Vellucci, Program Director then made a presentation on North Carolina Families Accessing Services Through Technology (NC FAST) (attachment 3).

Following the completion of the presentations, Representative Avila thanked the DHHS staff for their attendance and sharing valuable information.

The meeting adjourned at 9:50 a.m..

Marilyn W Avila
Representative Marilyn Avila
Presiding

Edna Pearce
Edna Pearce, Committee Clerk

Edna Pearce (Sen. Louis Pate)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, March 07, 2013 11:50 AM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Thursday, March 14, 2013 at 8:30 AM

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

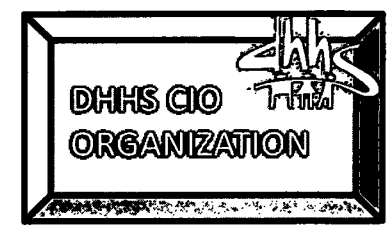
DAY	DATE	TIME	ROOM
Thursday	March 14, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Joint Appropriations Subcommittee on Health and Human Services

DHHS CIO ORGANIZATION

MARCH 14, 2013



AGENDA

1. Introductions
2. Observations from the first 30 days
3. DHHS CIO organizational review
4. MMIS update
5. NC FAST update

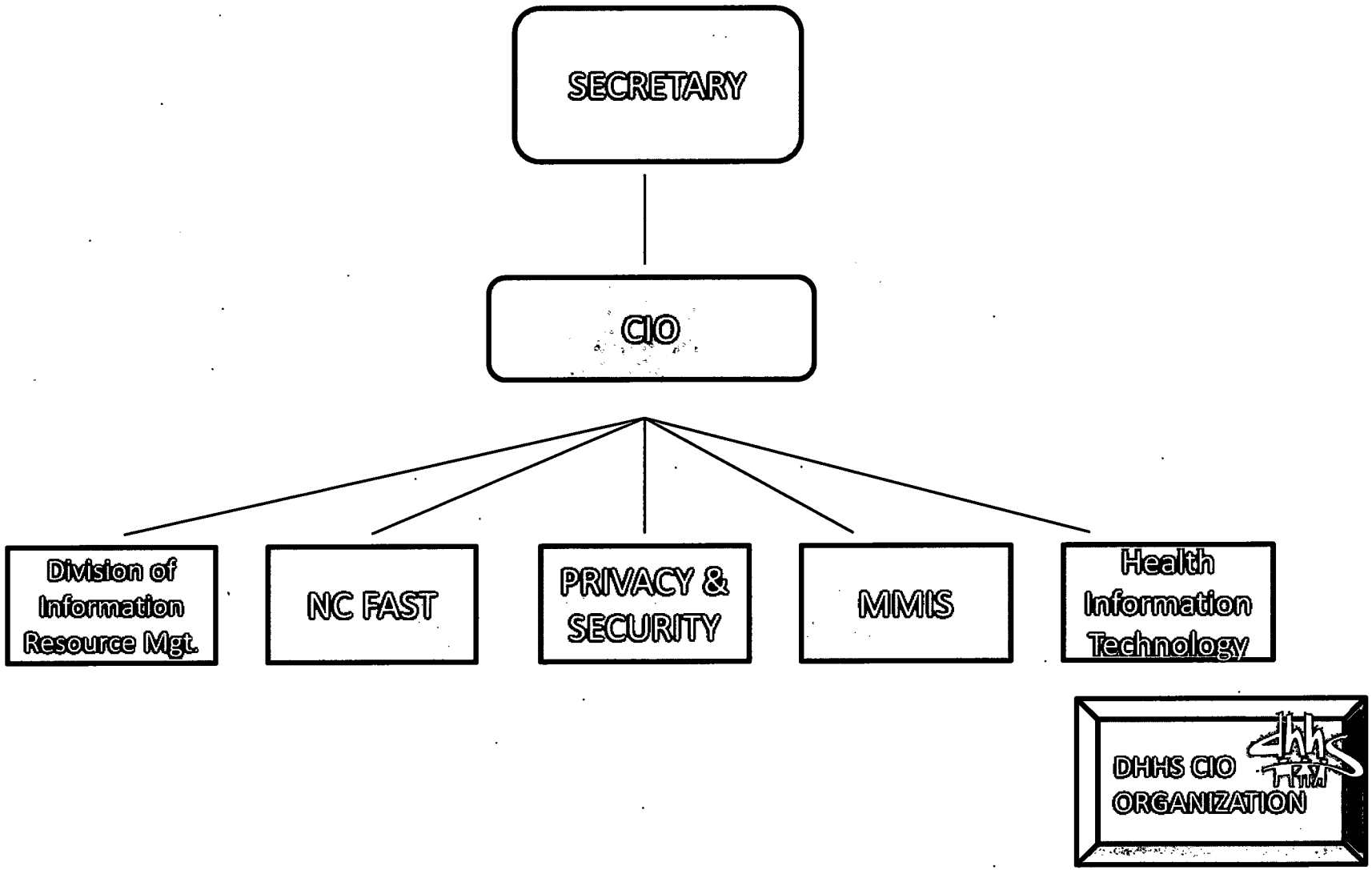
DHHS CIO ORGANIZATION

CIO OBSERVATIONS – FIRST 30 DAYS
MARCH 14, 2013

- **Large Scale Program Management**
  - Multiple methodologies/approaches used
- **Enterprise Standards**
  - Why have "1" document imaging system when you can have "5"
- **Older Technology**
  - Average age of PC's & Software – 5+ years
  - Security vulnerabilities
- **Vendor Management Office**
  - Nothing formal in place, multiple master agreements in place
- **DHHS Audit**
  - Reactive, not proactive
- **Information Security**
  - Both detection and enforcement is weak

DHHS CIO ORGANIZATION

DHHS CIO
ORGANIZATIONAL CHART



Questions?

MMIS Report
Joint Appropriations Subcommittee on Health and Human Services

March 14, 2013

Paul Guthery
Associate Program Director
Senior Program Manager
NC DHHS Office of MMIS Services

Ed Riley
Associate Program Director
Contract Manager
NC DHHS Office of MMIS Services

NCMMIS Program Purpose

- **Replacement MMIS Project (NCTracks)**
  - Design, develop and install a componentized, integrated, multi-payer Replacement Medicaid Management Information System (MMIS) and Fiscal Agent operations
  - Facilitate provider enrollment and consolidate claims processing activities for multiple DHHS health plans
    - Division of Medical Assistance – Medicaid & Health Choice
    - Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
    - Division of Public Health
    - Office of Rural Health and Community Care
  - Coordinate processing among the payers to ensure the proper assignment of the payer, benefit plan, and pricing methodology for each service on a claim

NCMMIS Program Purpose

- **Reporting & Analytics Project**
  - Design, develop and install a state-of-the-art Data Warehouse, and reporting solution that meets not only current DHHS needs, but provides a platform for changes leading to future growth with enhanced self-service by the end-user community
  - Surveillance Utilization Review System (SURS) – Detection of fraud and abuse
  - Decision Support System (DSS) – Healthcare data analytics to empower more informed policy decisions

NCMMIS Program Purpose

- **Business Process Automation System Project**
  - Identify and execute the procurement and implementation of a Business Process Automation System and associated business services for the DHHS Division of Health Service Regulation (DHSR)
  - Satisfy the information sharing requirements with the Replacement MMIS in the area of provider eligibility
  - Provide automation, using a common database, to support the business functions of DHSR
    - Certificate of Need
    - Construction
    - Licensure and Certification
    - Health Care Personnel Registry
    - Center for Aide Regulation and Education

Advantages of the Replacement MMIS

- Multi-payer system consolidating claims processing for multiple DHHS divisions, ensuring the proper assignment of payer, health plan, benefit plan, and pricing methodology for each claim line
- Provider Web Portal
  - Provider Enrollment
  - Changes to Provider enrollment information
  - Recipient Enrollment and Service Limits
  - Electronic Claims Submission
  - Fee Schedules and Rates
  - Prior Approval Inquiry and Request
  - Claims Status Information
  - Retrieval of Remittance Advices
  - Online access to training information

Advantages of the Replacement MMIS

- Recipient Web Portal
  - Online access to health care coverage information
  - Administrative contact information for benefit plans including managed care organizations
  - Health Plan and Benefit Plan name and coverage dates
- Claims Processing
  - Multi-detail, multi-payer claims submission
  - Outpatient hospital claims at a line item detail level for all revenue codes
  - Automated claims adjustments
  - Immediate adjudication of claims

MMIS Legacy System Synchronization

- Modifications to the legacy solutions continued after the system freeze date
- Limitations to the level of change that can be made to the system once final testing began while maintaining quality
  - System soft freeze began on March 2, 2012 – Hard freeze began on May 31, 2012
  - User Acceptance Testing (UAT) began August 29, 2012
  - Changes approved after freeze date not available for current UAT

MMIS Legacy System Synchronization

- CSC Contract Amendment #3 created to allow for the development and testing of the most critical of these changes
  - Additional capacity for change allocated
  - Move Operational Readiness Date from March 1, 2013 to July 1, 2013 to accommodate additional Medicaid changes
  - Maintain July 1, 2013 Operational Start
  - Use capacity originally allocated to ICD-10 (International Classification of Diseases 10th Revision)
    - Federally required compliance date moved from October 1, 2013 to October 1, 2014
    - Work continues on ICD-10 in preparation for system changes
  - Additional Final Integration and User Acceptance Testing Period
    - April / May 2013
    - Overlap additional testing with the execution of Provider Operational Preparedness (POP)

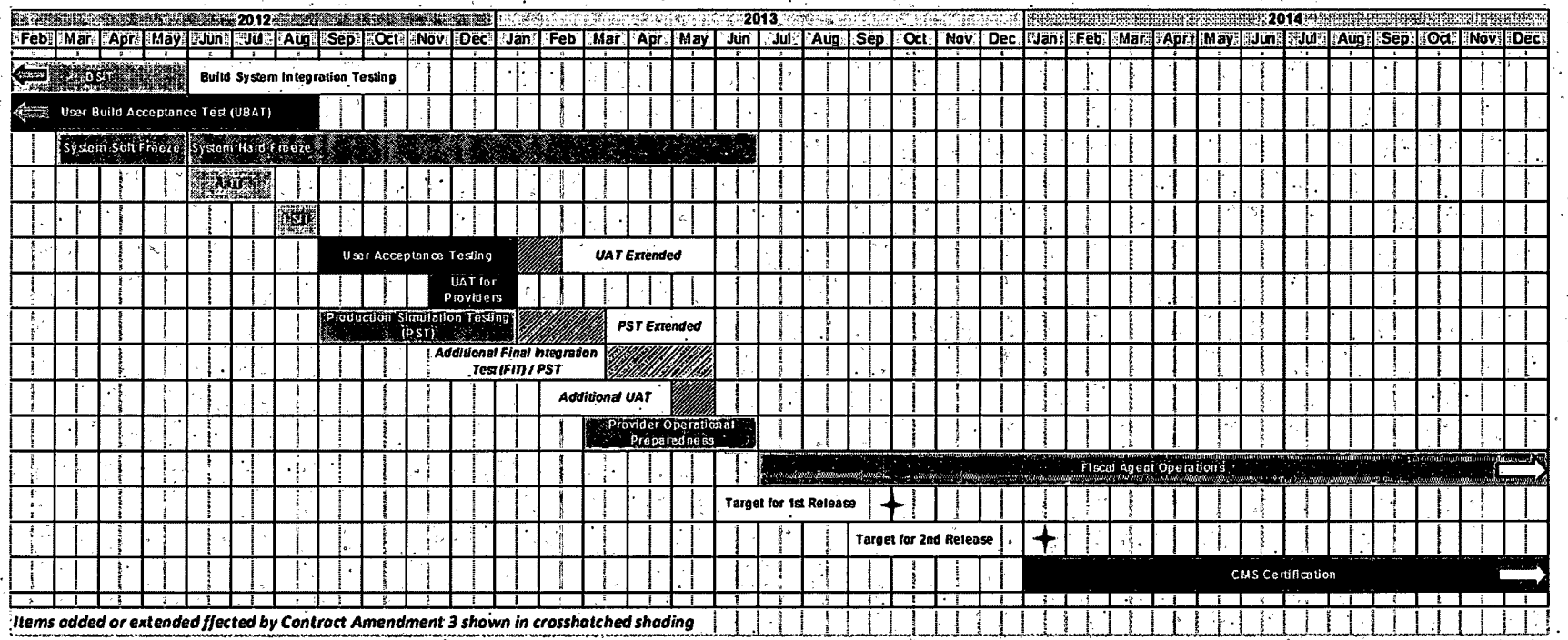
MMIS Legacy System Synchronization

- Additional Synchronization Gap Less Critical Functionality
  - Additional CSRs are currently in the CSC backlog to be implemented that will not be addressed by July 1, 2013
  - The first two post operational start software releases are scheduled for:
    - October 1, 2013
    - January 1, 2014
  - Workarounds required until the implementation of functionality

Workarounds Strategy

- Workgroup currently developing workarounds for 288 change requests
  - 120 Customer Service Requests (CSRs)
  - 168 State Memoranda
- The workaround strategies can be broadly grouped by the following categories:
  - Change policy, business rules, and/or claims filing instructions
  - Manual intervention performed by CSC, the State, or other vendor
  - Pay and chase or report
  - Monitor impacts
  - Cancel original change request
  - Suspend specific task in Division operations
- Workgroup to complete identification of workarounds by March 18
- Work beginning to define impacts and communications

Replacement MMIS Schedule



User Acceptance Test (UAT) Results

- User Acceptance Test Cases Completed by the State: 1,980
- Test Cases with no outstanding defects: 1,751 (88.4%)
- Total defects discovered during UAT: 1,520
  - Initial UAT period (8/29/2012 – 1/16/2013)

Severity	Exit Threshold	Discovered	Resolved	Open
1. System-wide Failure	0	33	33	0
2. Inconsistent Results	10% (83)	839	761	78
3. Workaround Exists	25% (134)	537	452	85
4. Cosmetic	n/a	96	51	45
5. Working as Designed	n/a	15	1	14
Total	n/a	1,520	1,298	222

Overall Program Budget

NCMMIS+ Program Budget					
Project	Initial	Current		Federal	State Share
Replacement MMIS					
Development	$ 114,704,823	$ 219,847,415		$ 192,695,227	$ 27,152,188
Ops & Maintenance	$ 196,790,210	$ 203,646,862		$ 142,836,157	$ 60,810,705
Early Operations	$ 8,751,865	$ 20,457,214		$ 17,261,493	$ 3,195,721
Reporting & Analytics					
Development	$ 14,752,168	$ 15,549,664		$ 13,994,698	$ 1,554,966
Ops & Maintenance	$ 45,073,315	$ 45,069,033		$ 33,801,775	$ 11,267,258
BPAS - DHSR					
Development	$ 6,167,739	$ 8,565,102		$ 4,697,413	$ 3,867,689
Ops & Maintenance	$ 6,119,699	$ 8,119,699		$ -	$ 8,119,699
Program-Level Project					
Development	$ 9,721,297	$ 15,803,746		$ 13,828,278	$ 1,975,468
Certification	$ 1,430,271	$ 2,440,790		$ 2,135,691	$ 305,099
Other Projects					
HIT Incentive Paymen	$ 31,586,627	$ 10,786,958		$ 9,708,262	$ 1,078,696
Medicaid Forecast	$ 1,739,914	$ 1,523,010		$ 1,370,709	$ 152,301
Business Initiatives	$ 11,535,538	$ 11,133,002		$ 9,790,332	$ 1,342,670
Total	**$ 448,373,466**	**$ 562,942,495**		**$ 442,120,034**	**$ 120,822,461**

Vendor Cost Savings - MMIS

- Over the five year operations & maintenance phase, the CSC contract cost will save on average $3 million per month over expected future costs of existing contracts that will be retired when NCTracks is implemented.
- The state appropriations savings over that same five year period is expected to average over $900,000 per month.
- Systems to be retired by NCTracks:
  - MMIS – HP
  - IPRS – HP
  - Pharmacy Prior Authorization Call Center – Xerox
  - Smart PA – Xerox
  - POMCS– DHHS

CSC Contract - MMIS

NCMMIS+ Program Contract Amendments			
Vendor	Amendment	Cost	State Share
CSC			
Development[1]	Base	$ 77,960,715	$ 9,901,010.81
Ops & Maintenance	Base	$ 187,243,759	$ 51,023,924.33
Development	Amend # 1	$ -	$ -
Ops & Maintenance	Amend # 1	$ -	$ -
Development	Amend # 2	$ 152,754,523	$ 18,025,033.71
Ops & Maintenance[2]	Amend # 2	$ 66,921,800	$ 18,236,190.50
Development	Amend # 3	N/A	N/A
Ops & Maintenance	Amend # 3	N/A	N/A
Total			
Development		$ 230,715,238	$ 27,926,045
Ops & Maintenance		$ 254,165,559	$ 69,260,115

[1] Although not included in the initial contract; $ 22M was budgeted for changes and approved by CMS.
[2] Two additional years of operations were added to the contact.

Program Risks and Issues

- Based on analysis by an outside consultant, Susan Young, the following risks and mitigation strategies have been identified:

Risk	Mitigation Strategy
Stakeholder Engagement	A supplementary communications approach has been developed and a resource allocated to integrate the specific plans into the overall program and management routines
Program Planning, Execution and Monitoring	The MMIS Program has now been aligned under the DHHS CIO, and availability of critical resources has been secured
Organizational Change Enablement	An external consultant will be engaged to drive our development of Division business processes and facilitate additional preparations for user testing and transition
Change Management	A hard freeze has been placed on further changes to the legacy and new systems. A team has been formed to identify gaps and define interim processes
Overall Implementation Strategy	Resources will be reallocated to support deployment planning efforts and bring focus to the most significant levers for the success of the initiative.
Test Planning and Execution	Critical resources to support testing cycles have been secured. Additional business process activities will make user testing and readiness assessments more effective

Program Risks and Issues

- As reported by CSC in their 2/14/2013 report to the NCMMIS+ Steering Committee

Risk	Mitigation Strategy
Provider Conversion	A number of data quality issues have been identified during PST and UAT that impact claims adjudication. The State and CSC have made good progress. 2 outstanding issues remain, 3 issues require data clean up and one potential workaround has been identified
Taxonomy	The current design requires a taxonomy at level 3 for professional providers and some may have credentials only to a level 2. CSC has determined the effort required to make the required modifications and will work with the State to determine how to implement by operational start.
Interfaces	CSC is still working through interface files from the State so end to end testing can occur during the extended PST. 8 interfaces will be tested during the May PST.
Legacy CSR Workarounds	There are approximately 120 Legacy CSRs and 168 State memoranda that will not be in NC Tracks at operational start. OMMISS and DMA are evaluating the workarounds with a 3/18/2013 completion target. Any impact to CSC operations must be reviewed and determined after that date.

Appendix

CMS Certification

- Review of the MMIS and operations
  - CMS Certification Checklists
- State requests certification after the closeout of two fiscal quarters
  - Operational start on July 1, 2013
  - North Carolina can request certification after closing out the quarter ending December 31, 2013
- Following the request, CMS and the State begin planning one week on-site certification review
  - Document collection and preparation
- One week on-site visit typically at least one year after operational start
- Based on the information collected, CMS may issue findings and require the State to take remedial action

CMS Certification

- Financial Impact
  - On the first day of operations, the Federal match for operations is 50%
  - Upon certification the Federal match for operations improves to 75%
  - When certification is achieved, the difference between the 50% and 75% Federal match is paid retroactively back to the day the system is deemed by CMS to be the system of record

Testing Participation

- CSC Staff
  - Build System Integration Testing
  - Final Integration Testing
  - Final System Integration Testing
  - Production Simulation Testing
- OMMISS Staff
  - User Build Acceptance Testing
  - User Acceptance Testing
  - Review of CSC Conducted Testing
- Division Testing
  - 46 participants from the DHHS divisions
  - Participants from DMA, DMH/DD/SAS, DPH

Testing Participation

- Providers
  - User Acceptance Testing for Providers
  - Worked with 25 Provider Associations for nominees
  - 37 Providers nominated by 8 associations participated over six weeks
    - Dental
    - Pediatrics, Novant, CCNC
    - LMEs
    - Public Health
    - Nursing Homes, Home & Hospice
    - Hospitals

Transition Planning
Deployment Planning Approach

Iteration	Content
Initial Framework (Delivered 11/26/2012)	Establishes the concept, structure, and layout of the deliverable, with a focus on the introductory information, high-level activity/task and schedule definition, establishment of assumptions and constraints, templates and integration with related documents.
Iteration 2 (Delivered 2/15/2013)	Focuses on the detailed rollout and deployment schedule/activities, post deployment activities, organization rolls and responsibilities, continued refinement of assumptions and constraints, populating the templates, and details of the back out plan.
Iteration 3 (Delivery 3/31/2013)	Continued expansion of the detailed rollout and deployment schedule/activities, expansion of the post deployment activities, finalization of the organization rolls and responsibilities, continued refinement of assumptions and constraints, continued refinement of the back out plan details.
Final Iteration (Delivery 5/31/2013)	Wrap-up of the detailed rollout and deployment schedule/activities, wrap-up of the post deployment activities, wrap-up of assumptions and constraints, wrap-up of the back out plan details.

Budget Update

- Overall Program Budget and Budget for Each Project
  - Initial
  - Current
  - Reasons for Changes
  - Operations and Maintenance Costs
  - Sources of Funding

Replacement MMIS Budget

Replacement MMIS Project Budget					
	Initial	Current	Reason	Federal	State Share
Development	**$ 114,704,823**	**$ 219,847,415**		**$ 192,695,227**	**$ 27,152,188**
Vendor Costs					
CSC	$ 90,820,113	$ 186,604,862	1	$ 163,359,494	$ 23,245,368
IV&V and Testing	$ 6,203,920	$ 9,939,959	2	$ 8,945,963	$ 993,996
Internal Costs	$ 17,680,790	$ 23,302,594	2	$ 20,389,770	$ 2,912,824
Ops & Maintenance (5 Years)	**$ 196,790,210**	**$ 203,646,862**		**$ 142,836,157**	**$ 60,810,705**
Vendor Costs	$ 188,450,458	$ 188,552,178		$ 131,515,144	$ 57,037,034
Internal Costs	$ 8,339,752	$ 15,094,684	3	$ 11,321,013	$ 3,773,671
Early Operations	**$ 8,751,865**	**$ 20,457,214**		**$ 17,261,493**	**$ 3,195,721**
CSC	$ 7,933,903	$ 18,272,214	4	$ 15,622,743	$ 2,649,471
Internal Costs	$ 817,962	$ 2,185,000	4	$ 1,638,750	$ 546,250
Total	**$ 320,246,898**	**$ 443,951,491**		**$ 352,792,877**	**$ 91,158,614**

Reason for Changes to the Replacement MMIS Budget

1. Schedule slipped 22 months; functionality has been added. Reasons for slippage:
   - Over estimation of the degree of fit with the baseline solution from CSC
     - Estimated 73% reuse – Realized 32% reuse
   - Approximately 200 legacy change requests that were not included in the original scope were added to the design
   - Federal Scope Expansion:
     - HIPAA 5010
     - ICD-10
     - National Correct Coding Initiative (NCCI)
     - Healthcare Reform
   - State Legislation: SL 2010 and SL 2011 changes
   - Added four months of Provider Operational Preparedness

Reason for Changes to the Replacement MMIS Budget

2. Added 22 months to the development phase impacting the Independent Verification and Validation (IV&V) and Testing vendors' contracts; and internal labor and project support costs
3. Revised estimate of the resources needed to manage vendors and to begin the next MMIS procurement cycle
4. Added 22 months to early operations (provider enrollment, credentialing and verification) and for drug utilization review; also realized a larger number of providers enrolling in Medicaid

Reporting & Analytics Budget

Reporting & Analytics Project Budget					
	Initial	Current	Reason	Federal	State Share
Development	**$ 14,752,168**	**$ 15,549,664**		**$ 13,994,698**	**$ 1,554,966**
Vendor Costs					
Truven	$ 6,877,113	$ 10,816,274	1	$ 9,734,647	$ 1,081,627
IV&V and Testing	$ 629,381	$ 1,077,750	2	$ 969,975	$ 107,775
Internal Costs	$ 7,245,674	$ 3,655,640	3	$ 3,290,076	$ 365,564
Ops & Maintenance (5 Years)	**$ 45,073,315**	**$ 45,069,033**		**$ 33,801,775**	**$ 11,267,258**
Vendor Costs	$ 43,428,927	$ 43,608,606		$ 32,706,455	$ 10,902,152
Internal Costs	$ 1,644,388	$ 1,460,427		$ 1,095,320	$ 365,107
Early Operations	**$ -**	**$ 316,000**		**$ 237,000**	**$ 79,000**
Truven	$ -	$ 316,000		$ 237,000	$ 79,000
Total	**$ 59,825,483**	**$ 60,934,697**		**$ 48,033,472**	**$ 12,901,225**

Reason for Changes to the Reporting & Analytics Budget

1. Due to the MMIS project being extended 22 months, the R&A project needed to be extended as R&A is dependent upon data from the Replacement MMIS. Also developed and implemented the Surveillance Utilization Review System (SURS) to operate with legacy data
2. Added 22 months to the development phase impacting IV&V and Testing vendor contracts
3. Although the development phase was extended, the staffing level required to support this R&A project was initially overestimated

Business Process Automation System (BPAS) Budget

Business Process Automation System (BPAS) Project Budget					
	Initial	Current	Reason	Federal	State Share
Development	**$ 6,167,739**	**$ 8,565,102**		**$ 4,697,413**	**$ 3,780,389**
Vendor Costs					
GLS	$ 4,205,970	$ 4,205,970		$ 2,102,985	$ 2,102,985
IV&V and Testing	$ 174,601	$ 174,601		$ 87,301	$ 87,301
Internal Costs	$ 1,787,168	$ 4,184,531	1	$ 2,507,127	$ 1,677,404
Ops & Maintenance	**$ 6,119,699**	**$ 8,119,699**		**$ -**	**$ 8,119,699**
Vendor Costs	$ 4,846,779	$ 4,846,779		$ -	$ 4,846,779
Internal Costs	$ 1,272,920	$ 3,272,920	1	$ -	$ 3,272,920
Total	**$ 12,287,438**	**$ 16,684,801**		**$ 4,697,413**	**$ 11,900,088**

Reason for Changes to the BPAS Budget

1. Staffing levels were initially underestimated and required hardware and software was omitted from the initial budget

Program Level Project

Program-Level Project Budget					
	Initial	Current	Reason	Federal	State Share
Development	**$ 9,721,297**	**$ 15,803,746**		**$ 13,828,278**	**$ 1,975,468**
Vendor Costs	$ -				
Internal Costs	$ 9,721,297	$ 15,803,746	1	$ 13,828,278	$ 1,975,468
Certification	**$ 1,430,271**	**$ 2,440,790**		**$ 2,135,691**	**$ 305,099**
Vendor Costs	$ -	$ -		$ -	$ -
Internal Costs	$ 1,430,271	$ 2,440,790	2	$ 2,135,691	$ 305,099
Total	**$ 11,151,568**	**$ 18,244,536**		**$ 15,963,969**	**$ 2,280,567**

Reason for Changes to the Program-Level Budget

1. The project length was extended by 22 months, additional staffing hours were required due to the extended schedule
2. Updated staffing requirements for the first year of operations to support maintenance and federal certification activities

Contract Amendments

Contract Amendments

- By Project and vendor
- Cost Increase associated with each

Truven Contract – Reporting & Analytics

NCMMIS+ Program Contract Amendments			
Vendor	Amendment	Cost	State Share
Truven			
Development	Base	$ 6,877,113	$ 687,711
Ops & Maintenance	Base	$ 43,428,927	$ 10,857,232
Development	Amend # 1	$ -	$ -
Ops & Maintenance	Amend # 1	$ -	$ -
Development	CSR 787	$ 1,511,370	$ 151,137
Development	Amend # 2	$ 1,441,798	$ 1,297,618
Ops & Maintenance	Amend # 2	$ 20,851,305	$ 5,212,826
Development	Amend # 3	$ -	$ -
Ops & Maintenance	Amend # 3	$ -	$ -
Total			
Development		$ 9,830,281	$ 2,136,467
Ops & Maintenance		$ 64,280,232	$ 16,070,058

GLS Contract – Business Process Automation System (BPAS)

NCMMIS+ Program Contract Amendments			
Vendor	Amendment	Cost	State Share
GLS			
Development	Base	$ 5,515,494	$ 2,757,747
Ops & Maintenance	Base	$ 3,537,255	$ 1,768,628
Development	Amend # 1	$ -	$ -
Ops & Maintenance	Amend # 1	$ -	$ -
Total			
Development		$ 5,515,494	$ 2,757,747
Ops & Maintenance		$ 3,537,255	$ 1,768,628

Maximus Contract – Independent Verification and Validation (IV&V)

NCMMIS+ Program Contract Amendments			
Vendor	Amendment	Cost	State Share
Maximus			
Development	Base	$ 2,549,968	$ 267,747
Ops & Maintenance	Base	$ 378,796	$ 94,699
Development	Amend # 1	$ -	$ -
Ops & Maintenance	Amend # 1	$ -	$ -
Development	Amend # 2	$ 1,459,752	$ 153,274
Ops & Maintenance	Amend # 2	$ 507,640	$ 126,910
Total			
Development		$ 4,009,720	$ 421,021
Ops & Maintenance		$ 886,436	$ 221,609

SLI Contract - Testing

NCMMIS+ Program Contract Amendments			
Vendor	Amendment	Cost	State Share
SLI			
Development	Base	$ 3,518,302	$ 358,867
Ops & Maintenance	Base	$ 2,081,113	$ 520,278
Development	Amend # 1	$ 3,575,996	$ 364,752
Ops & Maintenance	Amend # 1	$ (1,934,887)	$ (483,722)
Total			
Development		$ 7,094,298	$ 723,618
Ops & Maintenance		$ 146,226	$ 36,557

NC FAST

North Carolina Families Accessing Services through Technology

High-Level Program Status

March 14, 2013

Anthony Vellucci, Office of NC FAST Director

dhhs

Overview

Today's discussion includes the following:

- NC FAST Purpose and Benefits
- Program Areas Impacted by NC FAST
- Case Management Project 1: Global Case Management and FNS
- Case Management Project 2&6: Eligibility Information System
- Case Management Project 3: LIEAP, Child Care, and CIP
- Case Management Project 4: Child Services
- Case Management Project 5: Aging and Adult Services
- Case Management Project 7: NC FAST FFE Interoperability
- ePASS
- Document Management
- NC FAST Organization Chart and Director
- Program Budget
- Program Schedule
- Vendors
- Questions

Purpose of NC FAST

- Designed to improve the way NC DHHS and the 100 county departments of social services provide benefits and services to the people of North Carolina, and help families move to independence.
- Introduce new technological tools and business processes that will enable staff to reduce time spent on repetitive and cumbersome paperwork, and allow state and county staff to better focus their efforts on the complex issues presented by North Carolina families in need.
- Provide a truly integrated cross-functional social- and human-services delivery approach that moves beyond the current environment.

NC FAST: A New Way of Doing Business

- ✓ NC FAST system functionality presents a very different way of conducting the business of taking applications and processing cases.
- ✓ Data from 19 legacy systems is converted and consolidated into a central database for the integrated case management system.
- ✓ The system performs calculations and applies rules to make the eligibility decisions based on data entered in the system.
- ✓ Counties are adapting their local business practices to align with how NC FAST handles data and user tasks.
- ✓ NC DHHS is moving toward standardizing policies and processes across all 100 counties.
- ✓ NC DHHS is moving toward the "universal worker," where county staff are proficient in processing applications for all applicable programs and no longer specialized in only some.

Benefits of NC FAST

- **Families** will have:
  - ✓ "One-stop shopping" with one-time communication of their information and needs.
  - ✓ Confidence that their benefits will be determined in an expedited, consistent manner from any place in the state.
  - ✓ Benefits in a more timely manner, due to reduced application and processing time.

- **Communities** will have:
  - ✓ Increased responsiveness to community needs.
  - ✓ Increased community outreach.
  - ✓ Better outcomes for dollars invested.

- **County Departments of Social Services and their employees** will have:
  - ✓ Tools to share data and track cases across program areas/county lines.
  - ✓ More time to assist families as administrative tasks are automated.
  - ✓ Increased ability to work with families within existing resources.
  - ✓ Enhanced partnerships with employers, service providers and other support organizations.
  - ✓ Comprehensive case information to better assess and meet client needs.

Benefits of NC FAST (continued)

- **The State will have:**
  - ✓ Ability to implement policy changes efficiently and uniformly.
  - ✓ Access to current, accurate and useful data integrated across programs.
  - ✓ Comprehensive data on service delivery for accountability and decision-making purposes.
  - ✓ Enhanced partnerships with counties and other state entities.

- **Avoided Costs**
  - ✓ Reduction in clients' lost wages for time spent in county department of social services offices.
  - ✓ Reduction in county department of social services staff processing new applications and recertifications.
  - ✓ Reduction in overpayments as a result of human error in basic manual calculations as a portion of eligibility determination process.
  - ✓ Reduction in postage costs resulting from consolidation of verification mailings.

9 NC DHHS Program Areas Impacted by NC FAST

Economic Benefits

- Child Care
- Food and Nutrition Services
- Medicaid / SCHIP
- Work First
- Energy Assistance
  - Low Income Energy Assistance Program (LIEAP)
  - Crisis Intervention Program (CIP)
- Special Assistance
- Refugee Assistance

Services

- Child Welfare
- Adult and Family Services

Case Management Projects

- **Integration Projects:**
  - Project 1: Global Case Management and Food and Nutrition Services (FNS)
  - Project 2&6: Eligibility Information System (EIS)
  - Project 3: Low Income Energy Assistance Program (LIEAP), Child Care, and Crisis Intervention Program (CIP)
  - Project 4: Child Services
  - Project 5: Aging and Adult Services
  - Project 7: NC FAST FFE Interoperability
- **ePASS**
- **Document Management**

Project 1: Global Case Management and FNS

Status

- Hard Launch approach was divided into 2 stages:
  - ✓ Stage 1: Turn off capability to enter new applications in FSIS.
  - ✓ Stage 2: Turn off processing in FSIS entirely.
- Training approach was revised to two 2.5 day sessions to prepare staff for each of the two stages:
  - ✓ Session 1 occurs before Soft Launch.
  - ✓ Session 2 occurs before Hard Launch – Stage 2.
  - ✓ Feedback on the training has been positive.
- All counties have completed Soft Launch and Hard Launch – Stage 1.
- 98 counties have progressed through Hard Launch – Stage 2.
- On-Site Support (OSS) resources have been made available to counties to help them through Hard Launch – Stage 2.
- Counties converted early in schedule see productivity gains using NC FAST:
  - ✓ Counties experience a dip in productivity at each stage in the deployment process – which is expected.
  - ✓ Once caseloads are fully converted, efficiencies are achieved and sustained going forward.

Project 1: Global Case Management and FNS

Status (continued)

- The schedule for upcoming Hard Launches has been confirmed:
  - ✓ Full statewide NC FAST implementation will be completed March 2013.
- Reviewing, developing and testing high priority defects and enhancements for release on regular basis.
- As of 2/25, supported 488,554 issuances for active FNS and SNAP cases in February, representing approximately $443M in FNS benefits issued since go-live.
- Received over 17,300 Help Desk tickets since go-live, of which over 16,900 have been responded to and closed.
  - ✓ Working to address open ticket backlog.
  - ✓ NC FAST continues to provide OSS staff to help counties through the transition.
  - ✓ Reorganizing the Help Desk Tier 1 and Tier 2 to address the areas for improvement and lessons learned.

Project 1: Global Case Management and FNS

Areas for Improvement

- **Help Desk**
  - ✓ Revising the Help Desk approach to refine messaging, improve collaboration with other NC FAST teams, and increase staffing.
  - ✓ Moving forward with plan to have all tiers of Help Desk co-located and part of the NC FAST project team.
- **Speed of System**
  - ✓ Provided performance monitoring software to all 100 counties:
    - o Currently operational in 97 counties.
  - ✓ Identified network and performance challenges that counties experience at the local level; providing feedback to address system performance issues.
- **Communication**
  - ✓ Using email distribution list with all NC FAST users for system communications.

- **Communication to County DSS Board, Association and Commissioners**
  - ✓ Sending annual letter to county leaders:
    - o Focus of letter includes support for funding around staffing to include temps, equipment needs and anything else that might help the Directors to share their needs with their board and commissioners.
    - o Intent is to help counties better prepare for annual budgeting.

Areas for Improvement (continued)

- **Job Aids**
  - ✓ Updated job aids to provide clarification on specific steps.
  - ✓ Incorporating feedback from counties, as appropriate.
  - ✓ Coordinating with the NC FAST Business Team to ensure updates are accurate and in accordance with NC DHHS policy.

- **FAST Help**
  - ✓ Expanding robust online repository of user documentation, procedures, training materials and job aids.
  - ✓ Continuing to refine structure and content to incorporate feedback from users and project team members.
  - ✓ Improvements made include:
    - o Outbound communication when specific existing materials are updated to alert users
  - ✓ Monitoring back-end analytics and reporting to gain insight into how FAST Help is being used.

Project 2&6: Eligibility Information System (EIS)

Status

- Project 2&6 is on schedule to begin pilot production in June 2013, with full implementation to all 100 counties completed by February 2014.
- Project 2&6 has approximately 2500 Business System Functions (BSFs) covering program functionality for Medicaid, Work First, Special Assistance, and Refugee Assistance.
- NC FAST cumulative between Project 1 and Project 2&6 is only 14.4% extended beyond the out-of-the-box (OOTB) product.
- Detail Design (DD) is complete and development is in progress. As of March 1, the Application Development Team completed 75% the application development work (artifacts).
- Test condition and script development is in progress. The team will execute a 3-cycle test strategy prior to User Acceptance Testing, and is currently executing Cycle 1. Cycle 2 is scheduled to start in April.

Project 3: LIEAP, Child Care, and CIP

Status

Project 3 has not yet started; tentatively planned for October 2013 - September 2015.

Scope

- Screening, intake and assessment for LIEAP, Child Care, and CIP.
- Eligibility determination and benefit delivery for LIEAP, Child Care, and CIP.
- Legacy System replacement: LIEAP, Subsidized Child Care Reimbursement (SCCR), and CIP.

Definitions

- LIEAP (Low Income Energy Assistance Program): Provides an annual payment to help eligible families pay their heating bills.
- Child Care Program: Provides financial assistance to eligible families through county departments of social services to help pay for child care.
- CIP (Crisis Intervention Program): Provides assistance to low-income families who are experiencing or in danger of experiencing a heating or cooling related crisis.

Project 4: Child Services

Status

- Project 4 began reviewing the requirements in September 2012, with NC DHHS Management direction to expedite the project in the schedule to address the counties' urgent need for a comprehensive statewide child services system.
- NC DHHS received USDA FNS federal partner approval to expedite Project 4 after submittal of the 2012 NC FAST Annual Advanced Planning Document Update (APDu).
- NC DHHS did not receive HHS ACF/CMS federal partner approval to expedite Project 4 after several months of discussions after the 2012 APDu submittal, due to ACF/CMS concerns with the Project 4 cost allocation and with Project 4 being implemented at this time.
- NC DHHS continues to work with ACF/CMS to clearly define the cost allocation.
- At worse case, Project 4 will return to its original implementation timeframe. The planned timeframe to implement Project 4 is now from 7/1/14 to 6/30/16.

Project 5: Aging and Adult Services

Status

Project 5 has not yet started; tentatively planned for July 2015 through June 2017.

Scope

- Screening, intake and assessment for Adult Protective Services (APS) and general services.
- Facilities and service providers' licensure support.
- Service planning and provision of services.
- Resident Assessment Instrument (RAI) and general assessments.
- Guardianship services.
- Placement and payment for residential care.
- Adult care home case management.
- Court activities.
- Legacy System replacement: APS, Services Information System (SIS), Daysheets, Disinterested Public Agent Guardians (DPAG), SA In-Home.

Project 7: NC FAST FFE Interoperability (Federally-Facilitated Exchange)

Status

- Formerly the Health Benefit Exchange (HBE) Project, in partnership with NC DOI.
- North Carolina was awarded a Level 1 Cooperative Agreement Establishment Grant that included $45.7M for NC FAST to implement functionality required under ACA to support a partnership-based exchange.
- The team drafted revisions to the 2013 NC FAST As-Needed APDu to obtain funding to support implementing ACA required changes since the funds from the Level 1 Grant are unavailable beyond passage of SB4.
- Existing team members are conducting design sessions for functionality necessary to be ACA compliant in October 2013:
  - ✓ Develop intake process flows for various scenarios.
  - ✓ Review detail questions in the streamline FFE application and compare them with Cúram OOTB functionality to identify gaps and modifications required.
  - ✓ Develop a solution approach based on critical success factors for October 1, 2013.
  - ✓ Create a Verification Plan for submission to CMS.

Key Scope Components of NC FAST FFE Interoperability

The pursuit of an FFE model **does not significantly impact the scope of work North Carolina must complete from an eligibility determination standpoint**.

- North Carolina must still comply with and implement all federal MAGI rules.
- North Carolina must configure their existing Medicaid eligibility platform to service citizens and caseworkers under ACA legislation.
- North Carolina must build all the same integrations with the Federal Data Hub:
  - ✓ Verifications
  - ✓ Account Transfers
- North Carolina will still be responsible for making final Medicaid eligibility determinations.

Project 7: NC FAST FFE Interoperability (Federally-Facilitated Exchange)

Risks / Issues

- **Aggressive Timeline** – Only 208 days remain for North Carolina to implement changes required to be ACA compliant on October 1, 2013.

- **Funding** – Approval to fund initiative did not occur until March 5, 2013. This results in:
  - Delays in bringing on designers, developers and testers.
  - Qualified resources being deployed elsewhere.
  - Schedule slippage due to limited resources: Hours applied 31% of plan (January and February 2013).

- **Regulatory Uncertainty** – Critical outstanding regulatory questions remain unresolved (questions submitted January 22). The federal partners continue to publish, or expect to publish in the future, guidance in key areas necessary to be ACA compliant.

ePASS (Electronic Pre-Assessment Screening Service)

Status

- Completed Phase 2 Medicaid production deployment.
- Documented business requirements for Phase 3 FNS.
- Continued working with the software vendor on outstanding items to continue design development.
- Completed development, associated testing and implementation for the 2012-2013 COLA changes.
- Completed NC FAST Phase 3 FNS initiation tasks.
- Completed draft Functional Design Document for initial production pilot of Phase 3 FNS. The initial production pilot includes the ability for the client to complete the application and submit online to the county DSS office.
- Completed Detailed Design Document for initial production pilot of Phase 3 FNS. Currently in review.
- Began development for initial production pilot of Phase 3 FNS.

Document Management

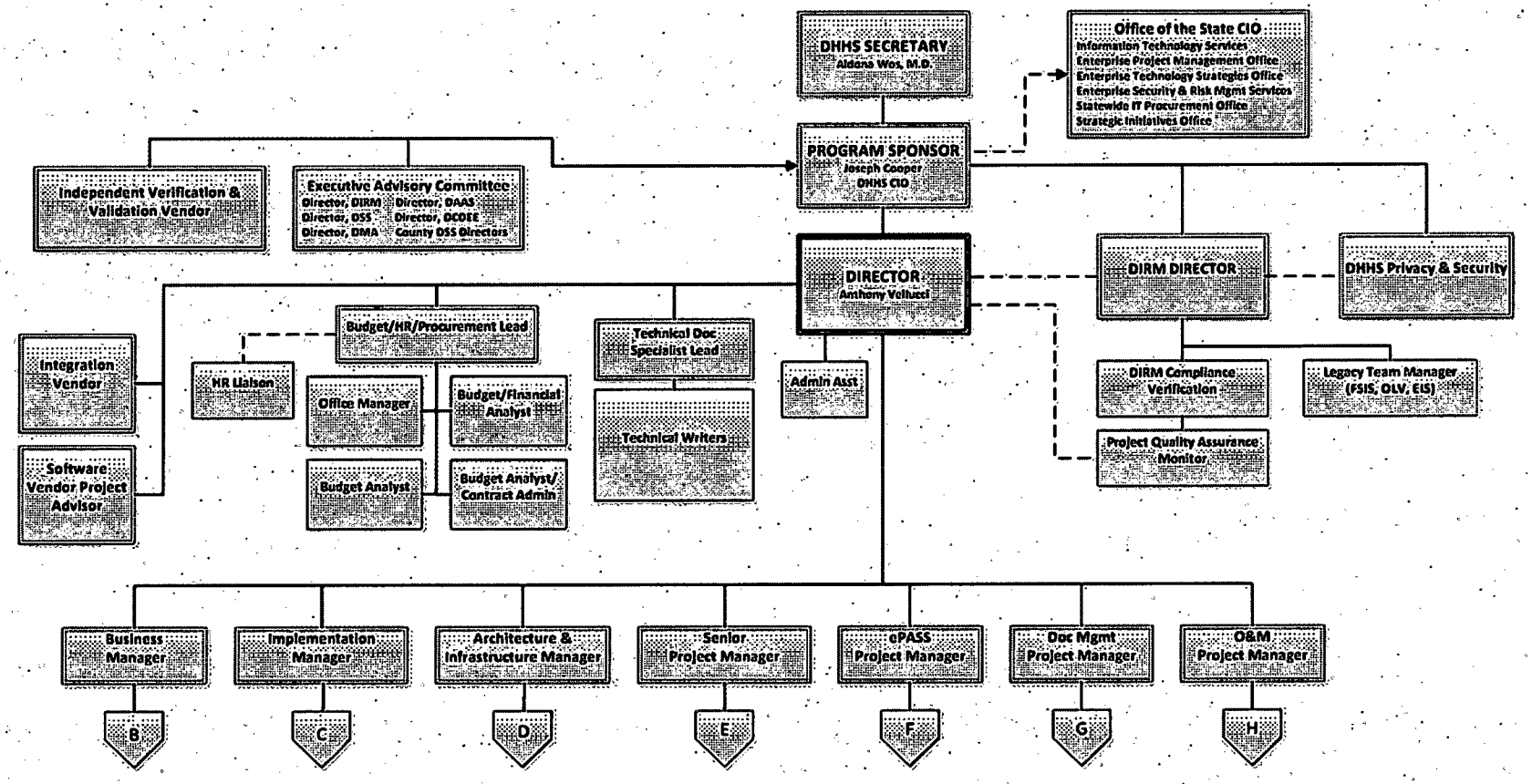
Status

- Why a separate document management system was required, and any system currently available within state agencies could not be used.
- NC FAST selected an enterprise class solution for a centralized electronic document management system with records retention.
- A software installation vendor/partner has been identified.
- The Business Team is working with the Document Management Team to define the product scope and technical approach for implementation.
- Project work schedule planning is under way.
- Infrastructure has been delivered, and in cooperation with the State ITS is in the process of being stood up in the Eastern and Western Data Centers.
- Pilot rollout is planned to coincide with Pilot rollout for Project 2&6.
- Scanner specifications communicated to all 100 counties on January 7.
- Counties may need to procure additional network bandwidth to support transmission of scanned images to central document management system.

NC FAST Organization Chart

NC FAST
North Carolina Families Accessing Services through Technology

Office of NC FAST Organization Chart

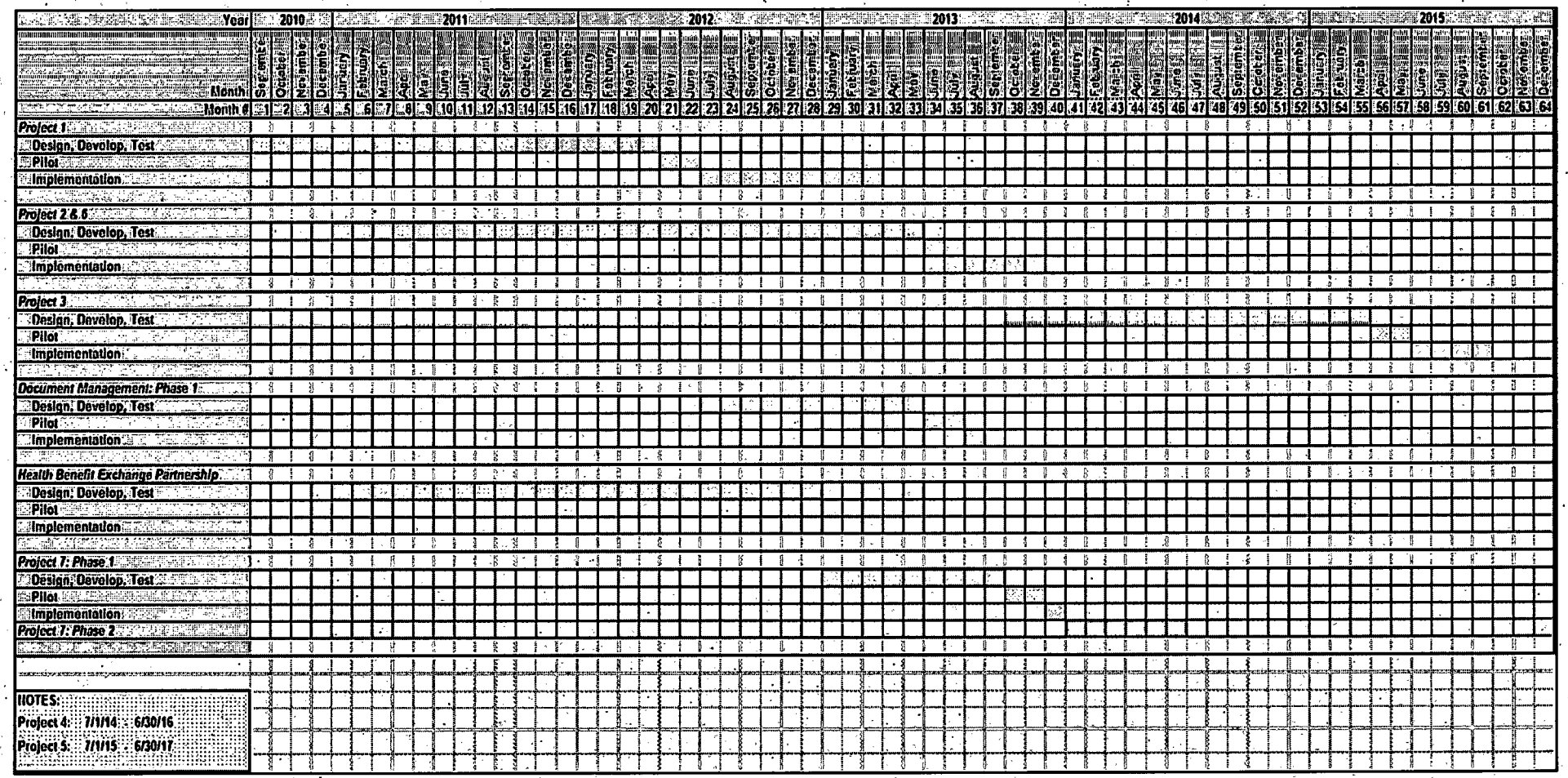


Program Budget

Summary of NC FAST Budget and Actual Expenditures as of January 31, 2013				
Description	Current Budget	Actual Expenditures as of January 31, 2013	Balance	Status
Prior Closed Projects	$ 13,635,685.21	$ 13,635,685.21	$ -	Completed
OLV	$ 6,125,611.30	$ 6,125,611.30	$ -	Completed
SDI	$ 1,070,976.20	$ 1,070,976.20	$ -	Completed
Case Management Software Installation	$ 11,785,880.15	$ 11,785,880.15	$ -	Completed
Program	$ 47,121,581.46	$ 20,443,158.01	$ 26,678,423.45	On Going
ePASS Phase 2 Medicaid	$ 535,751.00	$ 682,004.32	$ (146,253.32)	Completed
ePASS Phase 3 FNS	$ 416,675.00	$ 273,753.20	$ 142,921.80	
Client Services Data Warehouse (CSDW)	$ 3,000,000.00	$ 1,162,321.08	$ 1,837,678.92	On Going
Asset Verification	$ 2,000,000.00		$ 2,000,000.00	Future
Project 1: Global Case Management and Food and Nutrition Services (FNS)	$ 48,515,999.35	$ 46,324,542.59	$ 2,191,456.76	Implementation
Project 1 Pre Release Support (Pre O & M)		$ 5,780,753.00	$ -	
Projects 2 & 6: Eligibility Information System (EIS)	$ 93,124,543.06	$ 43,803,863.31	$ 49,320,679.75	Execute and Build
Project 3: Low Income Energy Assistance Program (LIEAP) Child Care and Crisis Intervention Program (CIP)	$ 34,297,688.00	$ -	$ 34,297,688.00	Future
Project 4: Child Services	$ 41,170,748.00	$ -	$ 41,170,748.00	Future
Project 5: Aging and Adult Services	$ 47,421,060.00	$ -	$ 47,421,060.00	Future
Total Budget Per 2012 Annual APDU	$ 350,222,198.73	$ 151,088,548.37	$ 204,914,403.36	
Note: Original Planned Budget not including Project 7 was $ 392,520,674.00				
Project 7: NC FAST Federally-Facilitated Exchange (FFE) Interoperability	$ 60,077,449.00	$ -	$ 60,077,449.00	Future
Total Budget per March 2013 As Needed APDu	$ 410,299,647.73	$ 151,088,548.37	$ 264,991,852.36	
Federal Revenue	$ 312,118,226.91	$ 103,026,236.17	$ 214,185,990.74	
State Dollars	$ 98,181,420.82	$ 48,062,312.20	$ 50,805,861.62	
Note: The amounts indicated for Future Projects are high level projections and are subject to change.				

Program Schedule

The following timeline shows the scheduled design, development, test, pilot and implementation dates for NC FAST projects.



Vendors

Case Management Procurement

Software

- Contract awarded to IBM (formerly Cúram Software, Inc.) December 22, 2008; result of Software RFP.
- Services: Software licenses, initial installation, training, optional technical support services, operations & maintenance, software support, releases and upgrades; full time onsite staff.
- Cúram Business Application Suite provides NC FAST framework.

Software Integration

- Contract awarded to Accenture August 30, 2010; result of Software Integration RFP.
- Services: NC FAST requirements integration into base product, product extension if needed; gap analysis; design document and code/interface development; data conversion; testing/defect resolution; training and county readiness; and project management and operations & maintenance support; full time onsite staff.

Questions?

Joint Appropriations Subcommittee on Health and Human Services

DHHS CIO ORGANIZATION

MARCH 14, 2013

DHHS CIO ORGANIZATION

AGENDA

1. Introductions
2. Observations from the first 30 days
3. DHHS CIO organizational review
4. MMIS update
5. NC FAST update

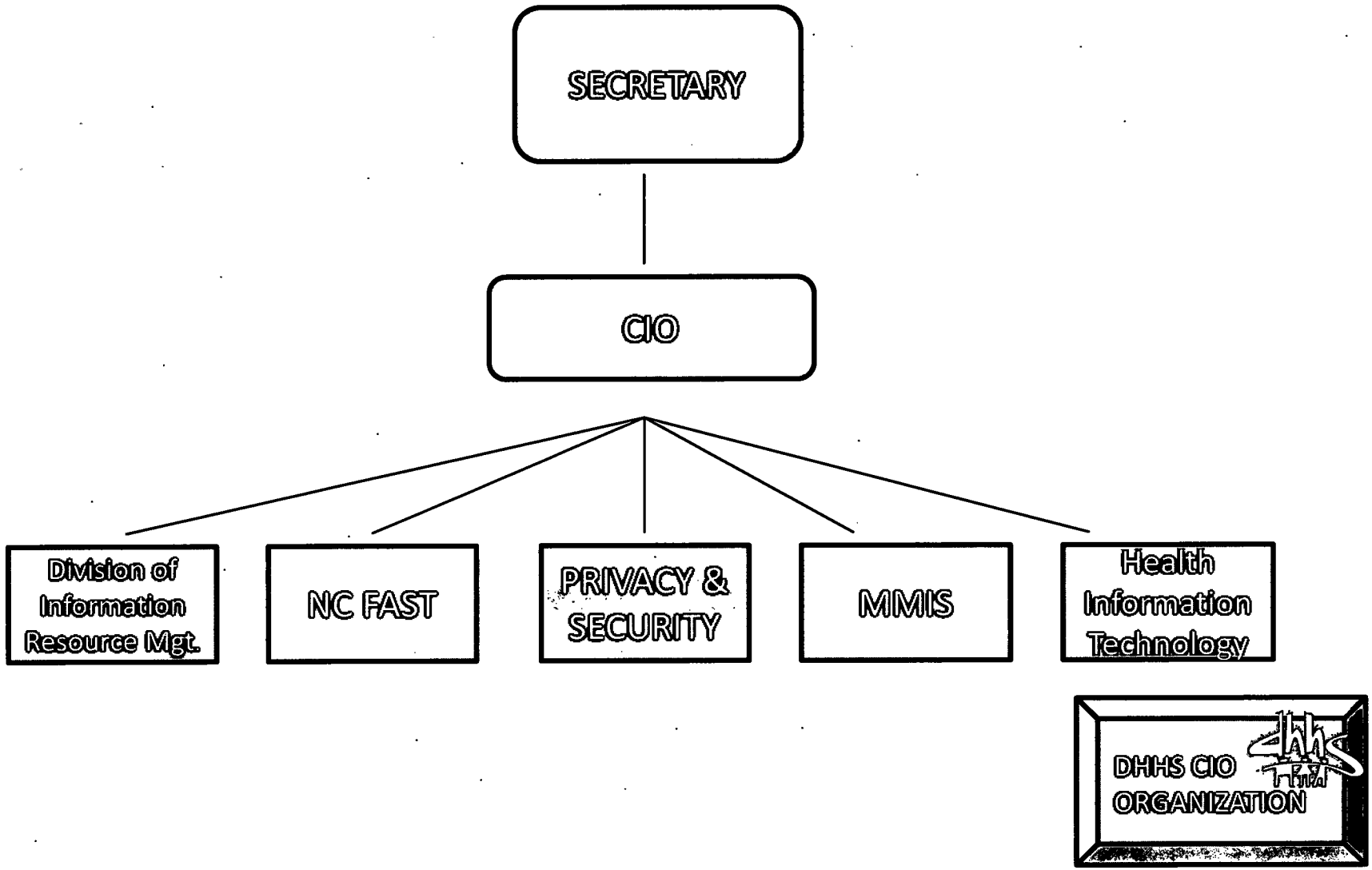
DHHS CIO ORGANIZATION

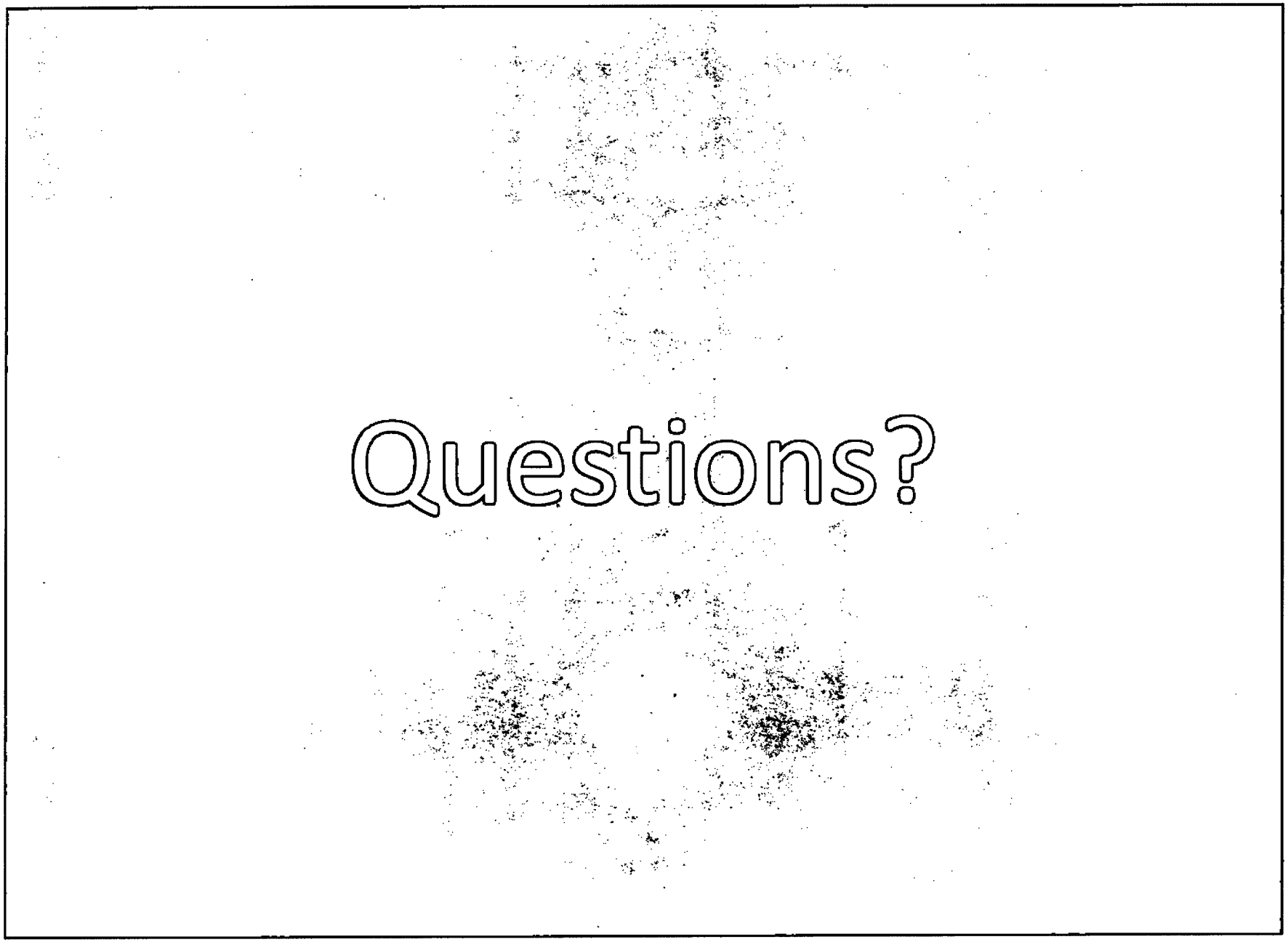
CIO OBSERVATIONS – FIRST 30 DAYS
MARCH 14, 2013

- **Large Scale Program Management**
  - Multiple methodologies/approaches used
- **Enterprise Standards**
  - Why have "1" document imaging system when you can have "5"
- **Older Technology**
  - Average age of PC's & Software – 5+ years
  - Security vulnerabilities
- **Vendor Management Office**
  - Nothing formal in place, multiple master agreements in place
- **DHHS Audit**
  - Reactive, not proactive
- **Information Security**
  - Both detection and enforcement is weak

DHHS CIO ORGANIZATION

DHHS CIO
ORGANIZATIONAL CHART




Questions?

MMIS Report
Joint Appropriations Subcommittee on Health and Human Services

March 14, 2013

Paul Guthery
Associate Program Director
Senior Program Manager
NC DHHS Office of MMIS Services

Ed Riley
Associate Program Director
Contract Manager
NC DHHS Office of MMIS Services

NCMMIS Program Purpose

- **Replacement MMIS Project (NCTracks)**
  - Design, develop and install a componentized, integrated, multi-payer Replacement Medicaid Management Information System (MMIS) and Fiscal Agent operations
  - Facilitate provider enrollment and consolidate claims processing activities for multiple DHHS health plans
    - Division of Medical Assistance – Medicaid & Health Choice
    - Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
    - Division of Public Health
    - Office of Rural Health and Community Care
  - Coordinate processing among the payers to ensure the proper assignment of the payer, benefit plan, and pricing methodology for each service on a claim

NCMMIS Program Purpose

- **Reporting & Analytics Project**
  - Design, develop and install a state-of-the-art Data Warehouse, and reporting solution that meets not only current DHHS needs, but provides a platform for changes leading to future growth with enhanced self-service by the end-user community
  - Surveillance Utilization Review System (SURS) – Detection of fraud and abuse
  - Decision Support System (DSS) – Healthcare data analytics to empower more informed policy decisions

NCMMIS Program Purpose

- **Business Process Automation System Project**
  - Identify and execute the procurement and implementation of a Business Process Automation System and associated business services for the DHHS Division of Health Service Regulation (DHSR)
  - Satisfy the information sharing requirements with the Replacement MMIS in the area of provider eligibility
  - Provide automation, using a common database, to support the business functions of DHSR
    - Certificate of Need
    - Construction
    - Licensure and Certification
    - Health Care Personnel Registry
    - Center for Aide Regulation and Education

Advantages of the Replacement MMIS

- Multi-payer system consolidating claims processing for multiple DHHS divisions, ensuring the proper assignment of payer, health plan, benefit plan, and pricing methodology for each claim line
- Provider Web Portal
  - Provider Enrollment
  - Changes to Provider enrollment information
  - Recipient Enrollment and Service Limits
  - Electronic Claims Submission
  - Fee Schedules and Rates
  - Prior Approval Inquiry and Request
  - Claims Status Information
  - Retrieval of Remittance Advices
  - Online access to training information

Advantages of the Replacement MMIS

- Recipient Web Portal
  - Online access to health care coverage information
  - Administrative contact information for benefit plans including managed care organizations
  - Health Plan and Benefit Plan name and coverage dates
- Claims Processing
  - Multi-detail, multi-payer claims submission
  - Outpatient hospital claims at a line item detail level for all revenue codes
  - Automated claims adjustments
  - Immediate adjudication of claims

MMIS Legacy System Synchronization

- Modifications to the legacy solutions continued after the system freeze date
- Limitations to the level of change that can be made to the system once final testing began while maintaining quality
  - System soft freeze began on March 2, 2012 – Hard freeze began on May 31, 2012
  - User Acceptance Testing (UAT) began August 29, 2012
  - Changes approved after freeze date not available for current UAT

MMIS Legacy System Synchronization

- CSC Contract Amendment #3 created to allow for the development and testing of the most critical of these changes
  - Additional capacity for change allocated
  - Move Operational Readiness Date from March 1, 2013 to July 1, 2013 to accommodate additional Medicaid changes
  - Maintain July 1, 2013 Operational Start
  - Use capacity originally allocated to ICD-10 (International Classification of Diseases 10th Revision)
    - Federally required compliance date moved from October 1, 2013 to October 1, 2014
    - Work continues on ICD-10 in preparation for system changes
  - Additional Final Integration and User Acceptance Testing Period
    - April / May 2013
    - Overlap additional testing with the execution of Provider Operational Preparedness (POP)

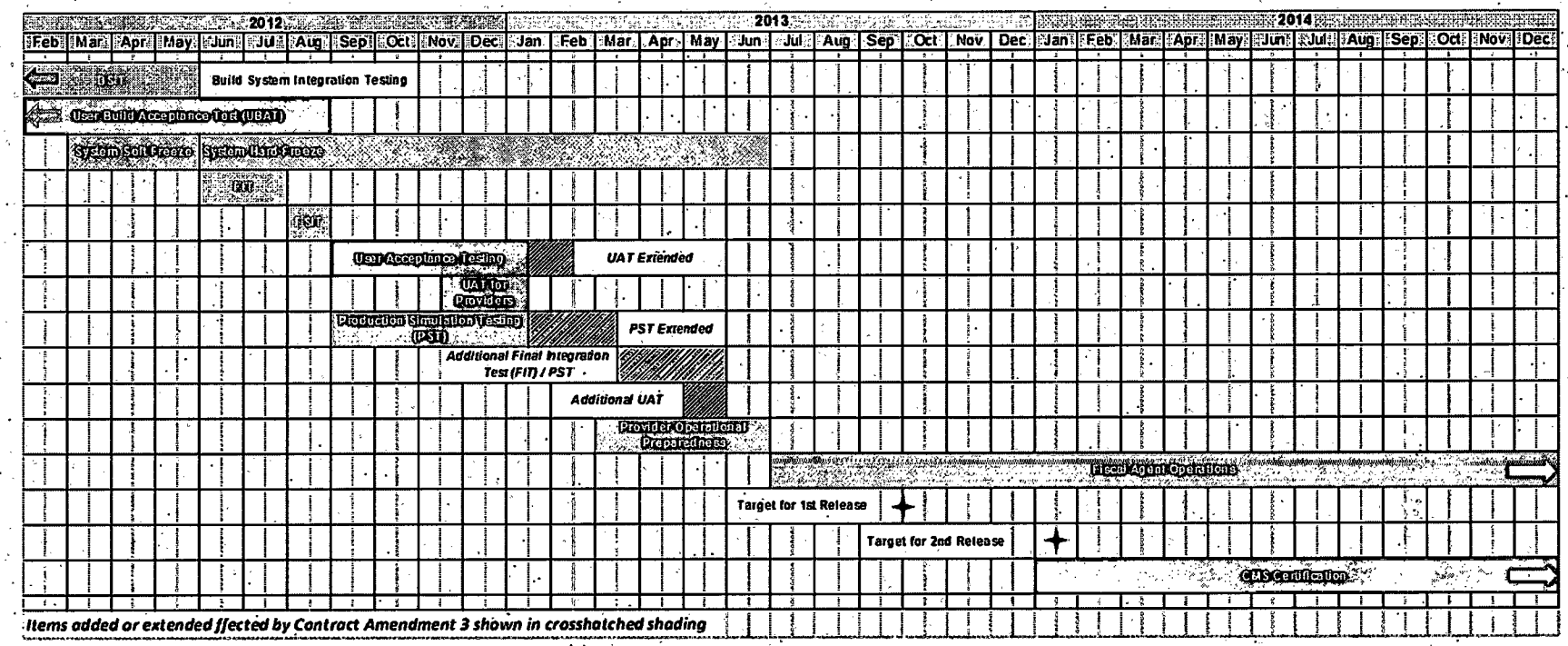
MMIS Legacy System Synchronization

- Additional Synchronization Gap Less Critical Functionality
  - Additional CSRs are currently in the CSC backlog to be implemented that will not be addressed by July 1, 2013
  - The first two post operational start software releases are scheduled for:
    - October 1, 2013
    - January 1, 2014
  - Workarounds required until the implementation of functionality

Workarounds Strategy

- Workgroup currently developing workarounds for 288 change requests
  - 120 Customer Service Requests (CSRs)
  - 168 State Memoranda
- The workaround strategies can be broadly grouped by the following categories:
  - Change policy, business rules, and/or claims filing instructions
  - Manual intervention performed by CSC, the State, or other vendor
  - Pay and chase or report
  - Monitor impacts
  - Cancel original change request
  - Suspend specific task in Division operations
- Workgroup to complete identification of workarounds by March 18
- Work beginning to define impacts and communications

Replacement MMIS Schedule



User Acceptance Test (UAT) Results

- User Acceptance Test Cases Completed by the State: 1,980
- Test Cases with no outstanding defects: 1,751 (88.4%)
- Total defects discovered during UAT: 1,520
  - Initial UAT period (8/29/2012 – 1/16/2013)

Severity	Exit Threshold	Discovered	Resolved	Open
1. System-wide Failure	0	33	33	0
2. Inconsistent Results	10% (83)	839	761	78
3. Workaround Exists	25% (134)	537	452	85
4. Cosmetic	n/a	96	51	45
5. Working as Designed	n/a	15	1	14
Total	n/a	1,520	1,298	222

Overall Program Budget

NCMMIS+ Program Budget					
Project	Initial	Current		Federal	State Share
Replacement MMIS					
Development	$ 114,704,823	$ 219,847,415		$ 192,695,227	$ 27,152,188
Ops & Maintenance	$ 196,790,210	$ 203,646,862		$ 142,836,157	$ 60,810,705
Early Operations	$ 8,751,865	$ 20,457,214		$ 17,261,493	$ 3,195,721
Reporting & Analytics					
Development	$ 14,752,168	$ 15,549,664		$ 13,994,698	$ 1,554,966
Ops & Maintenance	$ 45,073,315	$ 45,069,033		$ 33,801,775	$ 11,267,258
BPAS - DHSR					
Development	$ 6,167,739	$ 8,565,102		$ 4,697,413	$ 3,867,689
Ops & Maintenance	$ 6,119,699	$ 8,119,699		$ -	$ 8,119,699
Program-Level Project					
Development	$ 9,721,297	$ 15,803,746		$ 13,828,278	$ 1,975,468
Certification	$ 1,430,271	$ 2,440,790		$ 2,135,691	$ 305,099
Other Projects					
HIT Incentive Paymen	$ 31,586,627	$ 10,786,958		$ 9,708,262	$ 1,078,696
Medicaid Forecast	$ 1,739,914	$ 1,523,010		$ 1,370,709	$ 152,301
Business Initiatives	$ 11,535,538	$ 11,133,002		$ 9,790,332	$ 1,342,670
Total	**$ 448,373,466**	**$ 562,942,495**		**$ 442,120,034**	**$ 120,822,461**

Vendor Cost Savings - MMIS

- Over the five year operations & maintenance phase, the CSC contract cost will save on average $3 million per month over expected future costs of existing contracts that will be retired when NCTracks is implemented.
- The state appropriations savings over that same five year period is expected to average over $900,000 per month.
- Systems to be retired by NCTracks:
  - MMIS – HP
  - IPRS – HP
  - Pharmacy Prior Authorization Call Center – Xerox
  - Smart PA – Xerox
  - POMCS– DHHS

CSC Contract - MMIS

NCMMIS+ Program Contract Amendments			
Vendor	Amendment	Cost	State Share
CSC			
Development[1]	Base	$ 77,960,715	$ 9,901,010.81
Ops & Maintenance	Base	$ 187,243,759	$ 51,023,924.33
Development	Amend # 1	$ -	$ -
Ops & Maintenance	Amend # 1	$ -	$ -
Development	Amend # 2	$ 152,754,523	$ 18,025,033.71
Ops & Maintenance[2]	Amend # 2	$ 66,921,800	$ 18,236,190.50
Development	Amend # 3	N/A	N/A
Ops & Maintenance	Amend # 3	N/A	N/A
Total			
Development		$ 230,715,238	$ 27,926,045
Ops & Maintenance		$ 254,165,559	$ 69,260,115

[1] Although not included in the initial contract; $ 22M was budgeted for changes and approved by CMS.
[2] Two additional years of operations were added to the contact.

Program Risks and Issues

- Based on analysis by an outside consultant, Susan Young, the following risks and mitigation strategies have been identified:

Risk	Mitigation Strategy
Stakeholder Engagement	A supplementary communications approach has been developed and a resource allocated to integrate the specific plans into the overall program and management routines
Program Planning, Execution and Monitoring	The MMIS Program has now been aligned under the DHHS CIO, and availability of critical resources has been secured
Organizational Change Enablement	An external consultant will be engaged to drive our development of Division business processes and facilitate additional preparations for user testing and transition
Change Management	A hard freeze has been placed on further changes to the legacy and new systems. A team has been formed to identify gaps and define interim processes
Overall Implementation Strategy	Resources will be reallocated to support deployment planning efforts and bring focus to the most significant levers for the success of the initiative.
Test Planning and Execution	Critical resources to support testing cycles have been secured. Additional business process activities will make user testing and readiness assessments more effective

Program Risks and Issues

- As reported by CSC in their 2/14/2013 report to the NCMMIS+ Steering Committee

Risk	Mitigation Strategy
Provider Conversion	A number of data quality issues have been identified during PST and UAT that impact claims adjudication. The State and CSC have made good progress. 2 outstanding issues remain, 3 issues require data clean up and one potential workaround has been identified
Taxonomy	The current design requires a taxonomy at level 3 for professional providers and some may have credentials only to a level 2. CSC has determined the effort required to make the required modifications and will work with the State to determine how to implement by operational start.
Interfaces	CSC is still working through interface files from the State so end to end testing can occur during the extended PST. 8 interfaces will be tested during the May PST.
Legacy CSR Workarounds	There are approximately 120 Legacy CSRs and 168 State memoranda that will not be in NC Tracks at operational start. OMMISS and DMA are evaluating the workarounds with a 3/18/2013 completion target. Any impact to CSC operations must be reviewed and determined after that date.

Appendix

CMS Certification

- Review of the MMIS and operations
  - CMS Certification Checklists
- State requests certification after the closeout of two fiscal quarters
  - Operational start on July 1, 2013
  - North Carolina can request certification after closing out the quarter ending December 31, 2013
- Following the request, CMS and the State begin planning one-week on-site certification review
  - Document collection and preparation
- One week on-site visit typically at least one year after operational start
- Based on the information collected, CMS may issue findings and require the State to take remedial action

CMS Certification

- Financial Impact
  - On the first day of operations, the Federal match for operations is 50%
  - Upon certification the Federal match for operations improves to 75%
  - When certification is achieved, the difference between the 50% and 75% Federal match is paid retroactively back to the day the system is deemed by CMS to be the system of record

Testing Participation

- CSC Staff
  - Build System Integration Testing
  - Final Integration Testing
  - Final System Integration Testing
  - Production Simulation Testing
- OMMISS Staff
  - User Build Acceptance Testing
  - User Acceptance Testing
  - Review of CSC Conducted Testing
- Division Testing
  - 46 participants from the DHHS divisions
  - Participants from DMA, DMH/DD/SAS, DPH

Testing Participation

- Providers
  - User Acceptance Testing for Providers
  - Worked with 25 Provider Associations for nominees
  - 37 Providers nominated by 8 associations participated over six weeks
    - Dental
    - Pediatrics, Novant, CCNC
    - LMEs
    - Public Health
    - Nursing Homes, Home & Hospice
    - Hospitals

Transition Planning
Deployment Planning Approach

Iteration	Content
Initial Framework (Delivered 11/26/2012)	Establishes the concept, structure, and layout of the deliverable, with a focus on the introductory information, high-level activity/task and schedule definition, establishment of assumptions and constraints, templates and integration with related documents.
Iteration 2 (Delivered 2/15/2013)	Focuses on the detailed rollout and deployment schedule/activities, post deployment activities, organization rolls and responsibilities, continued refinement of assumptions and constraints, populating the templates, and details of the back out plan.
Iteration 3 (Delivery 3/31/2013)	Continued expansion of the detailed rollout and deployment schedule/activities, expansion of the post deployment activities, finalization of the organization rolls and responsibilities, continued refinement of assumptions and constraints, continued refinement of the back out plan details.
Final Iteration (Delivery 5/31/2013)	Wrap-up of the detailed rollout and deployment schedule/activities, wrap-up of the post deployment activities, wrap-up of assumptions and constraints, wrap-up of the back out plan details.

Budget Update

- Overall Program Budget and Budget for Each Project
  - Initial
  - Current
  - Reasons for Changes
  - Operations and Maintenance Costs
  - Sources of Funding

Replacement MMIS Budget

Replacement MMIS Project Budget					
	Initial	Current	Reason	Federal	State Share
Development	**$ 114,704,823**	**$ 219,847,415**		**$ 192,695,227**	**$ 27,152,188**
Vendor Costs					
CSC	$ 90,820,113	$ 186,604,862	1	$ 163,359,494	$ 23,245,368
IV&V and Testing	$ 6,203,920	$ 9,939,959	2	$ 8,945,963	$ 993,996
Internal Costs	$ 17,680,790	$ 23,302,594	2	$ 20,389,770	$ 2,912,824
Ops & Maintenance (5 Years)	**$ 196,790,210**	**$ 203,646,862**		**$ 142,836,157**	**$ 60,810,705**
Vendor Costs	$ 188,450,458	$ 188,552,178		$ 131,515,144	$ 57,037,034
Internal Costs	$ 8,339,752	$ 15,094,684	3	$ 11,321,013	$ 3,773,671
Early Operations	**$ 8,751,865**	**$ 20,457,214**		**$ 17,261,493**	**$ 3,195,721**
CSC	$ 7,933,903	$ 18,272,214	4	$ 15,622,743	$ 2,649,471
Internal Costs	$ 817,962	$ 2,185,000	4	$ 1,638,750	$ 546,250
Total	**$ 320,246,898**	**$ 443,951,491**		**$ 352,792,877**	**$ 91,158,614**

Reason for Changes to the Replacement MMIS Budget

1. Schedule slipped 22 months; functionality has been added. Reasons for slippage:
   - Over estimation of the degree of fit with the baseline solution from CSC
     - Estimated 73% reuse – Realized 32% reuse
   - Approximately 200 legacy change requests that were not included in the original scope were added to the design
   - Federal Scope Expansion:
     - HIPAA 5010
     - ICD-10
     - National Correct Coding Initiative (NCCI)
     - Healthcare Reform
   - State Legislation: SL 2010 and SL 2011 changes
   - Added four months of Provider Operational Preparedness

Reason for Changes to the Replacement MMIS Budget

2. Added 22 months to the development phase impacting the Independent Verification and Validation (IV&V) and Testing vendors' contracts; and internal labor and project support costs
3. Revised estimate of the resources needed to manage vendors and to begin the next MMIS procurement cycle
4. Added 22 months to early operations (provider enrollment, credentialing and verification) and for drug utilization review; also realized a larger number of providers enrolling in Medicaid

Reporting & Analytics Budget

Reporting & Analytics Project Budget					
	Initial	Current	Reason	Federal	State Share
Development	**$ 14,752,168**	**$ 15,549,664**		**$ 13,994,698**	**$ 1,554,966**
Vendor Costs					
Truven	$ 6,877,113	$ 10,816,274	1	$ 9,734,647	$ 1,081,627
IV&V and Testing	$ 629,381	$ 1,077,750	2	$ 969,975	$ 107,775
Internal Costs	$ 7,245,674	$ 3,655,640	3	$ 3,290,076	$ 365,564
Ops & Maintenance (5 Years)	**$ 45,073,315**	**$ 45,069,033**		**$ 33,801,775**	**$ 11,267,258**
Vendor Costs	$ 43,428,927	$ 43,608,606		$ 32,706,455	$ 10,902,152
Internal Costs	$ 1,644,388	$ 1,460,427		$ 1,095,320	$ 365,107
Early Operations	**$ -**	**$ 316,000**		**$ 237,000**	**$ 79,000**
Truven	$ -	$ 316,000		$ 237,000	$ 79,000
Total	**$ 59,825,483**	**$ 60,934,697**		**$ 48,033,472**	**$ 12,901,225**

Reason for Changes to the Reporting & Analytics Budget

1. Due to the MMIS project being extended 22 months, the R&A project needed to be extended as R&A is dependent upon data from the Replacement MMIS. Also developed and implemented the Surveillance Utilization Review System (SURS) to operate with legacy data
2. Added 22 months to the development phase impacting IV&V and Testing vendor contracts
3. Although the development phase was extended, the staffing level required to support this R&A project was initially overestimated

Business Process Automation System (BPAS) Budget

Business Process Automation System (BPAS) Project Budget					
	Initial	Current	Reason	Federal	State Share
Development	**$ 6,167,739**	**$ 8,565,102**		**$ 4,697,413**	**$ 3,780,389**
Vendor Costs					
GLS	$ 4,205,970	$ 4,205,970		$ 2,102,985	$ 2,102,985
IV&V and Testing	$ 174,601	$ 174,601		$ 87,301	$ 87,301
Internal Costs	$ 1,787,168	$ 4,184,531	1	$ 2,507,127	$ 1,677,404
Ops & Maintenance	**$ 6,119,699**	**$ 8,119,699**		**$ -**	**$ 8,119,699**
Vendor Costs	$ 4,846,779	$ 4,846,779		$ -	$ 4,846,779
Internal Costs	$ 1,272,920	$ 3,272,920	1	$ -	$ 3,272,920
Total	**$ 12,287,438**	**$ 16,684,801**		**$ 4,697,413**	**$ 11,900,088**

Reason for Changes to the BPAS Budget

1. Staffing levels were initially underestimated and required hardware and software was omitted from the initial budget

Program Level Project

Program-Level Project Budget					
	Initial	Current	Reason	Federal	State Share
Development	**$ 9,721,297**	**$ 15,803,746**		**$ 13,828,278**	**$ 1,975,468**
Vendor Costs	$ -				
Internal Costs	$ 9,721,297	$ 15,803,746	1	$ 13,828,278	$ 1,975,468
Certification	**$ 1,430,271**	**$ 2,440,790**		**$ 2,135,691**	**$ 305,099**
Vendor Costs	$ -	$ -		$ -	$ -
Internal Costs	$ 1,430,271	$ 2,440,790	2	$ 2,135,691	$ 305,099
Total	**$ 11,151,568**	**$ 18,244,536**		**$ 15,963,969**	**$ 2,280,567**

Reason for Changes to the Program-Level Budget

1. The project length was extended by 22 months, additional staffing hours were required due to the extended schedule
2. Updated staffing requirements for the first year of operations to support maintenance and federal certification activities

Contract Amendments

Contract Amendments

- By Project and vendor
- Cost Increase associated with each

Truven Contract – Reporting & Analytics

NCMMIS+ Program Contract Amendments			
Vendor	Amendment	Cost	State Share
Truven			
Development	Base	$ 6,877,113	$ 687,711
Ops & Maintenance	Base	$ 43,428,927	$ 10,857,232
Development	Amend # 1	$ -	$ -
Ops & Maintenance	Amend # 1	$ -	$ -
Development	CSR 787	$ 1,511,370	$ 151,137
Development	Amend # 2	$ 1,441,798	$ 1,297,618
Ops & Maintenance	Amend # 2	$ 20,851,305	$ 5,212,826
Development	Amend # 3	$ -	$ -
Ops & Maintenance	Amend # 3	$ -	$ -
Total			
Development		$ 9,830,281	$ 2,136,467
Ops & Maintenance		$ 64,280,232	$ 16,070,058

GLS Contract – Business Process Automation System (BPAS)

NCMMIS+ Program Contract Amendments			
Vendor	Amendment	Cost	State Share
GLS			
Development	Base	$ 5,515,494	$ 2,757,747
Ops & Maintenance	Base	$ 3,537,255	$ 1,768,628
Development	Amend # 1	$ -	$ -
Ops & Maintenance	Amend # 1	$ -	$ -
Total			
Development		$ 5,515,494	$ 2,757,747
Ops & Maintenance		$ 3,537,255	$ 1,768,628

Maximus Contract – Independent Verification and Validation (IV&V)

NCMMIS+ Program Contract Amendments			
Vendor	Amendment	Cost	State Share
Maximus			
Development	Base	$ 2,549,968	$ 267,747
Ops & Maintenance	Base	$ 378,796	$ 94,699
Development	Amend # 1	$ -	$ -
Ops & Maintenance	Amend # 1	$ -	$ -
Development	Amend # 2	$ 1,459,752	$ 153,274
Ops & Maintenance	Amend # 2	$ 507,640	$ 126,910
Total			
Development		$ 4,009,720	$ 421,021
Ops & Maintenance		$ 886,436	$ 221,609

SLI Contract - Testing

NCMMIS+ Program Contract Amendments			
Vendor	Amendment	Cost	State Share
SLI			
Development	Base	$ 3,518,302	$ 358,867
Ops & Maintenance	Base	$ 2,081,113	$ 520,278
Development	Amend # 1	$ 3,575,996	$ 364,752
Ops & Maintenance	Amend # 1	$ (1,934,887)	$ (483,722)
Total			
Development		$ 7,094,298	$ 723,618
Ops & Maintenance		$ 146,226	$ 36,557

SENATE PAGES ATTENDING

COMMITTEE: Joint: Health & Human Serv. ROOM: 643

DATE: 3-17 TIME: 8:30

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!

	Page Name	Hometown	Sponsoring Senator
1	Emma Burry	Charlotte	Rucho
2	Milizhica Mills	Winston-Salem	Parmon
May-11 3			
4			
5			
6			
7			
8			
9			
10			

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Thursday, March 14	**Room**	**Time**
JOINT APPROPRIATIONS HEALTH & HUMAN SERVICES	643	8:30 am

Name	County	Sponsor
Emily Hedrick	Alamance	Riddell
Jeffrey Manchester	Mecklenburg	Tillis
Jake Parrish	Carteret	McElraft

HHS Meeting

SENATE SGTS. AT ARMS: Charles Harper

Ed Kesler

CHARLES MARSALIS

HOUSE SGTS. AT ARMS: Fred Hines

Charles Godwin

SENATE PAGES: Emma Burri

MILIZHIA MILLS

HOUSE PAGES: EMILY HEDRICK

JEFFREY MANCHESTER

JAKE PARRISH

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

March 19, 2013
Legislative Office Building - Room 643
8:30 a.m.

Senator Ralph Hise, Presiding	Welcome, Opening Remarks
Division of Medical Assistance Prescription Drugs	Susan Jacobs, Committee Staff Fiscal Research Division
Division of Medical Assistance Prescription Drugs-North Carolina Policies	Carol Steckel, MPH State Medicaid Director
Adjourn	
Next Meeting:	Wednesday, March 20th, 8:30 a.m.

Joint House Committee on Appropriations Subcommittee on Health and Human Services
Tuesday, March 19, 2013, at 8:35 a.m.
Room 643

MINUTES

The House Committee on Appropriations Subcommittee on Health and Human Services met at 8:30 am on Tuesday, March 19, 2013 in Room 643. Representatives Avila, Brisson, Farmer-Butterfield, Ford, Fulghum, Hollo, Lambeth, Martin and Murray attended. Senators Hise, Pate, McKissick, Robinson and Barringer attended.

Senator Ralph Hise, presided.
Senator Hise, gaveled the meeting at 8:30 am made opening remarks and introduced the Pages and Sergeants and Arms.
House Pages: Steven Andreas and Wesley Hollingsworth
Senate Pages: Annissa Zak
Sergeants at Arms – House: Charles Godwin and Marvin Lee.
Sergeants at Arms – Senate: Ken Kirby and Steve Wilson.

Senator Hise introduced Ms. Susan Jacobs, Committee Staff for the Fiscal Research Division for the NC General Assembly. Ms. Jacob's presentation was on Division of Medical Assistance Prescription Drugs.

Senator Hise introduced Ms. Carol Steckle, MPH State Medicaid Director. Ms. Steckles presentation was on the Division of Medical Assistance Prescription Drugs – North Carolina Policies.

All presentations are attached to these minutes.

The meeting was adjourned at 9:25 am.

Senator Ralph Hise
Presiding

Caroline Stirling, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, March 14, 2013 12:59 PM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Tuesday, March 19, 2013 at 8:30 AM

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

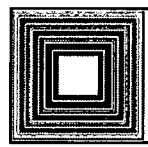
DAY	DATE	TIME	ROOM
Tuesday	March 19, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Department of Health and Human Services
Division of Medical Assistance
Prescription Drugs

Susan Jacobs
Fiscal Research Division

March 19, 2013



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

What are the Long-Term Goals for Medicaid?

- *What* does the General Assembly want in a Medicaid Program?
- Is the current program *designed* to meet legislative expectations and achieve long-term goals?
- Should the state, providers, and recipients share in the *financial risk*?
- Paying for Value: Are current payment policies designed to *reward better outcomes*?

Balancing Act: Access/Quality/Cost

Presentation Outline

- Overview
- Historical Expenditures
- Initiatives in Other States

Medicaid Prescription Drugs

In a fee-for-service payment model, payment elements include:

- **Ingredient Costs (Brand)-** The federal government has restrictions on how states can pay for drugs. On average the reimbursement amounts for drugs should not exceed the estimated acquisition cost plus a dispensing fee **or** the provider's usual and customary charge to the public for the drug. Most states reimburse based on list price.
- **Dispensing Fees-** Paid by states to pharmacies in addition to the ingredient cost. Rates vary significantly across all states and represents a small percentage of total prescription drug expenditures nationally and in North Carolina.
- **Drug Rebates** – A mandatory national drug rebate agreement between manufacturers and the U.S. Department of Health and Human Services. Savings from the rebates are shared between the federal and state government. Some states have implemented supplemental rebate programs with manufacturers to achieve additional savings.

Medicaid Prescription Drugs
Ingredient Costs

Average Wholesale Price (AWP):

- The list price from the wholesaler to the pharmacy, but does not represent the actual price paid because of negotiated discounts.
- Historically states have used AWP because it was the only information readily available.
- In 2011, the Office of the Inspector General issued a report that found that using method was "fundamentally flawed" and had "resulted in states paying too much for drugs in the Medicaid program".

Source: U.S. Department of Health and Human Services-Office of Inspector General "Replacing Average Wholesale Price: Medicaid Drug Policy" July 2011

Medicaid Prescription Drugs

Two Alternatives to Average Wholesale Price

- Wholesale Acquisition Cost (WAC) – The manufacturers list price to wholesalers. Currently used by North Carolina as well as other states.

- Average Acquisition Cost (AAC) – A **new benchmark** currently used in three states. This method is based on actual drug costs obtained from surveys from pharmacies. The Centers for Medicare and Medicaid Services is encouraging states to use this method.

Source: The Kaiser Commission on Medicaid and the Uninsured "Managing Medicaid Pharmacy Benefits: Current Issues and Options", September 2011.

Medicaid Prescription Drugs

Wholesale Acquisition Cost

Wholesale Acquisition Cost (WAC): In June 2010, the American Medicaid Pharmacy Administrators Association and the National Association of Medicaid Directors recommended that states use WAC as a temporary payment method until a better method is available.

Medicaid Prescription Drugs

Average Acquisition Costs

Average Acquisition Costs (AAC):

Alabama was the first state approved by the Centers for Medicare and Medicaid Services to switch to this method. Using this method, states require that randomly selected pharmacies submit invoices. States then use this information to determine AAC.

Medicaid Prescription Drugs
Single National Benchmark

National Average Drug Acquisition Cost

"The Centers for Medicare and Medicaid Services (CMS) has contracted with a national certified public accounting firm, to conduct surveys of drug ingredient costs from both independent and chain pharmacies in the United States, and to develop a national pricing benchmark".

"The purpose of this initiative is to perform a monthly nationwide survey of retail community pharmacy prescription drug prices and to provide states with on-going pricing files. We expect that these pricing files will provide state Medicaid agencies with an array of covered outpatient drug prices concerning acquisition costs and consumer purchase prices. State agencies can use this information to compare their own pricing methodologies and payments to those derived from these surveys".

Source: Draft Report – The Centers for Medicare and Medicaid Services: "Draft Methodology for Calculating the National Average Drug Acquisition Cost".

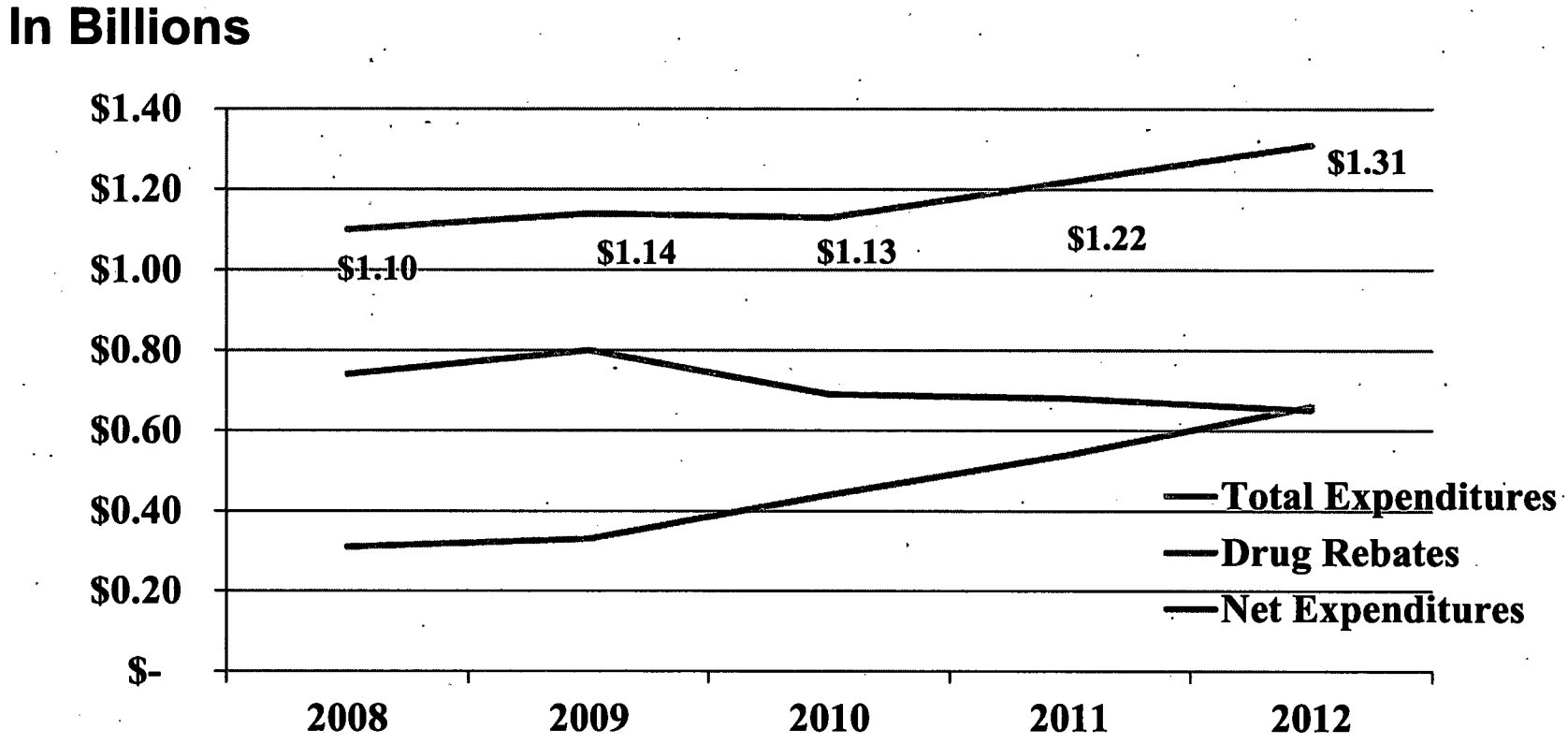
Historical Expenditures

Medicaid Prescription Drugs
Historical Expenditures – Total Funds

Fiscal Year	Prescription Drugs	Dispensing Fees	Rebates	Net Total Expenditure
2003	$ 1,211,655,124	Data Not Available	246,899,590	$ 964,755,534
2004	$ 1,481,226,912	Data Not Available	293,439,382	$ 1,187,787,530
2005	$ 1,648,039,897	Data Not Available	386,541,375	$ 1,261,498,522
2006	$ 1,385,039,301	Data Not Available	468,298,954	$ 916,740,347
2007	$ 934,276,607	Data Not Available	282,401,095	$ 651,875,512
2008	$ 986,504,775	$ 67,541,199	311,705,952	$ 742,340,022
2009	$ 1,065,558,422	$ 71,617,164	332,550,212	$ 804,625,373
2010	$ 1,057,077,053	$ 76,477,157	434,577,331	$ 698,976,879
2011	$ 1,137,850,317	$ 78,496,396	537,654,508	$ 678,692,205
2012	$ 1,217,315,028	$ 87,859,905	654,032,641	$ 651,142,292

Source: Department of Health and Human Services, Division of Medical Assistance.

Medicaid Prescription Drugs
Historical Expenditures*



Source: Department of Health and Human Services, Division of Medical Assistance. Total expenditures includes dispensing fee expenditures.

Medicaid Prescription Drugs
Dispensing Fees

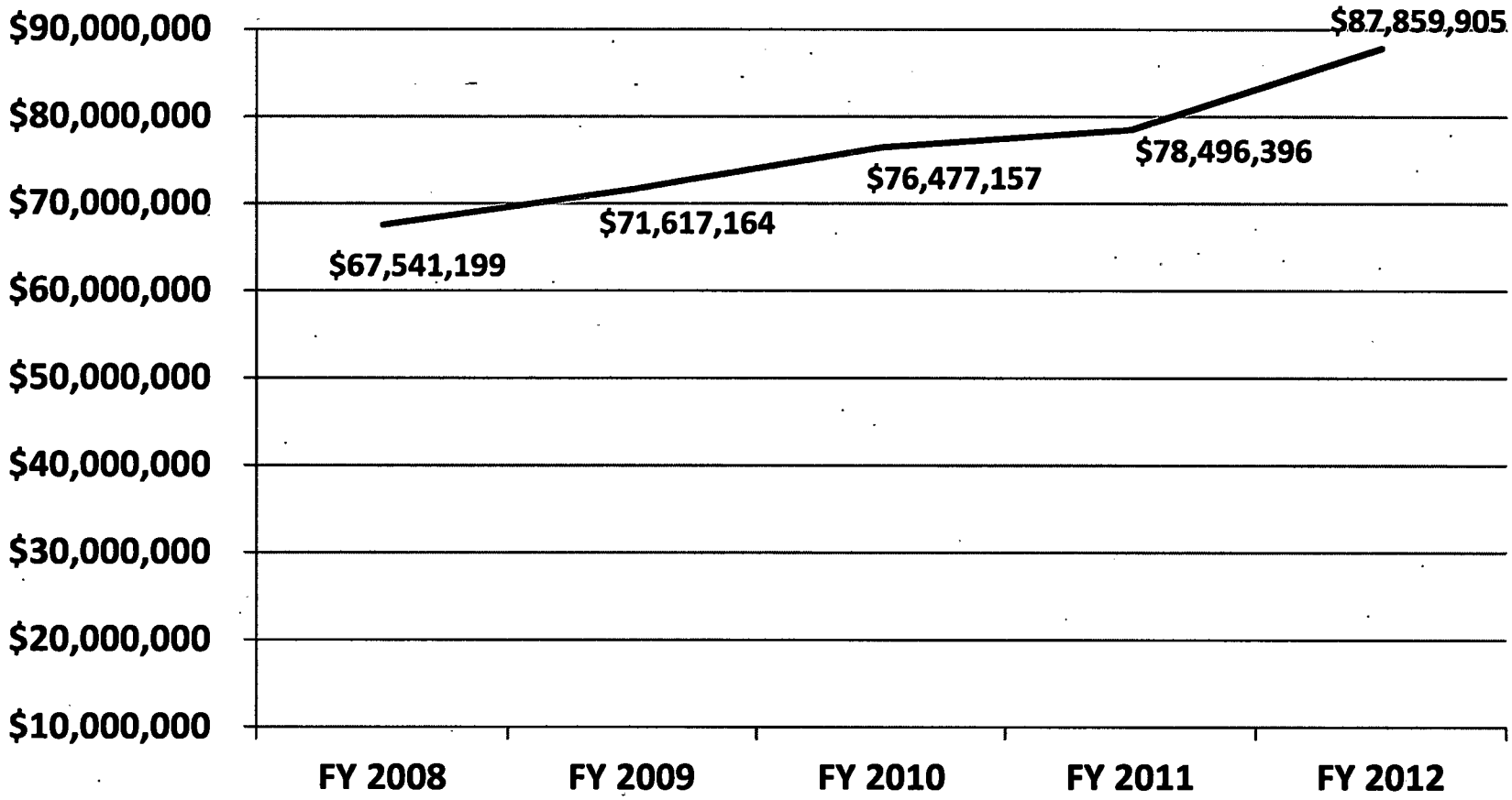
North Carolina Medicaid Generic* Drug Dispensing Fees**

	Effective October 1, 2012		Effective July 1, 2013	
	Claims per Quarter	Rate	Claims per Quarter	Rate
Tier 1	Greater than 82%	$7.75	80% or more	$7.75
Tier 2	Between 77.1% and 82%	$6.50	Between 75% and 79.9%	$6.50
Tier 3	Between 72.1% and 77%	$4.00	Between 70% and 74.9%	$4.00
Tier 4	Less than or equal to 72%	$3.00	Less than or equal to 69.9%	$3.00

* Brand-drug dispensing fee is $3.00

** Paid to all providers for initial dispensing and excludes refills within the same month for the identical drug or generic equivalent

Medicaid Prescription Drugs
Dispensing Fees – Historical Expenditures



Medicaid Prescription Drugs
Dispensing Fees

States are considering changes to dispensing fees. Changes being considered include:

- Market rates; and
- Benchmarking to commercial plans, managed care organizations, and Medicare.

Nationally, the Medicaid Program has historically paid more for dispensing fees and ingredients that other payers.

Source: The Kaiser Commission on Medicaid and the Uninsured, "Managing Medicaid Pharmacy Benefits: Current Issues and Options", September, 2011.

Initiatives in Other States

Medicaid Prescription Drugs

Initiatives in Other States

- **Average Acquisition Cost** (Alabama, Idaho and Oregon);
- **Most Favored Nations** (Georgia, Connecticut, Massachusetts, and South Carolina);
- **Mail Order;** and
- **Step Therapy.**

Medicaid Prescription Drugs

Initiatives in Other States

Most Favored Nations:

Requires that Medicaid will not pay a pharmacy more that the amount paid by other third party payers or than paid by the general public.

Medicaid Prescription Drugs

Initiatives in Other States

Mail Order:

- Several states offer a mail order option for beneficiaries.
- In 2011, Pennsylvania passed Senate Bill 201 now Act 207. The intent of the legislation was to assure that consumers received equivalent terms at individual pharmacies as they do through mail order and eliminated the lower co-pay advantage if purchasing through mail order. However, this is only applicable if the pharmacy will match the mail order rates.

Medicaid Prescription Drugs

Initiatives in Other States

Step-Therapy:

Some commercial insurers as well as state Medicaid programs, have implemented this method to shift patients to less expensive drugs.

Questions?

Fiscal Research Division

Room 619, LOB

919-733-4910

www.ncleg.net/fiscalresearch/

N.C. Department of Health and Human Services

Prescription Drugs North Carolina Policies

Carol Steckel, MPH

Medicaid Director

March 19, 2013

Medicaid Pharmacy Services

Pharmacy Services

- **Optional service provided each year**
  - to about 1.5 million beneficiaries
  - by 2,200 pharmacy providers
  - expenditures approximately $1.2 billion
  - average scripts per beneficiary: 2.85
- **Coverage is provided for**
  - prescription drugs
  - Over-the-Counter drugs (insulin + 4 classes where Rx alternatives are more costly)
  - 34 day supply unless qualifies for 90 day supply (i.e. generic, maintenance medication or prepackaged birth control or hormones)
  - a drug that is manufactured by a company that has signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS)

Medicaid Pharmacy Services

- **Rebates**
  - HHS Federal Rebates
    - Social Security Act, Section 1927
    - Must be in place for all covered drugs
    - Generics: 13% of base Average Manufacturer Price (AMP), however, 2% of this rebate is returned to the Federal government under the mandate in PPACA
    - Brands: 23.1% of base AMP plus CPI inflationary penalty, however 8% of this rebate is returned to the Federal government under the mandate in PPACA
    - Clotting Factors and drugs with exclusive pediatric indications: 17.1 % of base AMP plus CPI inflationary penalty, however 2% of this rebate is returned to the Federal government under the mandate in PPACA
  - State Supplemental rebates
    - tied to the Preferred Drug List

Medicaid Pharmacy Services

SFY	Total Expenditure	Rebates
2003	$ 1,211,655,124	$ 246,899,590
2004	$ 1,481,226,912	$ 293,439,382
2005	$ 1,648,039,897	$ 386,541,375
2006	$ 1,385,039,301	$ 468,298,954
2007	$ 934,276,607	$ 282,401,095
2008	$ 986,504,775	$ 311,705,952
2009	$ 1,065,558,422	$ 332,550,212
2010	$ 1,057,077,053	$ 434,577,331
2011	$ 1,137,850,317	$ 537,654,508
*2012	$ 1,217,315,028	$ 654,032,641

Medicaid Pharmacy Services

Drivers of pharmacy costs

- **Top Drug Classes** (based on paid amounts)
  - Mental health drugs have been in the top 5 since 2004
    - Examples: antipsychotics, anticonvulsants
  - ADHD drugs appeared in the top 5 beginning in 2007
  - Others consistently in the top 5:
    - Narcotic analgesics, proton pump inhibitors
- **Diagnoses (inferred from drug utilization)**
  - Psychotic disorders, bipolar disorder
  - Attention Deficit Hyperactivity Disorder
  - Pain
  - Gastrointestinal Disorders

Medicaid Pharmacy Services

	Drug Class (SFY 2012)	Net Paid	Patients	Claims
1	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	$113,428,491.25	44,747	353,414
2	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	$60,361,376.38	18,398	105,321
3	ANTICONVULSANTS	$58,234,443.16	119,453	961,823
4	TX FOR ATTENTION DEFICIT-HYPERACT(ADHD)/NARCOLEPSY	$50,582,512.74	47,819	311,555
5	ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	$49,972,088.51	49,734	319,601
6	ANALGESICS, NARCOTICS	$47,484,419.75	265,563	1,226,090
7	ANTIHEMOPHILIC FACTORS	$43,518,154.05	186	1,886
8	INSULINS	$37,264,593.34	20,866	182,807
9	PROTON-PUMP INHIBITORS	$33,345,609.57	100,176	501,435
10	GLUCOCORTICOIDS, ORALLY INHALED	$28,573,392.12	65,976	180,016

Medicaid Pharmacy Services

Reimbursement and Dispensing Fees

NC reimburses lesser of:

- NC Estimated Acquisition Cost is Wholesale Acquisition Cost (WAC) + 6%
- State Maximum Allowable Cost (SMAC) – rate based on highest of 192.5% of lowest cost generic or 120% of second lowest cost generic
- Federal Upper Limit – due to be updated this year
- Usual and Customary Charge – if lower than all of the above

Dispensing Fees:

- Brands: $3.00
- Generics: 4 tier structure
- Generic fees encourage generic dispensing
  - Average brand ingredient cost = $282.09
  - Average generic ingredient cost =$19.67
  - Generic dispensing rate was 69% prior to 2010; now 80.7%

Medicaid Pharmacy Services

Recent Legislative Changes

- **Dispensing Fees and WAC**
  - *Session Law 2011-145, Section 10.48(a)*
    - WAC + 7% decreased to WAC + 6%
    - Generic fees changed from $5.60 to 4 tiers
    - Generic Fees from $9.00 to $4.00 based on a pharmacy's generic dispensing rate percentage (GDR%)
  - *Session Law 2012-142, Section 10.48(a1)*
    - Tier ranges were adjusted
    - Brand dispensing fee changed from $4.00 to $3.00
    - Generic Fees from $7.75 to $3.00 based on pharmacy's GDR%

Medicaid Pharmacy Services

Generic Dispensing Fees

- Session Law 2011-145 budgetary changes
  - Changed from $5.60 to four tiers based on pharmacy GDR%
    - 80% $9.00
    - 75% - 79.9% $6.50
    - 70% - 74.9% $4.40
    - 69.9% - $4.00
- Session Law 2012-142 budgetary changes
  - Revised GDR% and fee amounts
  - Effective October 1, 2012
    - >82% $7.75
    - 77.1% - 82% $6.50
    - 72.1% - 77% $4.00
    - ≤ 72% $3.00

  Effective July 1, 2013
  - ≥ 80% $7.75
  - 75% - 79.9% $6.50
  - 70% - 74.9% $4.00
  - ≤ 69.9% $3.00

Medicaid Pharmacy Services

Recent Legislative Changes (continued)

- **Hemophilia Specialty Program**
  - Session Law 2012-142, Section 10.48(a2)
  - Standards of Care implemented on January 31, 2013
    - Assay management
    - Inventory management
    - Pharmacy certification requirements
    - Reporting requirements
  - 340B and Non-340B upper limits for hemophilia drugs

Department of Health and Human Services – Division of Medical Assistance

Pharmacy Reimbursement

Ingredient Cost

The cost of a drug is calculated from the lowest cost on file of the following: WAC + 6%, the federal (FUL) or state MAC (SMAC) price; the enhanced specialty discount; the hemophilia enhanced specialty discount, or the usual and customary charge. WACs are updated weekly via File Transfer Protocol (FTP) from First Data Bank. State MACs are updated monthly. Federal MACs are updated by CMS. The enhanced specialty discount drug list is updated quarterly. The hemophilia enhanced discount list is updated annually.

340B priced drugs are available to pharmacies who qualify as a 340B entity. If a 340B purchased drug is dispensed to a Medicaid beneficiary, the provider must submit the actual purchased drug price plus the dispensing fee unless the drug is a hemophilia drug. For hemophilia drugs, 340B providers may submit the state upper limit established for a 340B purchased hemophilia drug plus the dispensing fee.

Dispensing Fees

The dispensing fee for generic drugs or brand name drugs is added to the cost of the drug. The dispensing fee for generic drugs is based on a pharmacy's quarterly generic dispensing rate. The General Assembly mandates that a dispensing fee shall not be paid for refills of the same drug twice within the same month.

Definitions

340B priced drugs: The 340B Program provides discounts on outpatient drugs to safety net providers. The program allows safety net providers to increase patient services with savings realized from participation in the 340B program. Covered entities determine whether they will use 340B drugs for their Medicaid patients (carve-in) or whether they will purchase drugs for their Medicaid patients through other mechanisms (carve-out).

Enhanced Specialty Discount: The General Assembly [Session Law 2008-107, Section 10.10(e)] required a State-determined upper payment limit on select single-source specialty drugs that cost in excess of $1,500 per month.

FDB (First Data Bank): a national drug data file that provides prices, descriptions, and clinical information on drugs approved by the FDA.

FUL (Federal Upper Limit): a federal payment ceiling that applies to multiple source drugs. The ACA revised the Social Security Act to require a FUL as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices (AMP) for multiple source drugs that are available for purchase by retail community pharmacies on a nationwide basis.

Hemophilia Enhanced Specialty Discount and State Upper Limits for 340B Purchased Hemophilia Products: The General Assembly [Session Law 2012-142, Section 10.48(a2)] required establishment of a specialty pharmacy program for hemophilia drugs with savings primarily from 340B purchased drugs.

SMAC (State Maximum Allowable Cost): a state-determined reimbursement ceiling that applies to products with A-rated equivalents marketed by at least two labelers that is based on a percentage factor applied to the lowest priced generic.

U & C Charge (Usual & Customary Charge): the price that the general public would pay for the drug at the retail pharmacy.

WAC (Wholesale Acquisition Cost): a price developed by manufacturers and is the baseline price at which wholesale distributors purchase products

kaiser commission on MEDICAID FACTS

medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

September 2011

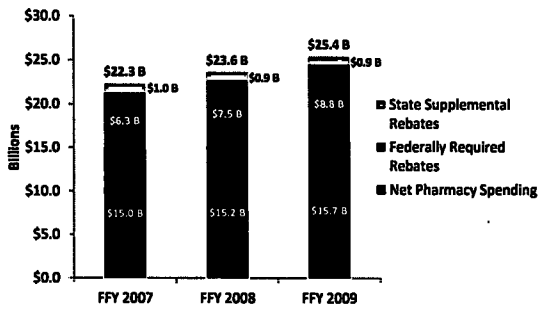
Medicaid Payment for Outpatient Prescription Drugs

Medicaid is the major source of outpatient prescription drugs for the low-income population. The program plays a critical role for enrollees with chronic physical or mental illnesses that require drug therapy and is the largest source of coverage for people with HIV/AIDS, a group with a particularly acute need for prescription medications.

Rising prescription drug expenditures are a perennial challenge for all payers, including state Medicaid programs. Outpatient prescription drug coverage is an optional benefit that all states currently provide. Both higher costs and increased prescribing volume have resulted in growth in spending. In 2009, Medicaid spent $25.4 billion in federal and state funds for prescription drugs (Fig. 1), excluding managed care spending and spending on specialty drugs, such as high-cost injectable therapies, covered under the program's medical benefit. This amount represented 6.6% of total Medicaid spending on all services for that year and 10% of total prescription drug spending in the United States.

FIGURE 1

U.S Medicaid Pharmacy Spending & Rebate Revenue Federal Fiscal Years 2007 - 2009



SOURCE: Financial Management Report for FY 2002 through FY 2009, CMS-64 Quarterly Expense Report, available at

In 2006, Medicaid drug coverage for beneficiaries also eligible for Medicare ("dual eligibles") moved to Medicare Part D plans. States continue to finance a portion of drug coverage for dual eligibles through "clawback" payments to the federal government. Some states also wrap around Medicare coverage, which may not be as comprehensive as Medicaid's, and this spending is not eligible for federal matching funds.

Medicaid Reimbursement for Drugs

States' methods of setting pharmacy reimbursements for drugs vary a great deal and evolve over time. Many enrollees are covered by Medicaid managed care plans in which drug payments are included in the capitated payments that plans receive from states. However, some states carve out prescription drug benefits from managed care plans and pay for them on a fee-for-service basis.

Medicaid Reimbursement for Fee-for-Service Drugs

In states' fee-for-service programs, payments for drugs include three major elements: ingredient costs, dispensing fees, and manufacturer rebates.

Ingredient Costs. Most states reimburse ingredient costs based on list prices, such as a discount of the average wholesale price (AWP) or a markup of the wholesale acquisition cost (WAC). Exact discounts or markups vary across states. While a majority of states use AWP, its validity has come under scrutiny amid claims that it is arbitrarily inflated, and the vendor that most states use to set AWP rates will stop publishing these prices in 2011. Alabama and Oregon have begun to use a new benchmark, average acquisition cost (AAC), which bases payments on actual drug costs obtained from surveys of pharmacies. The Center for Medicare and Medicaid Services is developing a national database of pharmacies' acquisition costs for states' use. Regardless of pricing method, ingredient costs of brand name drugs are much higher than those of generic drugs. While brand name drugs represent less than 30% of prescriptions, they account for nearly 80% of ingredient costs of drugs that Medicaid pays for on a fee-for-service basis.[1]

Dispensing Fees. States pay pharmacies a dispensing fee for costs that are in excess of ingredient costs and are associated with dispensing drugs to beneficiaries. These fees also vary widely across states, and some states have trimmed dispensing fees as a cost-saving measure.

Manufacturer Rebates. For the costs of a drug to qualify for federal Medicaid matching funds, manufacturers must sign an agreement with the Secretary of HHS stating that they will rebate a specified portion of the Medicaid payment for drugs to the states, which in turn share the rebates with the federal government. In return, Medicaid must cover almost all FDA-approved drugs that those companies produce. Some states require manufacturers to pay supplemental rebates in addition to the federally required rebate. The Affordable Care Act (ACA) includes provisions that increase federal minimum drug rebates and that require manufacturers to pay rebates

[1] *State Drug Utilization Data*, CMS, CY 2009, available at: http://www.cms.gov/MedicaidDrugRebateProgram/SDUD/list.asp and *Drug Product Data* available at: http://www.cms.gov/MedicaidDrugRebateProgram/09_DrugProdData.asp for drug type identifiers.

1330 G STREET, NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WWW.KFF.ORG/KCMU

to states for drugs purchased for beneficiaries by managed care plans with capitated payment arrangements.

Managing Medicaid Drug Use and Costs
States have considerable flexibility when administering Medicaid prescription drug benefits. Their options include a variety of strategies to control expenditures; Figure 2 lists strategies that states have most commonly adopted.

Generic Substitution. Most states now require that a generic version of a medication be substituted for the brand name drug when available. In some states, prescribers have the option to override the substitution by documenting that the brand version is medically necessary.

Prior Authorization. States can require that prescribers or dispensers get permission before providing a Medicaid beneficiary with a drug. States must make authorization decisions within 24 hours and provide a 72-hour supply of a medication in emergencies. States have increasingly and more systematically applied prior authorization to their formularies in order to create preferred drug lists (PDLs). PDLs include drugs that are covered without prior authorization. States use PDLs as an incentive to prescribers to choose formulary drugs because they can avoid having to seek prior authorization. States also use PDLs as an incentive to manufacturers to offer discounts in return for placing their products on the list.

Formularies. Most states also maintain a Medicaid formulary or list of approved products. Formulary restrictions vary by state, but exclusions must be justified and available through prior authorization when medically necessary. Medicaid managed care plans also use formularies to control utilization and obtain discounts from drug manufacturers. Managed care plans' formularies may differ from those of states' fee-for-service programs, typically covering fewer drugs, particularly brand name products, than states' PDLs.

Maximum Allowable Cost Programs. Nearly all states set Maximum Allowable Cost (MAC) rates that cap the prices that they will pay for drugs. States are allowed to set their own MAC rates, but they must fall within federal limits.

Purchasing Pools. A number of states have entered into purchasing pools with other states, or have developed intrastate pools that purchase drugs for several state programs, such as state employee plans, education, and corrections. These arrangements are meant to increase bargaining power and administrative efficiency.

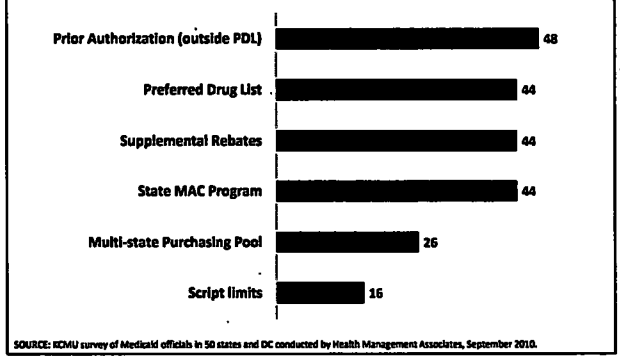
Disease Management. Disease management programs better coordinate care for enrollees with chronic conditions and improve adherence to evidence-based best practices through specialized treatment plans and enrollee support. While not a drug cost or utilization control, as it may actually increase drug spending by encouraging drug regimen adherence, disease management is an option states are exploring to control overall costs for high-cost populations.

Drug Utilization Review. States must also perform prospective and retrospective drug utilization review (DUR) for Medicaid outpatient drugs. Prospective DUR, performed prior to dispensing a drug, is intended to reduce medication errors and adverse drug events. Retrospective DUR reviews prescribing and dispensing history to identify safety and cost problems. Some states have reported that both strategies can improve quality of care while controlling costs.

Script Limits. Most states have limits on the number of concurrent prescriptions (as few as three in some states), amount of drug supplied at one time, or number of refills.

Cost Sharing. States may establish nominal copayments ($.65-$3.65) for beneficiaries. Under the Deficit Reduction Act of 2005, states can also charge up to 20% coinsurance on non-preferred drugs for beneficiaries above 150% FPL, but very few states do so. These strategies are only permitted for certain categories of beneficiaries.

FIGURE 2
Medicaid Pharmacy Cost Containment Measures in Place in FY 2010



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010.

Future Challenges for Medicaid's Drug Benefit
To control costs, states are striving to increase generic dispensing rates and examining new methods of setting ingredient cost reimbursements, such as AAC, that reflect actual acquisition costs. States are also focused on controlling the cost of mental health drugs, such as atypical antipsychotics, and specialty drugs by improving care management and negotiating deeper discounts. Understanding the effects of differences between fee-for-service and managed care pharmacy benefits will also be important, especially as states enroll more complex and vulnerable groups in managed care. In sum, preserving beneficiaries' access to necessary prescription drugs while constraining costs will be an ongoing challenge.

This publication (#1609-04) is available on the Kaiser Family Foundation's website at www.kff.org.

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

March 27, 2013
Legislative Office Building - Room 643
8:30 a.m.

Representative William Brisson, Presiding	Welcome, Opening Remarks
Governor's Recommended Budget FY 2013-15	Dr. Aldona Wos, Secretary Department of Health and Human Services
Governor's Recommended Budget FY 2013-15	Pam Kilpatrick Assistant State Budget Officer Office of State Budget and Management
Adjourn	
Next Meeting:	Thursday, March 28th, 8:30 a.m.

Joint Committee on Appropriations Subcommittee on Health and Human Services
Wednesday, March 27, 2013 at 8:30am
Room 643

MINUTES

The Joint Committee on Appropriations Subcommittee on Health and Human Services met at 8:30 am on March 27, 2013 in Room 643. Representatives Avila, Brisson, Earle, Farmer-Butterfield, Ford, Fulghum, Hollo, Insko, Lambeth, Martin, and Murry attended. Senators Hise, Pate, Barringer, McKissick, and Robinson attended.

Representative William Brisson presided.

Chairman Brisson introduced the Pages and Sergeants At Arms.

Chairmen Brisson welcomed Dr. Aldona Wos, Secretary of the Department of Health and Human Services. Dr. Wos made an introduction of the Govenor's Recommended 2013-2015 Budget as it relates to Health and Human Services.

Dr. Wos asked that Pam Kilpatrick,Assistant State Budget Officer from the Office of State Budget and Management go into the details of the recommended budget, give an overview and answer question on the budget.

The meeting adjourned at 9:50 a.m. The next meeting will be March 28, 2013 at 8;30 am.

Representative William D. Brisson, Chair Presiding

Susan Lewis, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, March 21, 2013 11:07 AM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Wednesday, March 27, 2013 at 8:30 AM

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	March 27, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Susan Lewis (Rep. Marilyn Avila)

'om:	Susan Lewis (Rep. Marilyn Avila)
ɜnt:	Thursday, March 21, 2013 03:00 PM
To:	Susan Lewis (Rep. Marilyn Avila)
Subject:	<NCGA> House Appropriations Subcommittee on Health and Human Services Committee Meeting Notice for Wednesday, March 27, 2013 at 8:30 AM

NORTH CAROLINA HOUSE OF REPRESENTATIVES
JOINT COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2013-2014 SESSION

You are hereby notified that the **House Committee on Appropriations Subcommittee on Health and Human Services** will meet as follows:

DAY & DATE: Wednesday, March 27, 2013
TIME: **8:30 AM**
OCATION: **643 LOB**

Respectfully,

Representative Marilyn Avila, Co-Chair
Representative William D. Brisson, Co-Chair
Representative Mark W. Hollo, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 2:58 PM on Thursday, March 21, 2013.

___ Principal Clerk
___ Reading Clerk – House Chamber

Susan Lewis (Committee Assistant)

OVERVIEW OF HEALTH AND HUMAN SERVICES

The Governor's Recommended 2013-15 Budget
Governor Pat McCrory

Presentation to the Joint Appropriations Subcommittee
on Health and Human Services, March 27, 2013

Prepared by
NC Office of State Budget and Management

TOTAL HEALTH AND HUMAN SERVICES GENERAL FUND BUDGETS						
	2011-12 Actual	2012-13 Authorized	2013-14 Recommended	% Change	2014-15 Recommended	% Change
Requirements	$19,528,811,309	$17,575,935,887	$18,494,128,258	5.2%	$19,051,739,102	8.4%
Receipts	$14,944,812,786	$12,875,232,484	$13,735,202,590	6.7%	$14,087,442,657	9.4%
GF Appropriation	$4,583,998,523	$4,700,703,403	$4,758,925,668	1.2%	$4,964,296,445	5.6%

Includes:

- ***Medicaid and Health Choice***
- ***Social Services***
- ***Mental Health***
- ***Public Health***
- ***Child Development and Early Education***
- ***Vocational Rehabilitation***
- ***Central Administration***
- ***Aging and Adult Services***
- ***Services for the Blind, Deaf and Hard of Hearing***

Summary of Recommended General Fund Appropriations 2013-15
Department of Health and Human Services

Fiscal Year 2013-14

	2011-12 Actual	2012-13 Authorized	Base Budget Adjustments	Recommended Base Budget	Reductions	Expansions	Total Appropriation	% Chg from Authorized
Central Management and Support	54,771,774	51,237,988	2,790,366	54,028,354	(672,617)	5,538,308	58,894,045	14.9%
Aging and Adult Services	43,867,854	94,264,677	(39,821,481)	54,443,196	(855)	500,000	54,942,341	-41.7%
Child Development and Early Education	261,687,029	262,754,083	(3,500,000)	259,254,083	(3,562,314)	9,131,559	264,823,328	0.8%
Public Health	174,628,613	166,503,679	(9,719,177)	156,784,502	(16,000,000)	2,052,000	142,836,502	-14.2%
Social Services	185,200,809	176,601,099	(5,971,195)	170,629,904	(1,672,818)	7,920,836	176,877,922	0.2%
Medical Assistance - Medicaid	3,057,376,970	3,102,444,193	(32,867,383)	3,069,576,810	(99,325,154)	241,828,664	3,212,080,320	3.5%
Medical Assistance - Health Choice	77,855,203	80,131,026	0	80,131,026	(16,225,263)	6,176,522	70,082,285	-12.5%
Services for the Blind and Deaf and Hard of Hearing	7,174,928	8,178,618	0	8,178,618	0	0	8,178,618	0.0%
Mental Health/DD/SAS	669,003,343	703,648,211	3,149,536	706,797,747	(15,644,509)	23,020,934	714,174,172	1.5%
Health Services Regulation	15,946,188	17,723,614	(961,622)	16,761,992	0	0	16,761,992	-5.4%
Vocational Rehabilitation	36,485,812	37,216,215	2,067,928	39,284,143	(10,000)	0	39,274,143	5.5%
Total Health and Human Services	**4,583,998,523**	**4,700,703,403**	**(84,833,028)**	**4,615,870,375**	**(153,113,530)**	**296,168,823**	**4,758,925,668**	**1.2%**

Summary of Recommended General Fund Appropriations 2013-15
Department of Health and Human Services

	Fiscal Year 2014-15							
	2011-12 Actual	2012-13 Authorized	Base Budget Adjustments	Recommended Base Budget	Reductions	Expansions	Total Appropriation	% Chg from Authorized
Central Management and Support	54,771,774	51,237,988	3,480,527	54,718,515	(672,617)	11,963,346	66,009,244	28.8%
Aging and Adult Services	43,867,854	94,264,677	(39,821,481)	54,443,196	(855)	700,000	55,142,341	-41.5%
Child Development and Early Education	261,687,029	262,754,083	(3,500,000)	259,254,083	(3,562,314)	9,131,559	264,823,328	0.8%
Public Health	174,628,613	166,503,679	(9,719,177)	156,784,502	(16,000,000)	2,052,000	142,836,502	-14.2%
Social Services	185,200,809	176,601,099	(5,971,195)	170,629,904	(1,672,818)	8,047,980	177,005,066	0.2%
Medical Assistance - Medicaid	3,057,376,970	3,102,444,193	(18,867,383)	3,083,576,810	(114,152,764)	467,000,000	3,436,424,046	10.8%
Medical Assistance - Health Choice	77,855,203	80,131,026	0	80,131,026	(30,126,415)	11,178,930	61,183,541	-23.6%
Services for the Blind and Deaf and Hard of Hearing	7,174,928	8,178,618	0	8,178,618	0	0	8,178,618	0.0%
Mental Health/DD/SAS	669,003,343	703,648,211	3,149,536	706,797,747	(15,228,245)	5,088,122	696,657,624	-1.0%
Health Services Regulation	15,946,188	17,723,614	(961,622)	16,761,992	0	0	16,761,992	-5.4%
Vocational Rehabilitation	36,485,812	37,216,215	2,067,928	39,284,143	(10,000)	0	39,274,143	5.5%
Total Health and Human Services	4,583,998,523	4,700,703,403	(70,142,867)	4,630,560,536	(181,426,028)	515,161,937	4,964,296,445	5.6%

2013-14 and 2014-15 General Fund Appropriation Base Budget Summary

		2013-14 Adjustment	*2014-15 Adjustment*
Central Administration			
1 NC FAST (Families Accessing Services through Technology) Operations and Maintenance		3,005,366	3,695,527
2 Budget Digital Transaction Fees		(215,000)	(215,000)
	Total	**2,790,366**	**3,480,527**
Aging and Adult Services			
1 Eliminate One-Time Legislative Funding for Short Term Support of Adult Care Homes		(39,700,000)	(39,700,000)
2 Eliminate One-Time Legislative Funding for Non-Profit (Senior Games)		(121,481)	(121,481)
	Total	**(39,821,481)**	**(39,821,481)**
Child Development/Early Education			
1 Eliminate One-Time Legislative Funding (Smart Start Literacy Pilot)		(3,500,000)	(3,500,000)
2 Eliminate One-Time Legislative Use of TANF grant for child care subsidies		6,352,644	6,352,644
3 Continue use of TANF grant for child care subsidies		(6,352,644)	(6,352,644)
4 Eliminate One-Time Legislative Use of CCDF grant for Smart Start		7,000,000	7,000,000
5 Continue use of CCDF grant for Smart Start		(7,000,000)	(7,000,000)
	Total	**(3,500,000)**	**(3,500,000)**

Public Health		
1 State Lab and Office of Chief Medical Examiner	130,237	130,237
2 Eliminate One-Time Legislative Funding for Non-Profit (Prevent Blindness)	(308,163)	(308,163)
3 Eliminate One-Time Legislative Funding for Check Meds	(1,695,379)	(1,695,379)
4 Eliminate One-Time Legislative Funding for Medication Assistance Program	(1,704,033)	(1,704,033)
5 Eliminate One-Time Legislative Funding for Roanoke Chowan Telehealth Network	(300,000)	(300,000)
6 Eliminate One-Time Legislative Funding for County Health Dept. Wellness Initiatives	(4,894,727)	(4,894,727)
7 Eliminate One-Time Legislative Funding for Maternity Homes	(375,000)	(375,000)
8 Eliminate One-Time Legislative Funding for Services for Rape Victims	(197,112)	(197,112)
9 Eliminate One-Time Legislative Funding for High Risk Maternity Clinics	(375,000)	(375,000)
Total	**(9,719,177)**	**(9,719,177)**
Social Services		
1 Adjustments for Foster Care and Adoption Assistance Caseload Mix and Federal Participation (No service reduction)	(3,971,195)	(3,971,195)
2 Eliminate One-Time Legislative Non-Profit Funding (Food Banks)	(2,000,000)	(2,000,000)
Total	**(5,971,195)**	**(5,971,195)**

Medicaid			
1 Eliminate One-Time Legislative Funding for Repayment of 2009 Federal Overdraw		(31,300,776)	(31,300,776)
2 Eliminate One-Time Legislative Funding for Federal Drug Rebate Repayment		(24,606,148)	(24,606,148)
3 Eliminate One-Time Legislative Funding for Managed Care Organization Delays		(1,700,000)	(1,700,000)
4 Eliminate One-Time Legislative Funding for Health Homes for Chronically Ill Enhanced FMAP		24,739,541	24,739,541
5 Eliminate One-Time Legislative Funding for CHIPRA Bonus Payment		14,000,000	14,000,000
4 Continue CHIPRA Bonus Payment (2013-14 only)		(14,000,000)	0
	Total	**(32,867,383)**	**(18,867,383)**
Health Choice			
NONE			
	Total	**0**	**0**
Mental Health, DD, Substance Abuse Services			
1 Budget Mixed Beverage Receipts to Actual Collections		(180,627)	(180,627)
2 Annualize Legislative Expansion of Cherry Hospital Staff		9,626,295	9,626,295
3 Eliminate One-Time Legislative funding for Non-Profits (ARC, Autism Society, The Mariposa School, Easter Seals, Residential Services, Inc., Oxford House and Brain Injury Association)		(6,296,132)	(6,296,132)
4 Restore 2 Year Legislative Non-Recurring Reduction of Community Services Funding		20,000,000	20,000,000
5 Continue Current Community Services Funding Level		(20,000,000)	(20,000,000)
6 Eliminate One-Time Legislative Use of SAPTBG grant for division administration		227,000	227,000
7 Continue SAPTBG for division administration		(227,000)	(227,000)
	Total	**3,149,536**	**3,149,536**

Blind, Deaf and Hard of Hearing			
NONE			
	Total	**0**	**0**
Health Services Regulation			
1 Budget Medicaid and Licensure Receipts to Actual Collections		(361,622)	(361,622)
2 Budget Medicare Receipts to Actual Collections		(600,000)	(600,000)
	Total	**(961,622)**	**(961,622)**
Vocational Rehabilitation (VR)			
1 Restore One-Time Legislative Reduction to VR Program		2,067,928	2,067,928
	Total	**2,067,928**	**2,067,928**
	Grand Total DHHS	**(84,833,028)**	**(70,142,867)**

Acronyms:
TANF - Temporary Assistance for Needy Families
CCDF - Child Care Development Block Grant
FMAP - Federal Medical Assistance Percentage
CHIPRA - Child Health Insurance Program Reauthorization Act
SAPTBG - Substance Abuse Prevention and Treatment Block Grant

REVIEW OF GOVERNOR'S RECOMMENDED BUDGET DOCUMENT

Medicaid

- Governor's recommended budget funds changes in enrollment, consumption, mix of services, mandatory cost increases and "woodwork" effect of the Affordable Care Act
- The Medicaid rebase assumes a current year shortfall of $100M in state funds.
- Outside of the Medicaid budget, the Governor recommends a $180 million for a Medicaid Risk Reserve over the biennium.

Medicaid Claims Payment Rebase - $185M/$390M

- The Medicaid program is evaluated every year to determine the funds required to continue the program at the current level without any state policy changes.

Rebase	2014	2015
Requirements	928,722,433	1,489,135,558
Receipts	743,722,433	1,099,135,558
Appropriation	**185,000,000**	**390,000,000**

- The rebase forecasts claims expenditures based on 5 factors: enrollment, consumption, federal mandates and cost, budget changes and new services. The rebase also adjusts federal receipts for the impact of changes in the federal medical assistance percentage (FMAP).

- **Enrollment** - is the single largest impact on the forecast. Enrollment includes the 'woodwork' effect from the Affordable Care Act. (ACA) Projected growth over the biennium:

	Without ACA	With ACA
SFY 2014	42,000	111,000
SFY 2015	51,000	54,000
Total Additional over the Biennium	93,000	165,000

- **Consumption –** is the amount of services an individual receives.

- **Federal Mandates/Cost** - Examples include federally set rates for Medicare Part A, B, and D, that Federally Qualified Health Centers be paid cost and that is hospice paid at Medicare rates. This category also includes increases due to way rates are set. Examples include nursing home case mix, hospital outpatient and prescription drugs.

- **Budget Changes –** This is the annualization of changes, positive or negative due to actions taken in the budget. MCO expansion and estimated savings achievement are included in the rebase

- **New Service** - Estimates cost for new services. When FDA approves a new drug, federal regulations require Medicaid to cover it and there is no generic version of a new drug. This also includes clinical policy changes and new technology

Cost Settlements Rebase - $18M/$18M

- Medicaid cost settles with certain providers such as hospitals, and Federally Qualified Health Care Centers.

- At the end of a facilities fiscal year they submit a cost report to the Division of Medical Assistance. The facility is then cost settled based on the payment policies in the state plan.

- Cost settlements are affected by the number of Medicaid recipients a facility serves and the facilities cost of doing business.

- This rebase projects current year expenditures forward and adjusts the federal matching percentage to produce the rebase.

Contracts Rebase - $11M/ $11M

- Funds are provided for Medicaid contracts that are connected to the number of Medicaid recipients. As enrollment grows contracts that ensure for proper provision of medical services, such as prior authorizations, utilization reviews and assessments increase in cost as vendors are paid by the number of services they provide.

- Medicaid contracts are currently projected to be over budget by 6%. This rebase funds this shortfall and then provides additional funds for the growth in the Medicaid eligible population.

- Funding is also provided for the Asset Verification contract which implements electronic verification of assets for the Aged, Blind and Disabled population and is required by federal law.

QUESTIONS

VISITOR REGISTRATION SHEET

HHS Appro
Name of Committee

3-27-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kerra Bolton	LCA
Daniel Ashburn	NCRMA
Doris Betts	DCAEC
Steve Mitchell	Astellas
Lee Franklin	NC AHTCF
Joe Donovan	SCNC
Cory Hamp	NCHA
Tim Wing	FWN
Sam Hayes	NCNA
Doug Mosteller	PSG
Hugh Tilson	NCHTA

VISITOR REGISTRATION SHEET

HHS Appro
Name of Committee

3-27-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jaye Peters	CSS
JOE LANIER	NELSON MULLINS
Shala Tanner	NCCU
Julia Adams	The Arc of NC/NCIRF
JEFF BARNHART	MWC
Wendy Kelly	BIC Group
Jud Maynard	[illegible]
Chris McClain	Brooks Pierce
CNelson	NCHA
Jonathan Babaker	Babaker & Assoc.
Paylin Mizell	[illegible]

VISITOR REGISTRATION SHEET

HHS Appro — 3-27-13

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Holly Connor	CVMC - AORN
Michele McGlamery	AORN / CVMC
Dill Gaither	allyn law
Heather Densmore	Nurse
Bill Rustin	ACP
Kelley Nicholson	UNC HC
Matt Sheffield	BI
Fred Boone	Boone + Asso.
Fred Wald	Eastern Tech UCP
Dan Cunningham	NC Council of Community Programs
Inga Downing	ECPA

HHS Appro 3/27

Name	Agency
Mark	BCS
James Bond	MI6
J Nichols	GC

VISITOR REGISTRATION SHEET

HHS Approx — Name of Committee

Mar 27-13 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathy Baker	Eastpointe
Sarah Wolfe	MWC LCC
Elizabeth Yuhasz	CFTF
K Vaa	NCGA - Senate Staff
Annaliese Dulin	Helpline
Sarah Rothacker	Brubaker Assoc
ALAN BRIGGS	NC FOOD BANKS
Jennifer Mahan	ASMC
[illegible]	SEARCH
Tracy Hayes	Alliance Beh. Healthcare
Colleen Kochanek	NCCEP

VISITOR REGISTRATION SHEET

HHS Approps — Name of Committee

Mar 27-13 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joe Hayek	DHHS
Madison Mackenzie	DOJ
George Smith	NP
Deana N. Thorpe	OSA
K. Denise Crowder	OSA
JAY PETERS	CSS
Judy Jenkins	OAPI
Matt Gross	NCDC
Kay Parker	NASW-NC
Mary Bode	AARP-NC
TRACY COLVARD	AHC

HHS Appros Mar 27-13

Ann Rodriguez	NC council of Comm Programs
Dana Hagale, MD	NC Child Treatment Prog'm

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

March 28, 2013
Legislative Office Building - Room 643
8:30 a.m.

Senator Louis Pate, Presiding	Welcome, Opening Remarks
Paying For Outcomes	Carol Steckel, MPH State Medicaid Director
Adjourn	
Next Meeting:	Tuesday April 2, 8:30 a.m. + Wed. No meeting Thursday

Joint Committee on Appropriations Subcommittee on Health and Human Services
Thursday, March 28, 2013 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations Subcommittee on Health and Human Services met at 8:30 AM on March 28, 2013 in Room 643 of the Legislative Office Building. Representatives Avila, Brisson, Farmer-Butterfield, Ford, Fulghum, Hollo, Insko, Lambeth, Martin, and Murry attended. Senators Hise, Pate, Barringer, McKissick,and Robinson attended.

Senator Louis Pate presided.

Senator Pate introduces the Pages and Sergeants At Arms. Senate Pages were Miss Jenna Johnson, Miss Mattie Tart, Mr. Spence Hutcheson and Mr. Davis Culton. The House Pages were Miss Lauren Applewhite, Miss Sasha Duncan, Mr. Justin Cianfarra and Mr. Randy Sitt.

Serving as Sergeants At Arms were Mr. Bob Myrick, Mr. Steve Wilson, Mr. Fred Hines, and Mr. Mike Clampitt.

Senator Pate introduced Director Carol Steckel of the State Medicaid Program to discuss Paying for Outcomes. (see the attached presentation)

After a brief question and answer period, the meeting was adjourned at 9:50 a.m.

Senator Louis Pate,Presiding Chair

Susan Lewis, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, March 21, 2013 11:09 AM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Thursday, March 28, 2013 at 8:30 AM

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Thursday	March 28, 2013	8:30 AM	643 LOB

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Susan Lewis (Rep. Marilyn Avila)

From: Susan Lewis (Rep. Marilyn Avila)
Sent: Thursday, March 21, 2013 03:03 PM
To: Susan Lewis (Rep. Marilyn Avila)
Subject: <NCGA> House Appropriations Subcommittee on Health and Human Services Committee Meeting Notice for Thursday, March 28, 2013 at 8:30 AM

NORTH CAROLINA HOUSE OF REPRESENTATIVES
JOINT COMMITTEE MEETING NOTICE
AND
BILL SPONSOR NOTIFICATION
2013-2014 SESSION

You are hereby notified that the **House Committee on Appropriations Subcommittee on Health and Human Services** will meet as follows:

DAY & DATE: Thursday, March 28, 2013
TIME: **8:30 AM**
LOCATION: **643 LOB**

Respectfully,

Representative Marilyn Avila, Co-Chair
Representative William D. Brisson, Co-Chair
Representative Mark W. Hollo, Co-Chair

I hereby certify this notice was filed by the committee assistant at the following offices at 3:01 PM on Thursday, March 21, 2013.

___ Principal Clerk
___ Reading Clerk – House Chamber

Susan Lewis (Committee Assistant)

N.C. Department of Health and Human Services

Paying for Outcomes

Carol H. Steckel, MPH

Medicaid Director

March 28, 2013

What do North Carolinians want to pay for?

- Improved health status of the population
- Stabilization of individuals with chronic illnesses
- Prevention
- Best practices

How can we achieve those goals?

- Incentive-based payments
- Value added services
- Bonuses
- Shared savings
- Non- financial incentives

Incentive-Based Payment

- Goal: improve health care results through more efficient and higher quality of service delivery
- Reimbursement based on health outcomes
- Rewards/incentivizes health care plans and providers based on established benchmarks:
  - Quality outcomes
  - Efficiencies in service
  - Satisfaction among its members

Incentive Based Payment

- Financial Models
  - Pay for Process
  - Bonus for achievement
  - Tiered bonus
  - Compensation at risk
  - Variable cost sharing
- Non-Financial Models
  - Performance profiling
  - Auto Assignment
  - Technical Assistance
  - Reduced administrative requirements

Incentive-Based Payment

- Combined Models (Financial and Non Financial incentives)
  - Shared Savings
  - Complimentary Incentives

Challenges

- Do incentive-based payments affect health care costs?
- Can one performance- based payment system control cost AND quality?
- How to measure savings? Control group, Trending, or baseline measure of cost?
- How large of performance incentive is necessary to affect provider behavior?
- How to measure effect of incentives: Overall costs (entire benefit package like transplants) or targeted performance?
- Should states incentive-based payments with risk adjusted capitation?

OREGAN HAS CONTROL GROUP

Conclusion

- NC pay for healthy outcomes
- More efficient delivery of care
- Increased access
- Motivate buy-in between provider and recipient

Conclusion

- Unleash the power of the health care community to provide:
  - The right service
  - At the right location
  - To the right person
  - At the right price

Inpatient Hospital Payments

- Claims payments
  - Inpatient
  - Outpatient
- Disproportionate share (DSH)
- GAP Plan supplemental payments

Hospital Inpatient Claims

- Based on a Diagnostic Related Group Methodology (DRG) – where all diagnoses are grouped into 900 DRG's that represent the relative intensity of services provided
- Each DRG has an average length of stay, cost outlier threshold, and day outlier threshold
- Once the cost or day outlier threshold is exceeded, a cost or day outlier payment is made (but not both)

Hospital Inpatient Claims

- Each hospital has an individual base rate that is used to calculate claims payments that is based on 1994 individual hospital cost
- Changes to base rate only occur in years when the Legislature approves an increase or decrease

Hospital Outpatient Claims

- Non-laboratory claims, including emergency services, paid at 80% of the hospital's individual costs determined annually based on cost reports
- Claims paid based on an interim rate and then settled to 80% based on the cost report
- Laboratory claims paid on fee schedule

Disproportionate Share Payments

- Federal allotment to each state to cover the impact of uncompensated care
- NC applies allotment in this order
  - State operated IMD's
  - UNC
  - Public hospitals
  - Private hospitals

Disproportionate Share Payments

- State operated IMD's receive 33% of allotment
- UNC paid 100% of cost of uncompensated care
- $43 million retained by the state
- Remaining amounts reimburses hospitals for uncompensated care & supplemental payments
- IGT's used as state share for enhanced supplemental payments to QPH hospitals

Hospital Gap Plan

- Approved in 2011, program to equalize hospital supplemental payments for inpatient and outpatient services
- Program supported by an assessment to all hospitals except UNC/Pitt and IMD's
- State retains $43 million of assessment

Hospital Gap Plan

- Inpatient supplemental payments equal to Medicare payment rates less the Medicaid rate
- Outpatient supplemental payments equal to 100% of Medicaid costs less the claims payments based on 80% of cost

Nursing Home Payments

- Nursing home rates reflect three elements – direct cost, indirect cost and facility costs (fair rental value)
- Rates based on 2005 cost for each facility
- Direct service rates adjusted quarterly for each facility's case mix

Nursing Home Payments

- Direct and indirect base rates adjusted in years when the Legislature approves an increase or decrease
- Facility costs (fair rental value) adjusted annually based on a national survey of costs

Questions?

Thursday, March 28	**Room**	**Time**
APPROPRIATIONS/HEALTH AND HUMAN SERVICES (JOINT)	643	8:30 am

Name	County	Sponsor
Lauren Applewhite	Pitt	Farmer-Butterfield
Justin Cianfarra	Wayne	Bell, J.
Randy Stitt	Mecklenburg	Moore, R.
Sasha Duncan	Wake	Avila

SENATE PAGES ATTENDING

COMMITTEE: Health & Hum. Serv. ROOM: 643

DATE: 3/28 TIME: 8:30

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!

Page Name	Hometown	Sponsoring Senator
1 Jenna Johnson	Benson	Rabin
2 Mattie Tart	Benson	Rabin
3 Spence Hutcheson	Durham	McKissick
4 Davis Cutton	Durham	Woodward
5		
6		
7		
8		
9		
10		

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

House Committee Pages / Sergeants at Arms

NAME OF COMMITTEE _____

DATE: 3/28/2013 **Room:** 643 LOB

***Name:** _____

County: _____

Sponsor: _____

***Name:** _____

County: _____

Sponsor: _____

***Name:** _____

County: _____

Sponsor: _____

***Name:** _____

County: _____

Sponsor: _____

***Name:** _____

County: _____

Sponsor: _____

House

House Sgt-At Arms:

Senate

1. Name: FRED HINES
2. Name: MIKE CLAMPITT
3. Name: _____
4. Name: _____
5. Name: Bob Myrick
6. Name: Steve Wilson

VISITOR REGISTRATION SHEET

JT. APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

3/28/2013
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sonya Ritter	CSS
Allison Walter	Allison Mullins
J. Ian Mayer	Policy Group
Steve Mistry	Policy Group
David Vanderwielde	NCGA
Doug Miskewicz	PSG

09-21-201

VISITOR REGISTRATION SHEET

JT. APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

3/20/2013
Date

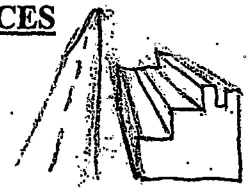
VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel VanLiere	Vidant Health
Susan Burch	State Auditor's Office
Laura Billock	"
Andy Chase	KMA
Kerra Bolton	LCA
Mary Bethel	AARP-NC
Caroline Cobb	The Policy Group
Fred Waddell	Easter Seals UCP
[illegible]	[illegible]
Townes Maxwell	PSG
[illegible]	NCRMA
[illegible]	GSN
[illegible]	Novant
E Nelson	NCHA
C Bland	NCHA
[illegible]	[illegible]
Jon Carr	Jordan Price

VISITOR REGISTRATION SHEET

JT. APPROPRIATIONS ON HEALTH AND HUMAN SERVICES

(Committee Name)



Health & Human Services

Date

3/28/13

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Madison Mackenzie	DOJ
Alan Briggs	NC Food Banks
Michelle Frazier	MFTS
Stephan Fangel	NCPC
Matt Gross	[illegible]
Jennifer Mahan	ASNC
Kathy Baker	Eastpointe
George Smith	Nexsen Pruet
[illegible]	[illegible]
Evelyn Hawthorne	NCMA; NCHAP
Lisa Hazirjian	NC AIDS Action Network
Chuck Stone	SEANC
Jeff Mayfield	GPM ; Kerr
Steve Mitchell	Astellas

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

April 4, 2013
Legislative Office Building - Room 643
8:30 a.m.

Representative Mark Hollo, Presiding	Welcome, Opening Remarks
Division of Child Development and Early Education - Overview	Donnie Charleston, Committee Staff Fiscal Research Division
Division of Child Development and Early Education	Sherry Bradsher, Deputy Secretary Department of Health and Human Services Rob Kindsvatter, Division of Budget and Analysis Department of Health and Human Services
Smart Start - Overview	Stephanie Fanjul, President NC Partnership for Children
Adjourn	

Joint Committee on Appropriations on Health and Human Services
Thursday, April 4, 2013 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations on Health and Human Services met at 8:30 AM on April 4, 2013, in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Jean Farmer-Butterfield, Carl Ford, Jim Fulghum, Beverly Earle, Mark Hollo, Verla Insko, Donny Lambeth, Susan Martin, and Tom Murry were present, along with 5 Senate members.

Representative Mark Hollo presided.

Representative Hollo opened the meeting by welcoming everyone and recognizing the House Pages—Amy Medford of Haywood County, Ben Perry of Stanly County, Maddie Pesce of Forsyth County, and Rachael Zimmerman of Madison County. Senate Pages were Garrett Boyd of Beaufort County, Gina Higgins of Wake County, Catherine Potter of Wilson County, and Harrison Rhoades of Wake County. He also recognized the Sergeants-at-Arms for the House —Charles Godwin and Marvin Lee—and the Senate Sergeants-at-Arms—Ed Kessler, Canton Lewis, and Steve Wilson.

Sen. Pate was recognized; he apologized for the cancellation without notice of the April 3rd committee meeting.

Donnie Charleston, Fiscal Research Division, presented an overview of the Division of Child Development and Early Education, which was followed by questions from members.

Sherry Bradsher, Deputy Secretary, Department of Health and Human Services, Division of Child Development and Early Education, spoke briefly about the NC Pre-K Program before introducing Rob Kindsvatter, Deputy Director for Budget, Department of Health and Human Services, who presented an overview of the NC Pre-K Program. At the end of the presentation, they answered questions from members.

Nancy H. Brown, Ph.D., Board Chair of The North Carolina Partnership for Children, Inc., presented an overview of Smart Start.

The meeting adjourned at 9:51 AM

Mark Hollo
Representative Mark Hollo
Presiding

Susan Fanning
Susan Fanning, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Wednesday, April 03, 2013 01:21 PM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Thursday, April 04, 2013 at 8:30 AM

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Thursday	April 4, 2013	8:30 AM	643 LOB

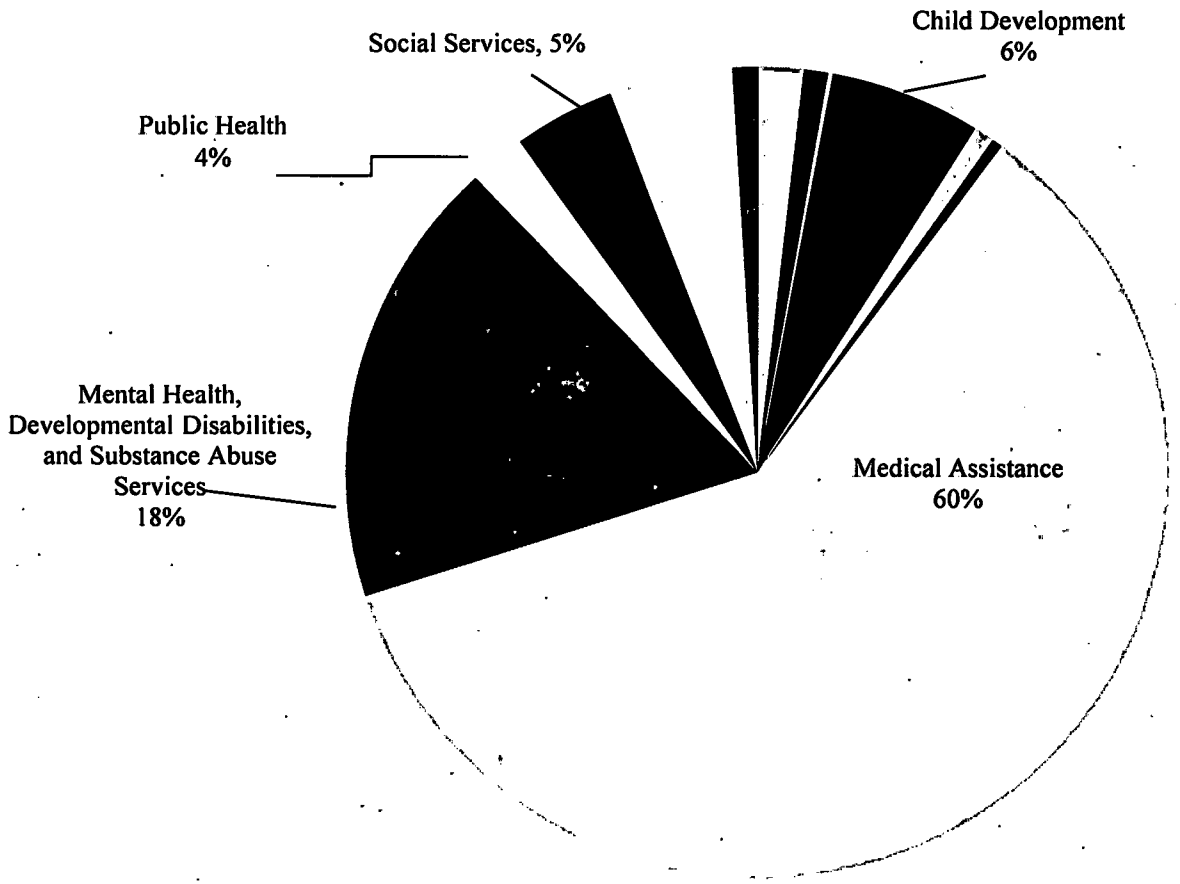
Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Division of Child Development and Early Education

April 4, 2013

Joint Appropriations Committee on Health and Human Services

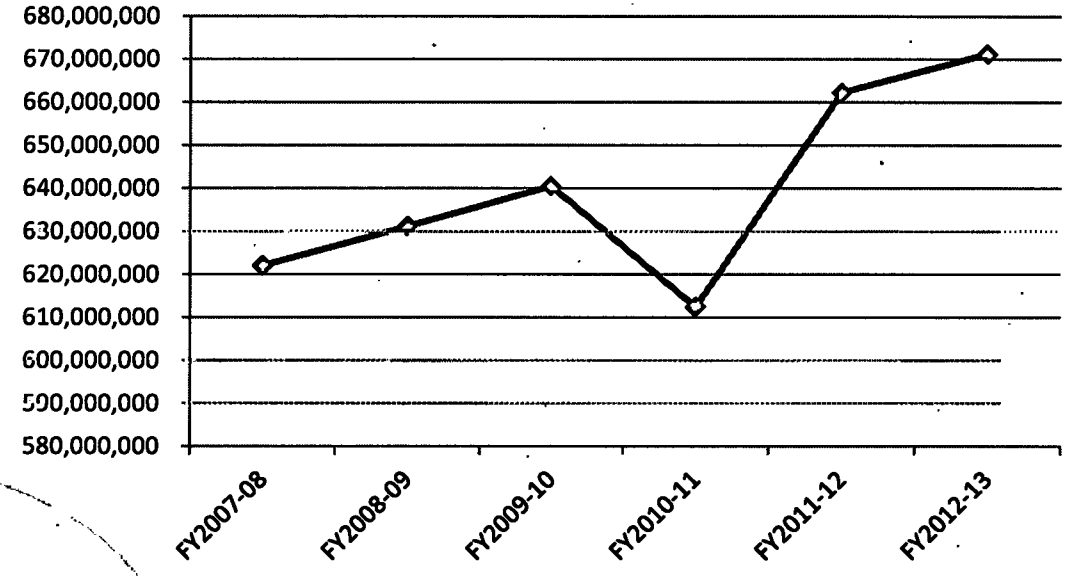
DHHS Budget Overview
General Fund $4.6 billion

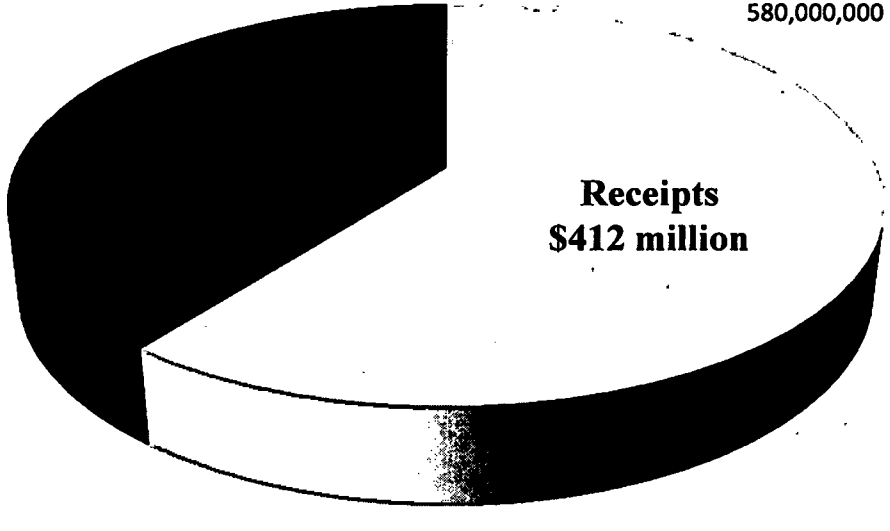


Division of Child Development

BUDGET

- SFY 2012-13: $675 million
  - $412 million receipts
  - $263 million State funds





Division of Child Development

PURPOSE

- Supports early childhood services, including:
  - Regulation and Licensure of child care centers and homes
    - 4,818 Centers
    - 2,830 Homes
    - Approximately 251,798 children in licensed care monthly (November 2012)
  - Administration of Child Care Subsidies
    - 74,961 Children Served

Division of Child Development

PURPOSE (continued)

- Early childhood initiatives
  - Smart Start
  - NC Pre-K
- Other
  - Criminal Background Checks for other agencies

Division of Child Development

RECENT BUDGET ACTIONS

2011-12

• Pre-Kindergarten Funds Transfer	($65,011,651)
• TANF Funding Swap	($6,352,644)
• Smart Start Reduction	($37,600,000)
• TEACH Program	($3,800,000)
• Social Services Admin Funding	($3,195,581)
• Post-Secondary Education Program	($7,052,797)

2012-13

• Block Grant Funding - CCDF	($7,000,000)
• Smart Start Initiatives	$3,500,000*
• TANF Funding Swap	($6,352,644)

*subject to stability of Medicaid budget

Division of Child Development

MAJOR PROGRAMS

CHILD CARE SUBSIDY	NC PRE-K	SMART START

SMART START	CHILD CARE SUBSIDY	NC PRE-K
School Readiness	Provide needs based child care funding	School readiness
All Children in North Carolina from birth to age 5	Low income families with children ages< 12yrs; below 75% Median Income	At-risk four-year-olds who have not been exposed to a child care setting
Planning and funding to:	• Enable parents to maintain or seek employment/training in order to support their family and achieve economic independence.	Planning and funding to:
• Improve access to child care	• Provide for the protection, care and developmental experiences for children	• Serve children who are not getting the educational preparation they need before starting school
• Improve the quality of child care	• Facilitate the reunification of families, aid families in crisis, and prevent foster care	• Create a standard, statewide Pre-K program
• Improve access to health services for young children		
• Improve family support services		
• Provide technical assistance to child care centers to improve quality	• Provide access to high quality care	• Provide high quality Pre-K
• Improve the quality of early childhood teachers	• Subsidize child care for low income families	• Set uniform, state standards for Pre-K, including curriculum, teacher credentials and class size
• Provide parent education and resources	• Enhance the availability of quality child care services	• Help Pre-K teachers improve credentials
• Provide access to health services for children	• Provide child care to children receiving protective services.	
• Umbrella statewide initiative with broad range of activities operated on a county-wide basis	• Statewide program available in 100 counties.	• Targeted statewide program with narrow focus
• Nonprofit organization at state and local levels	• Combination of State and Federal funding from Block Grants and the General Fund.	• State program with state funding, plus other sources of funding contributed according to local decisions
• Public/private partnership	• Locally administered program with State level support	• Standard program; local decision-making about location of pre-k classrooms; all classrooms meet state standards
• State and private funding		
• Local decision-making to address local needs		

Child Care Subsidy

Began: 1964

Serves: 75,490 kids (March 2012)

Funding: 2012-13: $348,321,539
2011-12: $359,712,290

Sources: 80% Block Grants (CCDF & TANF)
20% State General Fund

Child Care Subsidy Eligibility

- **Income eligible families earning less than 75% SMI**
- **Children who need child care services to support child welfare services.**
- **Children receiving foster care services who are in the custody of a county department of social services**
- **Requires a copay equal to 7-10% of gross income**

Child Care Subsidy

2012-13 Special Provisions

- **directs DCDEE to collect information on the program participation of subsidy applicants**

- **adjust subsidy distributions to minimize reductions due to formula changes**

Smart Start

Began: 1993

Serves: 100 Counties

Funding: 2012-13: $146 million
2011-12: $150 million
2010-11: $188 million

Smart Start

- **27 Member Board of Directors (10 GA appts.)**
- **77 Local Partnerships across NC**
- **Public-Private Partnership – Required to raise funding equal to 13% of State appropriation**
- **Mandatory 30% of funding for Child Care Subsidy & 70% of funding on direct services in local partnerships**

Smart Start

2012-13 Special Provisions

- **directs NC partnership to develop a salary schedule for Executive Directors of the local partnerships**
- **increase match for State funds from 10% to 13%**
- **appropriated funding for a literacy pilot and for assistance with fund raising**

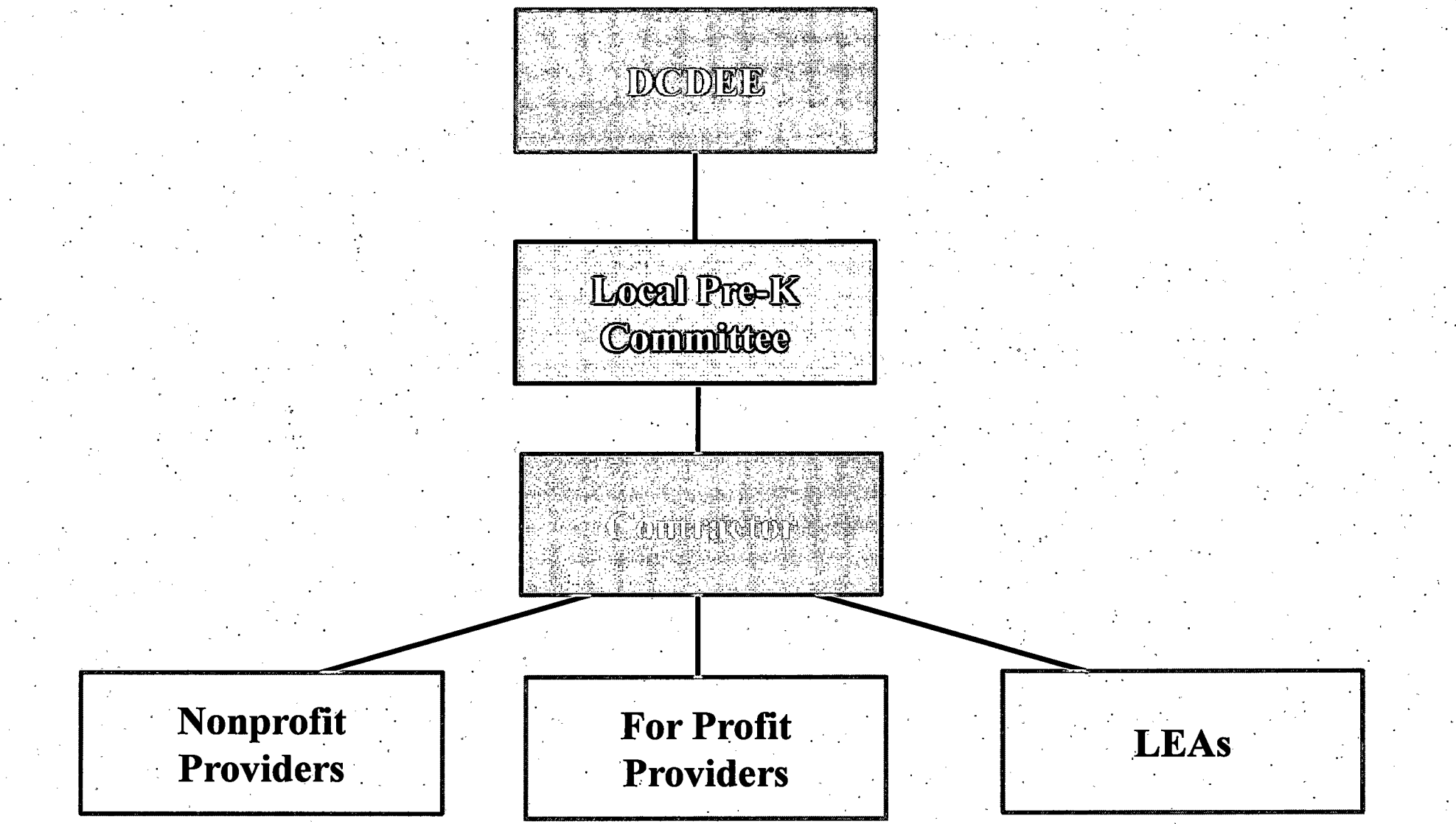
NC Pre-K

A voluntary Pre-Kindergarten program designed to prepare at-risk 4 year olds for school success.

- **High Quality Child Care Centers**
- **Approved academic focused curriculum**
- **Local Decision Making**
- **Leveraged funding**

More at Four

- **S.L. 2001-424 established More at 4 with an initial appropriation of $6 million**
- **Target four-year-olds at risk of kindergarten failure**
- **Required the use of a proven curriculum**
- **Established standards for minimum teacher qualifications**


DCDEE
Local Pre-K Committee
Nonprofit Providers
For Profit Providers
LEAs

NC Pre-K

Began: 2011 *(More at 4 - 2001)*

Serves: 29,000 kids *(March 2012)*

Funding: 2012-13: $131,970,705
2011-12: $130,291,706
2010-11: $160,647,360

Sources: 50% Lottery Funds
50% State General Fund

NC Pre-K

2011-12 Special Provisions

- **Transfer of More at 4 to DCDEE & renamed NC Pre-K**
- **Implemented a co-pay for Pre-K participation**
- **Standardize Pre-K service delivery hours**

NC Pre-K

2012-13 Special Provisions

- **Require NC Pre-K contractor to issue multiple-year contracts for private child care centers**
- **Creation of a pilot program funding Pre-K classrooms on a per classroom basis as opposed to slot funding**
- **Eliminates health issues as an eligibility factor (except for developmental or chronic health)**
- **Require data collection regarding program participation**

EXECUTIVE SUMMARY

Quality and Characteristics of the North Carolina Pre-Kindergarten Program 2011-2012 Statewide Evaluation

Ellen Peisner-Feinberg, PhD
Jennifer Schaaf, PhD
Lisa Hildebrandt, MA
Doré LaForett, PhD

UNC
FRANK PORTER GRAHAM
CHILD DEVELOPMENT INSTITUTE

Study Overview

The North Carolina Pre-Kindergarten Program (NC Pre-K) is a state-funded initiative for at-risk 4-year-olds, designed to provide a high quality, classroom-based educational program during the year prior to kindergarten entry. Children are eligible for NC Pre-K based on age, family income (at or below 75% of state median income), and other risk factors (limited English proficiency, identified disability, chronic health condition, and developmental/educational need). The statewide pre-k program was initiated in the 2001-2002 school year as the More at Four Pre-Kindergarten Program, and became the NC Pre-Kindergarten Program in 2011-2012, shifting from the Department of Public Instruction (DPI) to the Division of Child Development and Early Education (DCDEE) in the North Carolina Department of Health and Human Services (DHHS). In the 2011-2012 year, the NC Pre-K Program served over 29,000 children in a variety of settings across the state, including local school systems, private providers, and blended Head Start/pre-k classrooms.

The 2011-2012 evaluation study included information about characteristics of the NC Pre-K Program statewide and observations of classroom quality and teacher surveys in a random sample of 100 classrooms. The primary research questions addressed by this evaluation included:

- What were the key characteristics of the local NC Pre-K programs?
- What was the quality of the NC Pre-K classrooms attended by children?
- What factors were associated with better quality?
- To what extent were these results similar to past years under the More at Four Program?

Key Findings

Program Characteristics

The NC Pre-K Program has not changed substantially in comparison to prior years of its predecessor program More at Four. Similarities were found across most characteristics that were examined, including class size, curriculum, the variety of setting types, and the population of children (half boys and girls, variety of racial and ethnic backgrounds, 90% from poor families, and demonstrate a variety of other risk factors).

There were a few aspects in which the NC Pre-K Program differed in comparison to prior years of the More at Four Program. The NC Pre-K Program was slightly smaller than in recent years of the statewide pre-k program, serving just under 30,000 children. The children in NC Pre-K included a somewhat higher proportion of those who had never previously been served in a program, as well as all those who were unserved at the time of enrollment, compared to prior years. Further, the NC Pre-K Program continued to maintain the trend for improving the qualifications of teachers, both in terms of teacher education levels and B-K licensure.

Teacher Beliefs

NC Pre-K teachers generally reported being satisfied with their work environment. They rated a variety of aspects of the work climate fairly positively, including the adequacy of resources; the overall work environment; and their decision-making role, especially for areas more closely tied to daily teaching.

NC Pre-K teachers reported that they planned to remain in the early childhood field. These teachers were experienced, having taught in early childhood education for an average of 11 years. The majority (71%) of teachers surveyed reported that they planned to continue working in an early childhood setting for the next three years.

Classroom Quality

The quality of classroom practices in NC Pre-K was in the medium to high range overall. A variety of aspects of classroom practices was examined, including global quality, teacher-child instructional interactions, language and literacy interactions, and sensitivity of teacher-child interactions. Quality was relatively stronger in more global educational environment and teacher-child interactions than in more specific instructional practices. Further, there were no consistent patterns of predictors of quality, including teacher qualifications, class size, and classroom characteristics of children, although there was some evidence that teacher beliefs were associated with quality.

The quality of the NC Pre-K classrooms was similar in almost all areas when compared to recent years of More at Four. Scores did not differ between NC Pre-K and previous More at Four classes for measures of global classroom quality (ECERS-R), emotional support and classroom organization (CLASS), and sensitivity of teacher-child interactions (CIS). The one exception was in the area of instructional support (CLASS), where NC Pre-K classrooms scored lower than the More at Four classrooms. However, for both the NC Pre-K and More at Four classrooms, scores for this aspect of quality were substantially lower than for other aspects.

Conclusions

In sum, the primary characteristics of the NC Pre-K Program have remained quite similar to those of recent years of the More at Four Program, its predecessor. One important area to note in which the NC Pre-K Program has continued or maintained a trend toward improvement is in the area of teacher qualifications, both education and licensure levels. Two areas recommended to explore with regard to quality improvement include efforts focused on instructional practices and on beliefs about teaching practices. The quality of the NC Pre-K Program also was quite similar to recent years of the More at Four Program, indicating that there was little change at the level of classroom practices with the shift in program auspice. Taken in total, these results suggest that the NC Pre-K Program continues to offer a strong pre-k experience for at-risk 4-year-olds throughout the state. ■

Suggested citation: Peisner-Feinberg, E. S., Schaaf, J. M., Hildebrandt, L., & LaForett, D. R. (2013). *Quality and characteristics of the North Carolina Pre-Kindergarten Program: 2011-2012 Statewide evaluation*. Chapel Hill: The University of North Carolina, FPG Child Development Institute.

This study was funded by the North Carolina Division of Child Development and Early Education. The opinions expressed in this report do not necessarily reflect those of the funding agency.

The executive summary and full report of this study are available at **http://www.fpg.unc.edu/projects/evaluation-nc-pre-kindergarten-program**

Presentation on NC Pre-K

Joint Appropriations Committee

Health and Human Services

April 2013

1

Pre-K Agenda Overview

- Program Overview
- Eligibility Categories
- Contractor Type
- Monitoring Activities
- Waiting List
- Outcomes/Evaluation
- Implementation of S.L. 2012-142 provisions
- Update on Executive Order 128
- SEEK

Early Childhood Program Overview

Program	Ages Served	Income Criteria (as applicable)
Pre-K	4	Up to 75% of State Median Income or for Other Factors
Smart Start	0-5	
Head Start	3-5	100% of Federal Poverty Level
Subsidized Child Care	0-12	Up to 75% of State Median Income or for Other Factors

NC Pre-K Program Overview

- Purpose: Help at-risk 4-year-olds be more successful when entering school
- Total budget $151.7 M
- 29,652 children to be served at 1,223 sites in 2,137 classrooms
- Projected $152 M in other resources added to NC Pre-K by contractors

NC Pre-K Program Overview

- All licensed child care programs must have a 1-5 star rating
- NC Pre-K sites must have a 4- or 5-star rated license.
  - These are programs with the highest quality standards met for Program Standards and Staff Education

NC Pre-K Program Overview

Standardized Payment Rates in SFY 12-13 to better align payments with cost to provide services

- Head Start : $300 per child/month
- Public Schools: $473 per child/month
- Private Child Care:
  - B-K Licensed teacher - $650 per child/month
  - Degreed teacher (no B-K license) - $600 per child/month

NC Pre-K Eligibility

- Age 4 by August 31 and
- At or below 75% State Median Income
  - This equates approximately to 200% Federal Poverty Level
  - 95% of NC Pre-K children meet income eligibility

-- or --

- Eligible Military Family
- Limited English Proficiency
- Identified Disability
- Chronic Health Condition
- Concerns in One or More Developmental Domains

NC Pre-K Eligibility

2011/2012 Children Served by Need Category
(Data reflects some duplication)

Need Category	
Income Eligible	95.50%
Military	7.00%
Individual Education Plan	5.20%
Limited English Proficiency	21.80%
Chronic Health Condition	6.7%
Developmental Needs	24.90%

NC Pre-K Eligibility

2011/2012 Children Served in Need Categories who are also Income Eligible

Military	77.20%
Individual Education Plan	84.80%
Limited English Proficiency	97.90%
Chronic Health Condition	91.00%
Developmental Needs	91.30%

NC Pre-K Children Served by Family Income

Under 100% of the Federal Poverty Level (FPL)	65.4%
Between 101% – 130% of FPL	12.4%
Between 131% – 185% of FPL	13.5%
Between 186% – 200% of FPL	2.3%
Over 200% of FPL	6.5%

NC Pre-K Contractors

91 Contracts

- 45 Local Smart Start Partnerships (49%)
- 41 Public Schools (45%)
- 4 Head Start (4%)
- 1 Other Non-Profit (1%)

NC Pre-K Classrooms

Comparisons of Classrooms by Setting

Year	Head Start	Head Start in Public Schools	For-Profit	Non-profit	Public Schools
2006/2007	10.06%	2.65%	26.07%	11.12%	50.09%
2007/2008	15.87%	2.82%	22.90%	9.17%	49.23%
2008/2009	16.69%	3.22%	23.29%	8.56%	48.24%
2009/2010	16.66%	3.38%	22.56%	8.63%	48.77%
2010/2011	16.23%	3.20%	22.28%	8.80%	49.50%
2011/2012	13.37%	2.90%	23.68%	9.54%	50.51%
2012/2013	13.35%	2.81%	22.21%	8.87%	52.77%
after expansion 2012/2013	12.48%	3.08%	23.73%	9.10%	51.61%

NC Pre-K Teachers

Comparison of Lead Teacher Qualifications by Setting

	School Year 2011/2012	2012/2013
Public School (52% of Lead Teachers)		
B-K License	88%	89%
Other License	10%	10%
BA/BS degree	3%	1%
Head Start (17% of Lead Teachers)		
B-K License	61%	72%
Other License	12%	16%
BA/BS degree	27%	12%
Child Care (31% of Lead Teachers)		
B-K License	45%	58%
Other License	18%	22%
BA/BS degree	38%	21%

NC Pre-K Requirements Monitored

- **Program Standards**
  - Staff\child ratios
  - Class size
  - Teacher qualifications
  - Use of curriculum
- **Fiscal Activities**
  - Assuring expenditures are allowable
  - Verifying accuracy of eligibility determination
  - Validation of site rates

NC Pre-K Waiting List

- Currently there is not an automated way to collect NC Pre-K waiting list data on a regular basis
- The most recent date that DCDEE surveyed contractors for waiting list data was September 2012
- At that point in time, 11,678 children were waiting for Pre-K services

NC Pre-K 2011-12 Evaluation

- Contracted to the Frank Porter Graham Child Development Institute at UNC-CH
- This evaluation is conducted annually to review program characteristics, quality and outcomes.
- 2011-2012 statewide evaluation addressed:
  - What are the characteristics of local programs?
  - Who is served by the NC Pre-K Program?
  - What is the quality of services provided?

NC Pre-K
2011-12 Evaluation

- Observations of classroom practices
- Assessments of children's language, math, & social skills
- Teacher surveys
- The full report is available on-line at www.ncchildcare.net

NC Pre-K
2011-12 Evaluation

Key Findings

- The NC Pre-K Program has not changed substantially in comparison to prior years of its predecessor program More at Four – quality is being maintained.
- NC Pre-K teachers generally reported being satisfied with their work environment; and they planned to continue working in an early childhood setting for the next three years.

NC Pre-K S.L. 2012-142

- Sec. 10.1 (a) – DCDEE required Pre-K contractors to issue multi-year contracts to private providers
- Sec. 10.1 (b) – Required DCDEE to complete a pilot to pay Pre-K contractors on a per classroom basis. This pilot was not completed in SFY 12-13.

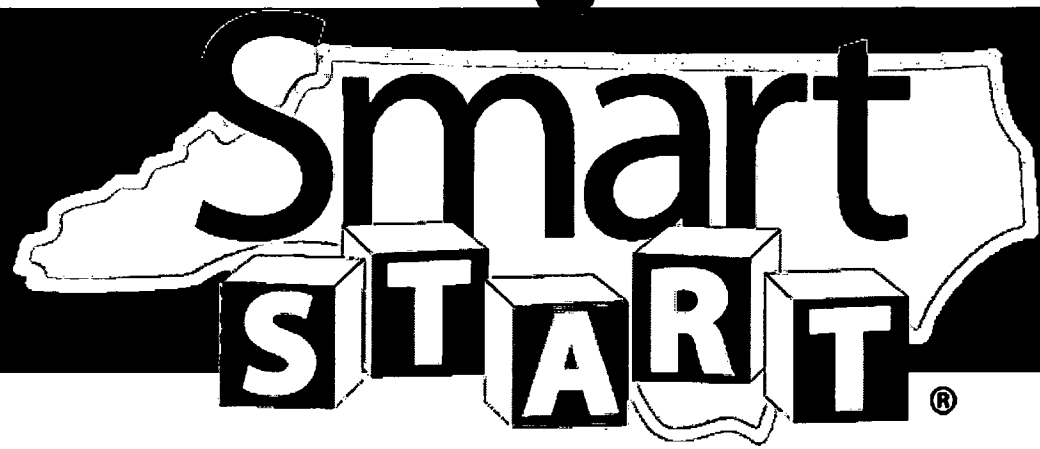
NC Pre-K Expansion

- Executive Order 128 issued in October 2012
- An additional $20 M in one time funding was identified to expand NC Pre-K during SFY 12-13.
- These funds provided services for an additional 4,908 children.
- The Governor's budget proposes an additional $26.2M in ongoing funding for NC Pre-K to support 5,000 four year olds.

Subsidized Early Education for Kids (SEEK)

- SEEK Phase I – Automates the capture of time and attendance for children served in subsidized child care and is currently being implemented.
- SEEK Phase II - Calculates the subsidized payments and reimburses the providers for services.

	SMART START	CHILD CARE SUBSIDY	NC PRE-K
Mission	School Readiness	Provide needs based child care funding	School readiness
Target Population	All Children in North Carolina from birth to age 5	Low income families with children ages < 12yrs; below 75% State Median Income	At-risk four-year-olds who have not been exposed to a child care setting
Objectives	Planning and funding to: • Improve access to child care • Improve the quality of child care • Improve access to health services for young children • Improve family support services	• Enable parents to maintain or seek employment/training in order to support their family and achieve economic independence. • Provide for the protection, care and developmental experiences for children • Facilitate the reunification of families, aid families in crisis, and prevent foster care	Planning and funding to: • Serve children who are not getting the educational preparation they need before starting school • Create a standard, statewide Pre-K program
Strategies	• Provide technical assistance to child care centers to improve quality • Provide opportunities for teachers in child care centers to improve their education in early childhood • Provide parent education and resources • Provide child care subsidies for low-income parents • Provide access to health services for children	• Provide access to high quality care • Subsidize child care for low income families • Enhance the availability of quality child care services • Provide child care to children receiving protective services.	• Provide high quality Pre-K • Set uniform, state standards for Pre-K, including curriculum, teacher credentials and class size • Help Pre-K teachers improve credentials
Scope	• Umbrella statewide initiative with broad range of activities operated on a county-wide basis	• Statewide program available in 100 counties.	• Targeted statewide program with narrow focus
Funding & Administration	• Nonprofit organization at state and local levels • Public/private partnership • State and private funding • Local decision-making to address local needs	• Combination of State and Federal funding from Block Grants and the General Fund. • Locally administered program with State level support	• State program with state funding, plus other sources of funding contributed according to local decisions • Standard program; local decision-making about location of pre-k classrooms; all classrooms meet state standards



The North Carolina Partnership for Children, Inc.

Joint Appropriations on Health and Human Services Committee

April 3, 2013

Nancy H. Brown, Ph.D., Board Chair

Stephanie Fanjul, President

The North Carolina Partnership for Children, Inc.

Smart Start

The North Carolina of tomorrow depends on the children of today.

Smart Start is:

- All children,
- All 100 counties—mountains, piedmont and coast,
- Innovation and problem-solving, and
- The best of North Carolina.

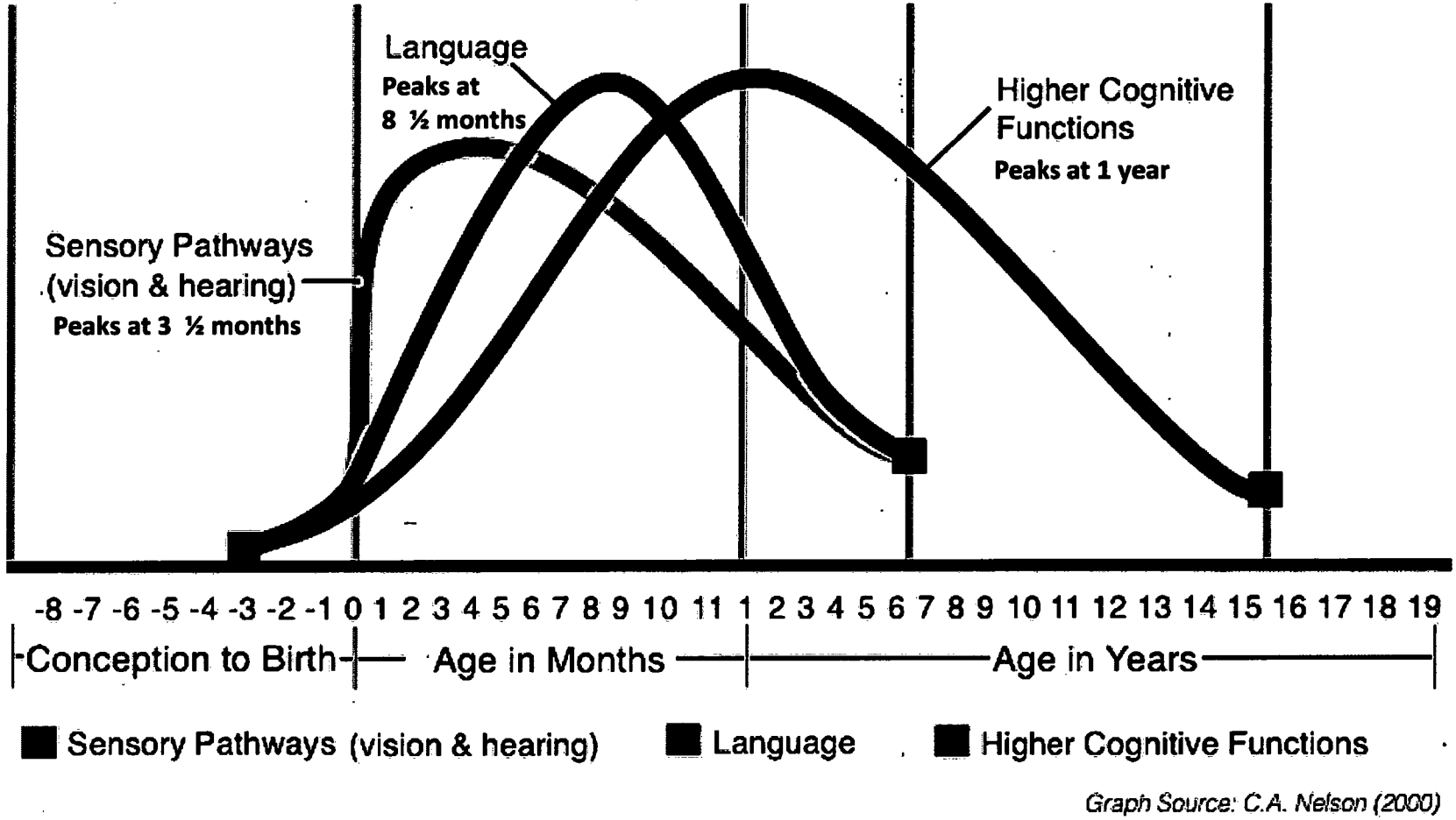
Why Birth to Five?

Early Experiences Have Lasting Impact

- There are only 2,000 days from the time a baby is born to when that child begins kindergarten. 90% of critical brain development occurs during that time.

- The wiring that forms the brain's architecture happens in infancy and early childhood. And how that wiring is formed, either as a strong or weak foundation, depends on a child's earliest experiences.

It's All About the Brain



Graph Source: C.A. Nelson (2000)

Early Experiences Build Future Success

Early experiences lay the groundwork for future health and form the foundation of the skills needed for academic and workplace success. For a strong foundation, children need:

- Strong families,
- Environments that support healthy outcomes, and
- High-quality early care and education programs that are safe and provide opportunities for learning.

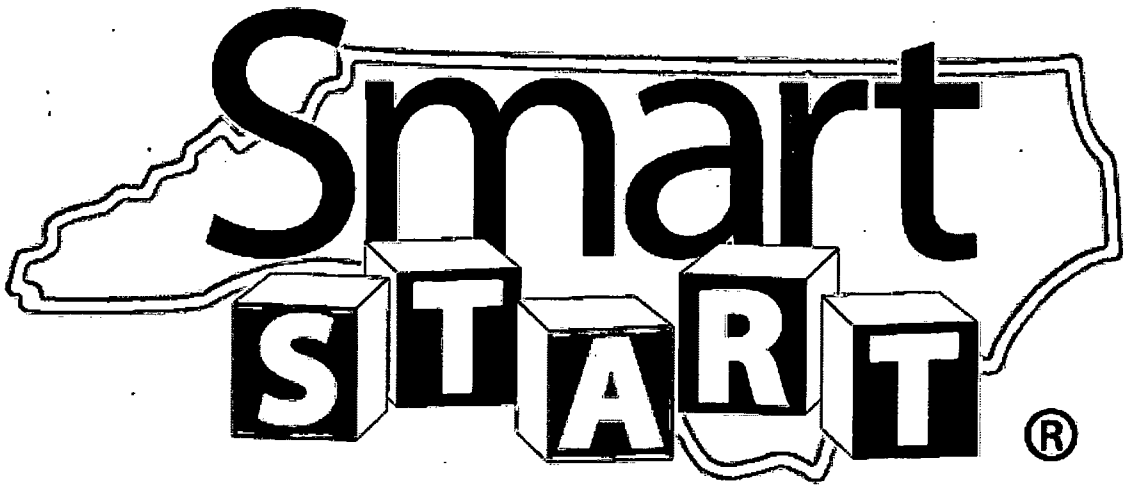
Building a brain right from the beginning is easier and more effective than trying to fix it later.

Early Care and Education

Approximately 80% of children birth to five participate in some type of early care and education arrangement prior to entering kindergarten, of which greater than 60% are in regulated child care settings.

Accountable, Efficient, Produces Outcomes

Smart Start is North Carolina's investment in children birth to five.



The North Carolina Partnership for Children, Inc.

Accountable

Smart Start is North Carolina's public/private partnership that creates innovative solutions to measurably increase the learning and healthy development of children birth to five.

- Led by The North Carolina Partnership for Children, Inc. (NCPC).
- 76 community-based Local Partnerships serve all 100 counties.
- NCPC establishes measurable statewide outcomes. Communities determine best approach to achieving them.

Accountable

NCPC ensures that Smart Start Local Partnerships fully meet all legislatively mandated requirements and operate to the highest standards of effectiveness, accountability, efficiency and integrity.

NCPC conducts rigorous annual monitoring of Local Partnerships; delivers training and technical assistance; and holds Local Partnerships accountable for meeting performance outcomes in governance, fiscal, and programmatic operations.

Accountable

NCPC and Local Partnerships maximize efficiencies, leverage resources and produce outcomes.

- Since 2000, there have been more than 500 audits by State auditors and/or independent auditors of NCPC and Smart Start Local Partnerships.

- Together, NCPC and 76 independent Local Partnerships are able to budget resources almost to the penny, reverting only a third of one percent (0.37%) in FY 2011-12.

Efficient

Smart Start gives local communities the responsibility and flexibility to determine how to increase the health, well-being and development of their children based on the needs and resources of their local communities.

- Smart Start staff are employees of private organizations, not state employees.

Efficient

NCPC provides cost effective tools and systems for Local Partnerships to do business to ensure reliability, accuracy and economies of scale, including:

- Centralized accounting;
- Centralized bidding process,
- Shared services, and
- Uniform reporting systems.

What We Do

Support child care businesses in raising quality and improving children's early care and education programs so they are safe, healthy and provide opportunities for children to learn skills they need for success in school. Local Partnerships provide:

- Tailored onsite technical assistance,
- Professional development and training,
- Support for child care professionals to obtain higher education, and
- Quality improvement plans.

What We Do

Make it possible for NC PreK to operate statewide. Smart Start Local Partnerships:

- Help private child care programs improve the quality of their classrooms so they may participate in NC PreK, and
- Administered NC PreK in 54 counties in FY 2011-12. That same year, 64% of children in NC PreK attended a program administered by a Smart Start Local Partnership.

What We Do

Provide tools to parents increase their knowledge of early childhood development and positive parenting practices. Programs focus on:

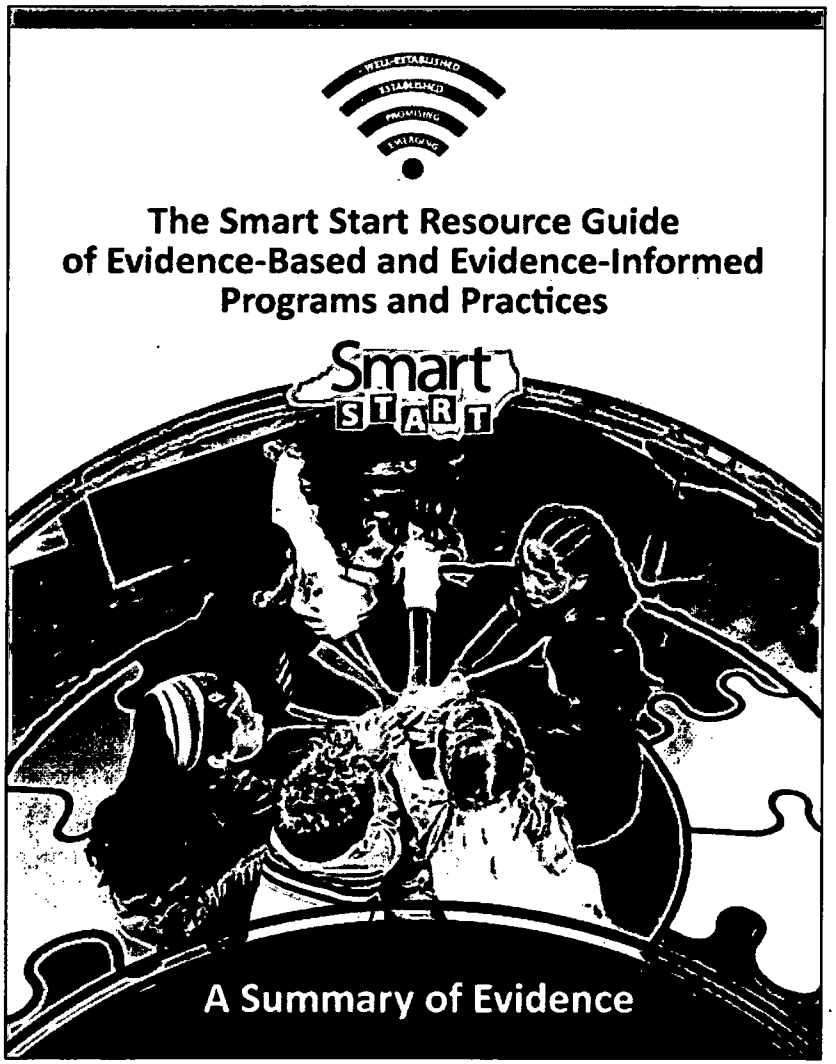
- Early literacy skills (Raising a Reader, Reach Out and Read),
- Education, information and resources (Parents as Teachers, Nurse Family Partnership), and
- Parent coping skills (Incredible Years).

What We Do

Promote children's healthy development. Programs focus on:

- Childhood obesity prevention(Shape NC, NAPSACC),
- Early identification of developmental delays (ABCD),
- Early intervention, and
- Child care health consultants.

Outcomes



NCPC has been at the forefront of an effort within the early childhood field to adopt evidence-based and evidence-informed programs—programs based on research with proven outcomes.

Outcomes

More children attend high-quality care. In FY 2011-12:

- 81% of children whose families receive subsidy attend 4- and 5-star centers as compared to 30% in 2001.
- 94% of children with special needs whose families receive subsidy attend 4- and 5-star centers as compared to 61% in 2001.
- 411 one- and two-star programs improved their star ratings, impacting approximately 12,300 children.

Outcomes

More families have the tools they need to raise successful children.

- The Reach Out and Read Pilot Program is working with 53 medical practices that will impact more than 26,000 children five and under.
- Parents served by Reach Out and Read are up to four times more likely to read aloud to their children.
- During the preschool years, children served by Reach Out and Read score three to six months ahead of their non-Reach Out and Read peers on vocabulary tests.

Outcomes

More children with disabilities are identified at a younger age and are referred to early intervention services. In FY 2010-11:

94% of children whose medical offices participated in the Assuring Better Child Health and Development (ABCD) program received recommended developmental screenings at their most recent well-child visit, compared to 85% before ABCD.

Today, North Carolina has the highest rate of developmental screenings in the nation.

Outcomes

More children benefit from better nutrition and physical activity. In FY 2011-12:

- 72% of child care programs provided 90 minutes or more of daily physical activity as compared to 14% prior to participating in Shape NC.
- 100% of participating child care programs increased healthy food options for children.

Outcomes

More children have better third-grade outcomes. An independent study by researchers from Duke University found:

- Children had higher third-grade reading and math scores and fewer special education placements in counties that received more funding for Smart Start when those children were younger.
- Investments in Smart Start had a "spillover" effect throughout the community, benefitting children who may not have participated in Smart Start supported programs or early education of any kind.

Outcomes

More private investment in early education, health and family support.

- Since 2000, Smart Start has leveraged an additional $400 million for the state's young children in cash and in-kind contributions.

- Since 2000, North Carolinians have devoted more than 747,000 volunteer hours (the equivalent of 30 FTEs each year) to Smart Start Local Partnerships and NCPC.

Challenges

Increasing number of children 5 and under.
749,369 (101,474 more than in 2000)

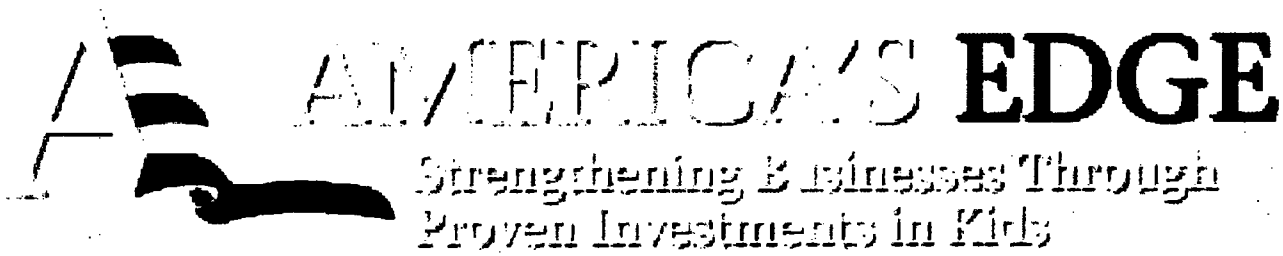
More children under 5 in poverty.
30% (up from 19% in 2000)

Least investment goes to children in first three years of life, when 80% of brain development happens. Babies and toddlers whose parents need to work to support their families are in lower quality care.

Thank You

The North Carolina of tomorrow depends on the children of today.

Nancy H. Brown, Ph.D.
NCPC Board Chair
nhbrown@smartstart.org



Joint Legislative Oversight Committee
Health and Human Services

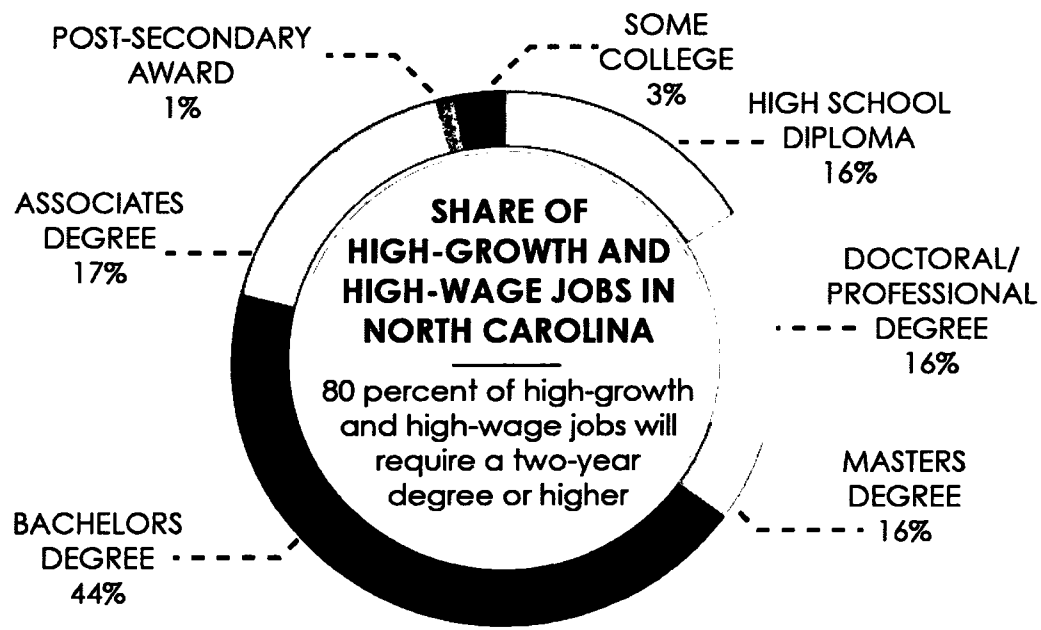
April 3, 2013

Business Leaders' Bottom Line

Investments in high-quality early learning programs:

- **Boost our state's economy today.**
- **Ensure pipeline of skilled workers for North Carolina businesses.**

Share of High-Growth and High-Wage Jobs



Note: Based on 2012-2022 growth projections.

Source: Chmura Economics and Analytics, 2012

Source: Chumura Economics and Analytics (2012)

North Carolina's "Skills Gap"

By 2022:

Shortage of **46,000 highly-educated workers.**

Sources: Chumura Economics and Analytics (2012); Carnevale, A.P., Smith, N. & Strohl, J. (2010)

North Carolina's Future Job Market

- Jobs requiring post-secondary education expected to grow **65% faster** than for high school dropouts.
- **Twice** as many jobs requiring post-secondary education compared to jobs requiring high school or less.
- By 2018, **91%** of **STEM jobs** will require post-secondary education.

Sources: Chumura Economics and Analytics (2012); Carnevale, A.P., Smith, N. & Strohl, J. (2010)

State's Current Workforce and Recent Graduates

- **38%**: working adults with post-secondary education.
- **30%**: 2012 high school graduates meeting ACT benchmarks.
- **31st**: NC's national ranking in science and engineering degrees.

Sources: Milken Institute State Technology and Science Index; Lumina Foundation (2012); ACT, Inc. (2012)

North Carolina Businesses Need "Soft Skills" to Compete

- Communication
- Collaboration
- Critical thinking

***6 OUT OF 10** NC employers reported skill gaps in communications.*

***HALF** reported gaps in critical-thinking and problem-solving.*

Source: America Management Association (2010)

North Carolina's Next Generation

- **22%** of high school students do **not** graduate on time
- **66%** of eighth graders are below grade level in math
- **68%** of fourth graders read below grade level

Nationally, **60%** of 3- to 5-year olds are not ready for kindergarten

Sources: Education Week; US Department of Education (2012); National Center for Education Statistics (2011)

Short-Term Economic Benefits

Every $1 invested in early learning generates **$1.91 in sales of goods and services** from North Carolina businesses.

Source: IMPLAN Analysis (2010)

The "Multiplier" Effect

The Early Learning sector in North Carolina generates more additional spending in the economy than other major economic sectors

Economic Sectors	Output Multipliers
Early Care and Education[1]	**$1.91**
Retail Trade	1.87
Transportation	1.85
Farming, Logging, Fishing, Hunting	1.81
Construction	1.81
Wholesale Trade	1.69
Mining, Oil, Gas	1.64
Manufacturing	1.57
Utilities	1.31

Every $1 invested in the early learning sector generates an additional 91 cents in the local economy.

1. The early care and education sector is part of the larger services sector, which on average generates a multiplier of $1.91 for every $1 invested.

Source: IMPLAN, 2010 analysis of Type SAM Output Multipliers for North Carolina

Source: IMPLAN Analysis (2010)

Negative Impact of Cuts to Early Care and Education

Every $1 cut from early care and education programs results in a **loss of $1.91 in sales and services** from North Carolina businesses

Source: IMPLAN Analysis (2010)

Savings to North Carolina Businesses

- Reduce absenteeism
  - —costs businesses **$3 billion** each year.
- Reduce turnover
- Increase retention
- Increase productivity

Source: Shellenback (2004)

NC Working Parents

- **65%**: children under age 6 with both or only parent working.
- **450,000**: Children under age 5 not in regulated early learning programs.

Source: Annie E. Casey Foundation (2012)

North Carolina's High-Quality Early Learning System

Workforce

Productivity

Economic development

Success in Kindergarten

9 of out 10 kindergarten teachers agree more children will succeed if all families had access to high-quality early learning programs.

Source: Mason-Dixon Polling and Research (2004)

Increased Success in School

- Increase pre-math skills: **21%**
- Increase pre-reading skills: **52%**
- Develop **social** and **emotional** skills critical for **soft skills.**

Source: Schweinhart, Montie, Xiang, et al., (2005)

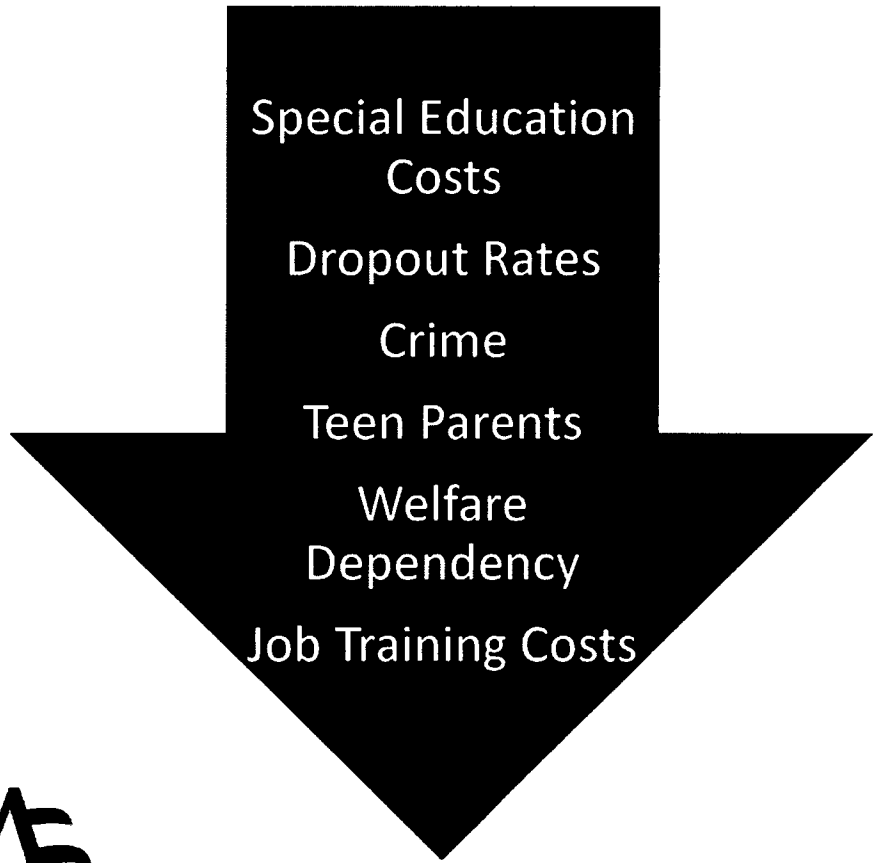
Good for NC Businesses

- **44%**: Graduate high school
- **31%**: Hold skilled job
- **4 times**: Earn four-year degree
- **36%**: Higher earnings

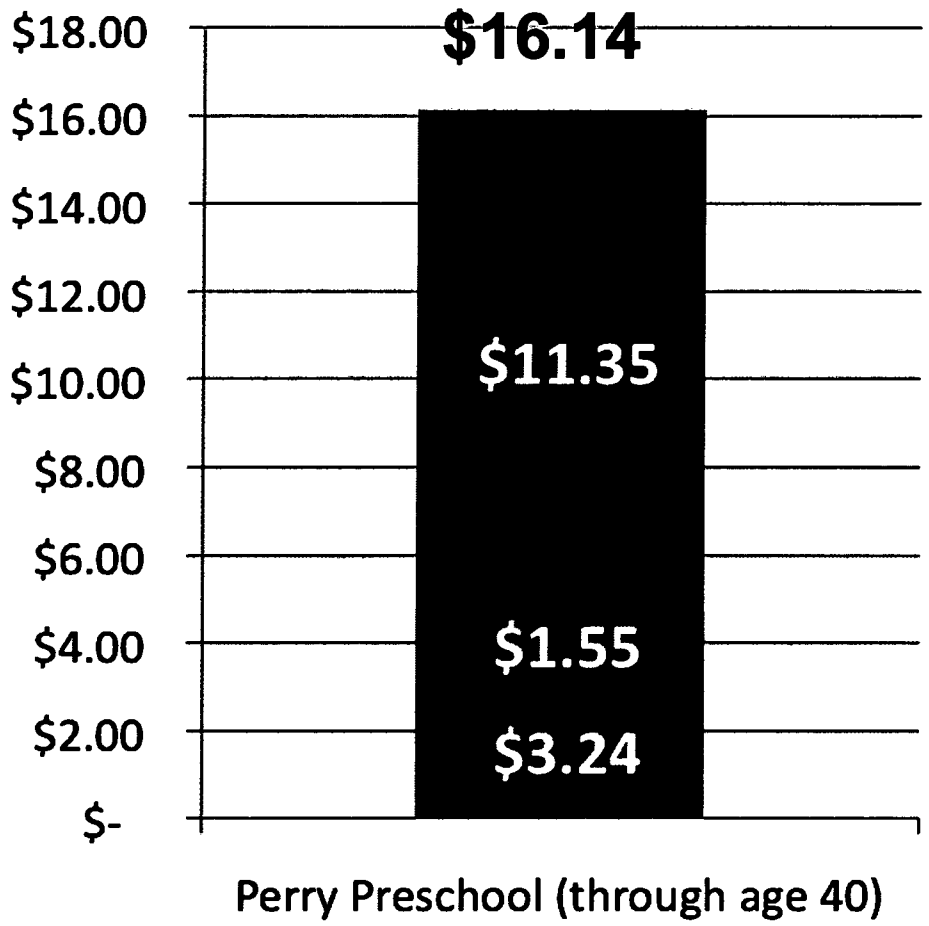
Source: Schweinhart, Montie, Xiang, et al., (2005)

ROI of Early Childhood Learning

Studies Show Early Learning Influences Long-Term Success



Cost/Benefit of Early Education



- Crime-Cost Savings
- Special Ed, Welfare, Income Taxes
- Increased Earnings

$244,881 net benefit per child

Source: Schweinhart, Montie, Xiang, et al. (2005)

North Carolina – Quality Leader

- Quality Rating and Improvement System (QRIS) – **Key Components:**
  - –Appropriate teacher-to-child ratios
  - –Properly educated teachers
  - –Strong parental involvement and coaching
  - –Screening and referral services

North Carolina's Quality Trend

70% of all children are in regulated early learning programs rated 4-5 stars.

Source: Schaefer, S., Gates, S., & Kiernan, M. (2012)

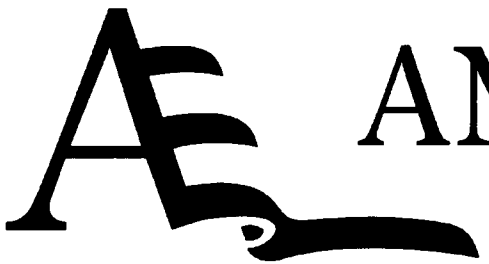
Sustained Results from Quality Programs

- 123 Studies – statistical analysis
- North Carolina Pre-K Program and SmartStart – 2012 Duke study
- North Carolina's Abecedarian Project – 30 year longitudinal study
- Chicago's Child-Parent Center Education Program – longitudinal study

Ensuring a Future Skilled Workforce

Invest in What Works:

High-quality early care and education



AMERICA'S EDGE

VISITOR REGISTRATION SHEET

JT. APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

April 4, 2013
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Janice Fain	DHHS/DCDEE
Rob Kindsvatter	DHHS/BBA
Sherry Bradshaw	DHHS/DSS
Adam Sholar	DHHS
Fred Bone	Bone Assoc.
Andy Chase	KMA
Kara Bolda	LCA
Amanda Horaker	Trautman Sanders
Dan Caughlin	NC Council of Community Programs
Thom[illegible]	Fmm
Daniel VanLierde	Vidant Health
Kara Weisbecker	Smith Anderson
Daniel Amburn	NCRMA
Nathan Robinson	NCRMA
[illegible]	mwc
[illegible]	NCSAA
Downes Maxwell	PSG

09-21-201

VISITOR REGISTRATION SHEET

JT. APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

April 4, 2013
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
CAROL ORNITZ	NC Brain Injury Advisory Council
Alex Bodyer	GSS
[illegible]	[illegible]
Gill Scoggin	[illegible]
Matt Violl	CW Consult
ENelson	NCHA
Connie Wilson	Citizen for Free Speech
Joel Maynard	HCAFP
TOM TERRELL	NC BAR ASSOC.
[illegible]	NCAE
[illegible]	NMRS
Ken Melton	K.M.A.
[illegible]	NCAE
[illegible]	SVA
Christine Cruz	WakeMed
[illegible]	Barbados & Assoc.
Nathan Ramsey	NC House Dem.

09-21-201

VISITOR REGISTRATION SHEET

JT. APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

April 4, 2013
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Crawford	AFANC

09-21-201

VISITOR REGISTRATION SHEET

JT. APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

4-4-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Russell	NC Early Childhood Assn.
Michele Rivet	N.C. Child Care Coalition
Madison Mackenzie	DOJ
George Smith	Nexsen Pruet
Sarah Wolfe	MWC LLC
Lisa Finnell	NC Partnership for Children
[illegible]	Covenant w/ NC's Children
Pam Dowdy	H Lake Co. Smart Start
Linda Hindman	Orange County Partnership
Sarah Rothacker	Blakeley & Associates
TRACY GLOVER	[illegible]
[illegible]	MWC
LESLIE KARLGGAN	NCPC
JEFF BARNHART	MWC
Elizabeth Hudgins	CFTF
[illegible]	Nelson Mullins
[illegible]	APPCNC

09-21-201

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

April 18, 2013
Legislative Office Building - Room 643
8:30 a.m.

Senator Ralph Hise, Presiding	Welcome, Opening Remarks
Department of Health and Human Services- Medicaid Reform Plan	Dr. Aldona Wos, Secretary Department of Health and Human Services Carol Steckel, MPH State Medicaid Director
Questions From Members	
Adjourn	

Senate Committee on Appropriations on Health and Human Services
Thursday, April 18, 2013 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Appropriations on Health and Human Services met at 8:30 AM on April 18, 2013 in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Jean Farmer-Butterfield, Beverly Earle, Carl Ford, Jim Fulghum, Mark Hollo, Verla Insko, Donny Lambeth, Susan Martin, and Tom Murry were present, along with 5 Senate members.

Senator Ralph Hise, Chair, presided.

Senator Hise opened the meeting by welcoming everyone and recognizing the Pages. For the Senate were Candace Brown and Maranda Judd of Wake County, Colton Estes of Mecklenburg County, and Sawyer Strand of Duplin County. For the House were Alexus Jones of Guilford County, Lindsay Kihnel of Haywood County, and Sierra Owens of Northampton County. Senator Hise recognized the Senate Sergeants-at-Arms—Ed Kessler, Anderson Meadows, Ron Spann, and Steve Wilson—and the House Sergeants-at-Arms—Charles Godwin, Marvin Lee, and B.H. Powell.

Senator Hise explained that bill text before the committee—Partnership for a Healthy North Carolina.-AB—is the Department of Health and Human Services's proposal for Medicaid reform; however, the committee would not be moving the bill forward, since that would be a separate operation for both the Senate and the House.

Dr. Aldona Wos, Secretary, Department of Health and Human Services, was recognized to present the Department's Medicaid Reform Plan—Partnership for a Healthy North Carolina.-AB. At the conclusion of Secretary Wos's presentation, Carol Steckel, MPH, State Medicaid Director, joined her to answer questions from members of the committee.

Two members of the public were recognized to speak for two minutes each, Mary Short and Adam Searing.

Senator Hise thanked Secretary Wos and Director Steckel for coming before the committee to present the proposal.

The meeting adjourned at 10:52 AM

Senator Ralph Hise, Chair
Presiding

Susan Fanning, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Monday, April 15, 2013 12:08 PM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Thursday, April 18, 2013 at 8:30 AM

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Thursday	April 18, 2013	8:30 AM	643 LOB

For discussion: The Department's Medicaid Reform Plan

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

H/S D

HOUSE DRH30442-ME-83* (04/16)

Short Title: Partnership for a Healthy North Carolina.-AB (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ENACT THE PARTNERSHIP FOR A HEALTHY NORTH CAROLINA AS DEVELOPED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND TO TRANSFORM THE STATE MEDICAID PROGRAM, AS DEVELOPED BY THE DEPARTMENT AND APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AS REQUIRED BY FEDERAL LAW.

Whereas, the current State Medicaid Program is fragmented and ineffective in its administration and delivery of services to our State's most vulnerable citizens; and

Whereas, an effective State Medicaid Program must have as its focus the provision of services that are person-centered, that are accessible statewide by all Medicaid and other eligible recipients, and that lead to improved health outcomes; and

Whereas, the State has a responsibility to its tax payers to utilize its limited resources for health services efficiently and effectively to maintain system viability and predictability in planning and budgeting; and

Whereas, responses to the Department of Health and Human Services' recent "Request for Information" from Medicaid providers and recipients and other interested parties call for substantive system reform in the areas of accessibility, system coordination, provider availability, and quality of services, as well as other areas that need attention; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1.(a) This act shall be known as the "Partnership for a Healthy North Carolina Act." As used in this act, reference to Medicaid includes North Carolina Health Choice.

SECTION 1.(b) The Department of Health and Human Services (Department) shall proceed with its development of system reform through phased-in statewide restructuring of the management and delivery of and reimbursement for services under the State Medicaid Program, including the North Carolina Families Accessing Services through Technology (NCFAST) system and the North Carolina Transparent Reporting, Accounting, Collaboration, and Knowledge management System (NCTracks). As developed by the Department, reform efforts and outcomes shall be designed to produce an integrated delivery system of health care services that is person-centered, applies statewide, and is structured and administered to maximize efficiency and improve health outcomes. Full system reform may be implemented in phases as determined by the Department and shall be completed no later than July 1, 2018. At the time of full implementation, the State Medicaid Program shall be capable of managing all public resources that may become available for Medicaid services, including federal block grant funds, federal funding for Medicaid, and other public funding sources.

SECTION 1.(c) The Department shall include in its restructuring efforts those State-funded services and reimbursements provided for under North Carolina Health Choice, State-operated facilities, and Local Management Entities/Managed Care Organizations (LMEs/MCOs).

SECTION 1.(d) The Department's application to the Centers for Medicare and Medicaid Services (CMS) for an innovative 1115 waiver or other federal authority shall provide for statewide delivery of services to Medicaid recipients and, as developed by the Department, shall include:

(1) Service delivery through at least two but not more than four Comprehensive Care Entities.
(2) A single system for provider enrollment and credentialing.
(3) A single system for the submission of claims, claims reimbursement, and claims adjudication.

SECTION 1.(e) In the event of a conflict between this act and the provisions of any other law pertaining to the State Medicaid Program, North Carolina Health Choice, LMEs/MCOs, and State-operated facilities, including, but not limited to, payments, services, program integrity, and provider credentialing, this act shall control to the extent of the conflict and with respect to the development of the Department's system reform.

SECTION 2. The Department's Request for Proposal (RFP) for participation and the provision of services shall provide for the selection of at least two but not more than four Comprehensive Care Entities. Comprehensive Care Entities selected by the Department to provide or contract for services must have the capacity to effectively:

(1) Develop and maintain comprehensive networks of providers to ensure that recipients have seamless access to person-centered services.
(2) Conduct health risk and functional needs assessments for each recipient to determine appropriate care.
(3) Provide care and case management to recipients, including those currently served through LMEs/MCOs, Community Alternatives Programs (CAP) programs, Community Care of North Carolina (CCNC) networks, and long-term services and supports.
(4) Utilize the State's claims payment system effectively and in a timely manner.
(5) Operate under a risk-adjusted per member/per month (PMPM) rate.
(6) Operate under or perform any other requirement of the Department as provided in the applicable waiver, State Plan Amendment, contract, or RFP.

SECTION 3. The Department shall report to the House and Senate Appropriations Subcommittees and the Fiscal Research Division on the status and progress of system reform. The Department shall submit its reports on or before the convening of the 2013 General Assembly, Regular Session 2014, and upon the convening of each session of the 2015 General Assembly and shall issue its final report on the status of full implementation upon the convening of the 2017 General Assembly.

SECTION 4. In addition to the reporting requirements of Section 3 of this act, the Department shall provide to the 2013 General Assembly, Regular Session 2014, legislation for introduction and consideration that proposes statutory and session law changes necessary to continue the Department's development and implementation of system reform under this act.

SECTION 5. The Department of Health and Human Services, Division of Medical Assistance, and the Department of Insurance shall work together to identify any statutory or regulatory provisions under the authority of the Department of Insurance that may conflict with or otherwise impair the development and administration of system reform.

SECTION 6. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

HEALTH & Human Svcs — 4/18/13

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Lanier	Nelson Mullins
Allison Waller	Nelson Mullins
Susanna Davis	Williams Mullen
Mona Sharma	GSK
Kara Weishaar	SA
John DelGiorno	Brubaker + Assoc.
Dana Simpson	SA
Doug Miskew	PSG
Heather Robinson	NCRMA
Bill Roston	ACP
Mike Jones	ACP

VISITOR REGISTRATION SHEET

Joint Comm HHS — 4/18/13

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bill Gilkeson	Bailey & Dixon
Adam Linker	NC Justice Center
Terry Miller	FDP parent
Janell Albany	daughter
Ben Money	RCCHCA
Lisa Ward	NC Dent-l Society
Alec Parker	" " "
Tracy Edwards	AHC
Tony Caplan	MWC
Wanda Mitchell	OSBM
Wayne Williams	OSBM

VISITOR REGISTRATION SHEET

Joint Comm HHS — 4/18/13

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
PAIGE WORSHAM	NC Center for Public Policy Research
Maureen Trotter	NCAOC
Chuck Stone	SEANC
Mary Short	Parent
Kattie Short	Adult IDD/Recipient
Jarel Albany	Adult IDD/Recipient
Paula Cox Fishman	Volunteer IDD advocate
CAROL ORNITZ	NC Brain Injury Advisory Council
Kerra Bolton	LCA
Tracy Hangs	Alliance BHC
Colleen Kochanek	NCCEP

VISITOR REGISTRATION SHEET

HHS — 4-18-13

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kelly Nicholson	UNC HC
Yolanda Stith	Capitol Access
Towns Maxwell	
Ann Rodriguez	NC Council of Comm Programs
Andy Chase	KMA
[illegible]	NCALHD
Angel Sams	CP
Theresa K	CP
Amy Elle	NCPA
[illegible]	
[illegible]	BCBS

VISITOR REGISTRATION SHEET

HHS — 4/18/13

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michelle Frazier	MFHS
John Hawkins	MFHS
Mac Boxley	NC Fast Growth Society
Annaliese Dolph	Dolph Law
Corye Dunn	DRNC
Kelley Kleinfelt	NAMI NC
Mary Bethea	AARP-NC
George Smith	NP
TAD CLODFELTER	SOUTHLIGHT/Coalition
[illegible]	[illegible]
Amanda Honaker	Troutman Sanders

VISITOR REGISTRATION SHEET

Joint Comm HHS — 4/18/13

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ariel Reynolds	North Carolina Coalition to End Homelessness
Dean Plunkett	PS

VISITOR REGISTRATION SHEET

Joint Comm HHS — 4/18/13

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Wolfe	mmt LLC

SENATE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

May 20, 2013
Legislative Office Building - Room 643
4:00 p.m.

Senate
Sen. Ralph Hise, Co-Chair
Sen. Louis Pate, Co-Chair
Sen. Austin Allran
Sen. Tamara Barringer
Sen. Floyd McKissick
Sen. Martin Nesbitt
Sen. Gladys Robinson

Senator Louis Pate, Presiding Chair

Welcome and Opening Remarks

Review Proposed Senate HHS Budget — Sen. Ralph Hise, Co-Chair

Questions and Discussion

Adjourn

Senate Committee on Appropriations on Health and Human Services
Monday, May 20 at 4:00 pm
Room 643

MINUTES

The Senate Committee on Appropriations on Health and Human Services met at 4:00 p.m. on May 20, 2013 in Room 643. Five members were present.

Senator Louis Pate presided.

Senator Pate called the meeting to order and recognized the Sergeants-at-Arms: Ken Kirby, Steve Wilson and Robert Young. He further explained the manner in which the meeting would be conducted along with the Rules for Considering Amendments (attachment I). He then called on Co-Chair, Senator Ralph Hise to explain the Senate's proposed budget for Health and Human Services.

Senator Hise began by thanking the entire HHS Research Team led by Susan Jacobs, and congratulating them on their hard work and the excellent job they had done. He called everyone's attention to the "Senate Appropriations on Health and Human Services Money Report" (attachment II). Senator Hise began by explaining that the budget spends $434 million for continuation of the Medicaid program at its current level, accounting for changes in enrollment and health care services used. He then went through all aspects of the Report explaining each portion in detail. Afterwards, Senator Hise opened the floor for questions from committee members.

After all questions had been answered, Senator Pate opened the floor for public comment. Anyone desiring to speak would be allowed 3 minutes. Ms. Mary Bethel with AARP was the first to speak. She introduced herself and commented regarding the budget and how she felt it would affect the public. Adam Linker, a policy analyst for the NC Health Access Coalition spoke next. He explained how he thought the budget would shift costs to low-income people and make health care more difficult to obtain for anyone in this category. Senator Pate asked if there was anyone else in the audience who would like to speak regarding the budget; however, no one else desired to comment.

The meeting adjourned at 6:10 p.m.

Louis M Pate Jr.
Senator Louis Pate
Presiding

Edna Pearce
Edna Pearce, Committee Clerk

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Monday	May 20, 2013	4:00 PM	643 LOB

HHS Budget

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Senate Appropriations/Base Budget Committee

Rules for Considering Amendments

If amendments are offered, then the following rules must be met in order to make the amendment eligible for consideration:

1. Money can only be transferred among items within the same subcommittee section.

2. Amendments where money is being transferred among items within a subcommittee must clearly identify the items/programs that are being increased and decreased.

3. Nonrecurring reductions cannot be made to fund recurring additions.

4. Amendments that spend reversions are not allowed.

5. Amendments that increase or create new management flexibility reserves are not allowed.

6. Amendments that increase spending in the subcommittee budgets are not allowed.

7. Amendments are not allowed where funding for an item comes from statewide reserves.

8. Since this is a meeting of Full Appropriations, amendments that address finance portions of the bill will not be heard.

9. Amendments must be in writing, the original signed, with 75 copies available for distribution.

10. To be considered, a proposed amendment must have been logged in by the committee clerk in room 643 by 10:00 a.m. on Tuesday, May 21, 2013.

SENATE APPROPRIATIONS ON HEALTH AND HUMAN SERVICES

SENATE BILL 402
NORTH CAROLINA GENERAL ASSEMBLY

MONEY REPORT

MAY 20, 2013

Health and Human Services

GENERAL FUND

	FY 13-14		FY 14-15	
Recommended Continuation Budget	**$4,615,870,375**		**$4,630,560,536**	

Legislative Changes

(1.0) Division of Central Management and Support

1 Office of Citizen Services Positions Eliminates six positions associated with the elimination of the NC Care Line in S.L. 2011-145. -6.00 60037847 Processing Assistant III 60037849 Community Service Consultant 60037850 Administrative Officer I 60037854 Processing Assistant V 60037855 Human Service Planner/Evaluator II 60090103 Administrative Officer I	($339,787)	R	($339,787) -6.00	R
2 Adjustment Based on Historical Transfers Reduces funds based on transfers from the Division of Central Management to the Division of Medical Assistance. In FY 2010-11 approximately $3.7 million was transferred from lapsed salary, contracts and Division of Information and Resource Management (DIRM) administration accounts. In FY 2011-12 approximately $2.7 million was transferred from lapsed salary and indirect cost accounts. These funds were transferred to the Division of Medical Assistance to cover Medicaid shortfalls in both years.	($1,982,830)	R	($1,982,830)	R
3 North Carolina Families Accessing Services Through Technology (NC FAST) Provides funds to match federal receipts and continue the development and implementation of NC FAST.			$864,655	NR
4 Department of Justice Settlement Agreement Provides funds pursuant to the agreement between the State and the U.S. Department of Justice to develop and implement housing, support, and other services for people with mental illness. The funds will be used to provide services to an additional 150 people in FY 2013-14 and up to 708 people in FY 2014-15.	$3,834,275	R	$9,394,658	R
5 Medicaid Management Information System (MMIS) Directs the Department to use prior-year earned revenue to fund this system. FY 2013-14: $9,658,152 NR FY 2014-15: $1,666,625 NR				

	FY 13-14		FY 14-15	
6 DHHS Competitive Block Grant for Non-Profits				
Creates a performance-based, competitive block grant process to fund services historically provided by the non-State entities specifically designated for direct appropriation in S.L. 2012-142, Section 10.19(a). In FY 2012-13, funds were provided in specific amounts to these non-profit entities on a nonrecurring basis. Funds appropriated in FY 12-13 (approximately $9.2 million), funds provided to the High School Athletic Association (approximately $300,000), and the federal block funding indicated below have been consolidated into a State block grant to be administered by the Office of the Secretary in the Department of Health and Human Services. The Department is directed to create a Request For Application (RFA) process that will allow non-State entities to receive State funds on a competitive basis.	$9,529,134	NR		
Additional federal block grant funds available for this purpose include:				
Social Service Block Grant (SSBG) - $3,852,500 Maternal and Child Health Block Grant - $89,374 Preventive Health Services Block Grant - $1,331,961				
(2.0) Division of Child Development and Early Education				
7 Regulatory Positions Shifted from State to Federal Funding	($900,000)	R	($900,000)	R
Transfers $604,541 in salaries and $204,962 in benefits for14 positions as well as $90,497 in operating costs to receipt support by utilizing the Child Care Development Fund block grant. The Child Care Regulatory fund has $1.5 million remaining in state appropriations. The following positions are affected:	-14.00		-14.00	
60038736 Child Day Care Specialist 60038746 Child Day Care Specialist 60038747 Child Day Care Specialist 60038610 Child Day Care Specialist 60038743 Child Day Care Specialist 60038742 Child Day Care Specialist 60038735 Child Day Care Specialist 60038741 Child Day Care Specialist 60038745 Child Day Care Specialist 60038734 Child Day Care Specialist 60038739 Child Day Care Specialist 60038749 Child Day Care Specialist 60038730 Child Day Care Specialist 60038835 Program Assistant V				
8 Seat Management Funding Elimination	($38,125)	R	($38,125)	R
Eliminates funding for seat management, the outsourcing of management of workstation capabilities for employees, including hardware and software.				

	FY 13-14		FY 14-1	
9 Adjustments Based on Historical Transfers Reduces funds based on transfers from the Division of Child Development and Early Education to the Division of Medical Assistance. In FY 2011-12 approximately $870,000 was transferred from lapsed salary, contracts and administrative services to the Division of Medical Assistance to cover the Medicaid shortfall.	($652,500)	R	($652,500)	R
10 Pre-K Slot Transfers Transfers 2,500 Pre-K slots in FY 2013-14 and 5,000 in FY 2014-15 along with the General Fund appropriation to Child Care Subsidy. $52.6 million in General Fund appropriation is available for Pre-K in FY 2013-14, and $40.1 million General Fund appropriation is available for Pre-K in FY 2014-15.	($12,440,000)	R	($24,880,000)	R
11 Child Care Subsidy Increase Increases funding to address the waiting list for Child Care Subsidy. FY 2013-14 funding will serve approximately 2,600 additional children. FY 2014-15 funding will serve approximately 5,200 additional children.	$12,440,000	R	$24,880,000	R
12 State Funds for Child Care Subsidy Replacement Replaces the General Fund appropriation for child care subsidy with block grant funds and a transfer from the Pre-K Program. There is an overall net increase to child care subsidy of $9.8 million in FY 2013-14 and a net increase of $22.2 million in FY 2014-15. Total funds from all sources will be $360 million in FY 2013-14 and $372 million in FY 2014-15.	($2,624,189)	NR	($2,624,189)	NR
(4.0) Division of Social Services				
13 Seat Management Funding Elimination Eliminates funding for seat management, the outsourcing of management of workstation capabilities for employees, including hardware and software.	($606,695)	R	($606,695)	R
14 Adjustment Based on Historical Transfers Reduces funds based on historical transfers from the Division of Social Services to the Division of Medical Assistance. In FY 2010-11 $9.7 million was transferred from contracts, unused adoption and foster care services funding, and other administrative funds. In FY 2011-12 the division transferred approximately $15.3 million. Of this amount approximately $4.5 million was from unspent foster care and adoption services funding, $600,000 from lapsed salary, $1 million in contracts, and $4 million from non-recurring revenue from prior year earned revenue, indirect costs and prior year audit and adjustments. The remaining funds came from administration, including seat management. Some of the historical transfers are reduced in the seat management and contract and administrative reduction items. Foster Care and Adoption services funding was reduced in the continuation budget.	($1,875,000)	R	($1,875,000)	R

	FY 13-14		FY 14-15	
15 Contract and Administrative Savings Eliminates funds for the Child Welfare Multiple Response System (MRS) Conference that trained county staff on MRS. The conference is no longer needed as MRS has been implemented statewide. Also eliminates funds for the forms and supply warehouse that is no longer needed as the warehouse has closed. The remaining reduction is from administration and internet billing costs.	($1,066,123)	R	($1,066,123)	R
16 Federal Funds for County Child Welfare Services Replacement Provides funds to partially replace federal funding for child welfare administration due to a change in the application of federal policy. The State supports county DSS agencies at an overall rate of 31% of the non-federal share of their county budgets for public assistance and service programs. This appropriation replaces 33% of the lost federal funding on a nonrecurring basis to support the counties while the North Carolina Families Accessing Services through Technology (NCFAST) information system is being developed and implemented. Once fully implemented, NCFAST is projected to save administrative costs for counties.	$4,826,346	NR	$4,826,346	NR
17 NC Reach - Child Welfare Postsecondary Education Provides funds to support an additional 100 former foster care youth and children adopted after age 12 who attend college within the UNC and Community College systems. NC Reach funding is the payer of last resort and covers items such as books, supplies, transportation, and room and board not covered by other funding sources.	$547,245	R	$610,817	R
(6.0) Division of Vocational Rehabilitation				
18 Independent Living Program Administration Reduction Reduces the administrative budget for the Independent Living Program.	($10,000)	R	($10,000)	R
19 Vocational Rehabilitation Services Administration Funding Replaces General Fund appropriations budgeted for administrative expenses in the Vocational Rehabilitation Basic Support program with program receipts.	($102,236)	R	($102,236)	R
20 State Funding in the Assistive Technology Program Replaced Replaces the General Fund appropriation in the Assistive Technology Program with program receipts.	($98,738)	R	($98,738)	R
21 Historical Transfers to Medicaid Reduces funding based on transfers from the Division of Vocational Rehabilitation to the Division of Medical Assistance. In FY 2011-12 approximately $845,000 was transferred from indirect costs funds to the Division of Medical Assistance to cover the Medicaid shortfall.	($300,000)	R	($300,000)	R

	FY 13-14		FY 14-1	
(7.0) Division of Aging and Adult Services				
22 Seat Management Funding Elimination Eliminates funding for seat management within the Division. The Department discontinued outsourcing management of its workstation capabilities including hardware and software.	($855)	R	($855)	R
23 Adjustment Based on Historical Transfers Reduces funding based on transfers from the Division of Aging and Adult Services to the Division of Medical Assistance. In FY 2011-12 approximately $470,000 was transferred from lapsed salary and administration accounts were transferred to the Division of Medical Assistance to cover the Medicaid shortfall.	($300,000)	R	($300,000)	R
24 Home and Community Care Block Grant (HCCBG) Reduces the HCCBG and transfers the funds to expand Project C.A.R.E. statewide. $24.6 million in General Fund appropriation remains in the HCCBG to provide home and community-based services to seniors and disabled adults.	($2,900,000)	R	($2,900,000)	R
25 Caregiver Alternatives to Running on Empty (Project C.A.R.E.) Provides $500,000 to replace an expiring federal grant and an additional $2.4 million to expand Project C.A.R.E. statewide. The program provides respite and support services to families caring for a person with dementia at home.	$2,900,000	R	$2,900,000	R
26 Long-Term Care Ombudsman Replaces lost federal receipts and maintains the current level of service. In the FY 2011-13 budget, General Fund support for the Long-Term Care Ombudsman was replaced with federal civil monetary penalties receipts. Since then, the Centers for Medicare and Medicaid Services (CMS) has restricted the use of those federal receipts for this purpose.			$200,000	R
(8.0) Division of Public Health				
27 Early Intervention - Children's Developmental Services Agencies Reduces FY 2013-14 funding to the Division of Public Health based on historical transfers to the Division of Medical Assistance. In FY 2010-11, approximately $17.1 million was transferred from lapsed salary, administration, and contract accounts to address the Medicaid shortfall. In FY 2011-12, approximately $17.4 million was transferred. Of the amounts transferred, over half was lapsed salary and other unspent funds budgeted to the Early Intervention Branch. Also eliminates funding, effective July 1, 2014, for 4 of the 16 Children's Development Service Agencies (CDSAs). In determining which CDSAs to close, the Division shall make it a priority to maintain the CDSAs that have the highest caseloads of children who reside in rural or medically underserved areas of the State.	($8,000,000)	NR	($10,000,000) -160.00	R

	FY 13-14		FY 14-15	
28 AIDS Drug Assistance Program (ADAP) Drug Purchases Reduces ADAP funding to more accurately reflect current spending levels. ADAP provides pharmaceuticals to financially-eligible persons with AIDS. There are currently two ADAP funding sources: federal Ryan White CARE Act and State appropriations. Nonrecurring funds are provided in each year of the biennium to address potential waiting lists for AIDS pharmaceutical assistance.	($8,000,000) $6,000,000	R NR	($8,000,000) $6,000,000	R NR
29 Food and Lodging Permit Fee Reduces the General Fund appropriation and budgets increased food and lodging permit fee receipts. Effective July 1, 2013, the annual food and lodging permit fee increases from $75 to $120; the State's portion increases from $25 to $50.	($750,000)	R	($750,000)	R
30 Oral Health Section Eliminates 39 dental hygienist, 2 dental technician, and 7 administrative positions effective October 1, 2013, and reduces funding for administration. A portion of the savings will be allocated to local health department dental clinics to increase the number of dental hygienists and dental assistants providing clinical dental treatment and services. In addition to the 41 dental hygienist and dental equipment technician positions, the following administrative positions are eliminated: 60039581 Accounting Clerk V 60039585 Dental Hygienist Regional Coordinator 60039588 Public Health Regional Dentist Supervisor 60039589 Dental Hygienist Regional Coordinator 60039608 Public Health Regional Dentist Supervisor 60039627 Public Health Regional Dentist Supervisor 60039644 Education Media Specialist I	($2,865,762) -48.00	R	($3,583,681) -48.00	R
31 Local Health Department Dental Clinics Provides funding to local health departments that operate or sponsor dental clinics, effective October 1, 2013. The local health departments shall use the funds to hire dental hygienists to provide clinical dental treatment and services.	$1,558,257	R	$2,077,677	R
32 State Public Health Laboratory Provides funding for the State Public Health Laboratory to offset receipts lost due to FY 2010-11 Medicaid provider rate reductions.	$1,052,000	R	$1,052,000	R
33 NC Tobacco Use Quitline Provides funds to continue the operation of the North Carolina Tobacco Use Quitline (NC Quitline). NC Quitline provides free tobacco cessation services and treatment for NC residents.	$1,400,000	R	$1,400,000	R

(9.0) Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

	FY 13-14		FY 14-1	
34 LME/MCO Administration Reduces funds provided for Local Management Entities (LME)/Managed Care Organizations (MCO) administration funding formula. The LME/MCO transition phase will be fully implemented by July 1, 2013 resulting in savings to the General Fund.	($15,228,245)	R	($15,228,245)	R
35 Gambling Fund Balance Budgets accumulated lottery budget receipts transferred to the Division for gambling addiction education and treatment programs. This reduction is not anticipated to affect the level of services provided.	($416,264)	NR		
36 Alcohol and Drug Abuse Treatment Centers (ADATC) Closes the three State-operated ADATCs, effective July 1, 2013. Each ADATC has 80 beds, with average bed costs ranging from $570 to $670 per day. A portion of the resulting savings will be added to the single-stream funding and will be allocated to the Local Management Entities/Managed Care Organizations to be used for alcohol and substance abuse treatment services.	($37,951,761) -548.88	R	($50,602,349) -548.88	R
37 Alcohol and Substance Abuse Treatment Budgets a portion of the savings resulting from the closure of the three State-operated residential alcohol and drug abuse treatment facilities (ADATCs) to fund community-based and residential alcohol and substance abuse treatment services.	$10,000,000	R	$20,000,000	R
38 NC High School Athletic Association (NCHSAA) Eliminates the special appropriation for the NCHSAA and transfers the funding to the Division of Central Management and Support to be used for the performance-based, competitive block grant process, for which NCHSAA would be eligible to apply.	($332,491)	R	($332,491)	R
39 Wright School Closes the Wright School, a 24-bed residential school for children with mental health or behavioral disorders, effective July 1, 2013.	($2,709,912) -40.15	R	($2,709,912) -40.15	R
40 Broughton Hospital Beds Realigns the Division's base budget to transfer $3,513,000 recurring from Fund Code 1910 - Reserves and Transfers to Fund Code - 1561 Broughton Hospital to open 19 additional adult psychiatric care beds. These funds were originally appropriated by S.L. 2012-142 for this purpose but contingent upon the status of the Medicaid budget. Due to the contingency, FY 2012-13 funds were placed in the reserve account and then transferred to Budget Code 14445 to address the Medicaid budget shortfall. In the Division's FY 2013-15 continuation budget, the funds remain in Fund Code 1910.				

	FY 13-14		FY 14-15	
41 Three-Way Contracts Realigns the Division's base budget to transfer $9 million recurring from Fund Code 1910 Reserves and Transfers to Fund Code 1464, Crisis Services to increase the number of three-way contract community hospital beds available to Local Management Entities/Managed Care Organizations from 141 to 186. These funds were originally appropriated by S.L. 2012-142 for this purpose but contingent upon the status of the Medicaid budget. Due to the contingency, FY 2012-13 funds were placed in the reserve account and then transferred to Budget Code 14445 to address the Medicaid budget shortfall. In the Division's FY 2013-15 continuation budget, the funds remain in Fund Code 1910.				
42 Statewide Telepsychiatry Program Provides funds to establish a statewide telepsychiatry program to provide consultant services as an alternative to alleviate hospital emergency department wait times, involuntary commitments, and local law enforcement involvement in the transport of patients who have been involuntarily committed, especially in rural and medically underserved areas. The funds shall be used to establish and administer the program and to purchase telepsychiatry equipment for the State-owned hospitals.	$2,000,000	R	$2,000,000	R
43 New Broughton Hospital Provides funds to purchase medical equipment, furniture, and information technology infrastructure for the new, expanded Broughton Hospital scheduled to open in December 2014.	$11,510,467	NR	$16,598,589	NR
44 NC Child Treatment Program Provides funds for the statewide implementation of the NC Child Treatment Program. Funds will be used to provide clinical training to Medicaid-certified physicians, child trauma treatment services, and to develop an online database system.	$1,818,745 $250,000	R NR	$1,818,745 $250,000	R NR
(10.0) Division of Health Service Regulation				
45 Adjustment Based on Historical Transfers Establishes a recurring reduction in the Division of Health Service Regulation at the level of historical transfers made to cover Medicaid shortfalls. Approximately $600,000 was transferred to the Division of Medical Assistance in FY 2010-11; approximately $800,000 was transferred to the Division of Medical Assistance in FY 2011-12.	($300,000)	R	($300,000)	R

(11.0) Division of Medical Assistance

46 Health Homes for the Chronically Ill ($3,757,682) NR

Reflects the last quarter of increased federal match under the Health Homes for the Chronically Ill program for qualified care management per member per month expenditures. Includes an enhanced federal match for all Medicaid care management payments for recipients with comorbid conditions including a chronic health condition and severe and persistent mental health conditions paid through September 30, 2013.

47 Mental Health Drug Management ($4,975,290) R ($11,258,127) R

Reduces funds for prescription drugs. Mental health drugs will be subject to prior authorization to ensure appropriate use and clinical outcomes effective January 1, 2014. A 72-hour emergency supply may be provided if a beneficiary is waiting for acknowledgement of the prior authorization request. This will put mental health drugs on parity with all other medications paid for by Medicaid.

48 Hospital Provider Assessment ($7,000,000) R ($7,140,000) R

Effective July 1, 2013 the hospital provider assessment will be modified so the State's retention of hospital assessments will be 15.6% of the total assessment paid by hospitals instead of a stated amount of $43 million.

49 Report Separately Payments to CCNC and CCNC Providers $59,340,923 R $62,046,0' R

Establishes a separate budget item for per member per month payments to the North Carolina Community Care Network for care management activities and to Community Care North Carolina (CCNC) physicians for CCNC activities for reporting and tracking purposes. The respective amounts are

FY 2013-14	Total Requirements	State Funds
Care Management	$125,800,000	$44,000,000
Provider Payments	$ 43,800,000	$15,300,000
FY 2014-15		
Care Management	$131,600,000	$46,100,000
Provider Payments	$ 45,700,000	$16,000,000

	FY 13-14		FY 14-15	
50 Physician Expenditures Adjustment to Appropriately Report CCNC Payments	($59,340,923)	R	($62,046,013)	R

Establishes a separate budget item for per member per month payments to the North Carolina Community Care Network for care management activities and to Community Care North Carolina (CCNC) physicians for CCNC activities for reporting and tracking purposes. The respective amounts are:

FY 2013-14	Total Requirements	State Funds
Care Management	($125,800,000)	($44,000,000)
Provider Payments	($ 43,800,000)	($15,300,000)
FY 2014-15		
Care Management	($131,600,000)	($46,100,000)
Provider Payments	($ 45,700,000)	($16,000,000)

51 Hospital Base Rates	$0	R	$0	R

Recalibrate the hospital inpatient payment system so that the base rates will be regionally set for all hospitals in that region to eliminate the disparity in rates for the same services between hospitals that exist in the current system. Hospital inpatient services are paid based on a diagnosis related group (DRG) system. There are 746 DRG's in the Medicaid program that represent classifications of services provided during an inpatient hospitalization. Each of the 746 DRG's has a weight that represents the relative resources required for services related to that diagnosis, recipient age, sex and the presence of complications or comorbidities. Hospital payment is determined by applying a base rate, unique to each hospital, to the DRG weight. The hospital base rates were developed using each hospital's costs in 1994. Changes to these base rates have only occurred when the General Assembly has approved an increase or decrease in rates. DHHS will work with hospitals to identify appropriate regional differences and define regional definitions.

52 Medicaid Co-payments	($3,308,100)	R	($4,962,150)	R

Increases nominal copays for eligible Medicaid services to the maximum allowed by the Centers for Medicare and Medicaid Services (CMS) effective November 1, 2013. Services that are excluded from copays by CMS are medical emergency services, family planning services, "preventative" services for children and pregnancy-related services. DHHS will maintain all nominal copays at the maximum allowed by CMS.

53 Medicaid Contract Reductions	$0	R	($2,016,771)	R

Adjusts contract expenditures in the second year of the biennium to reflect a reduced cost of operation and adjudication of claims related to the new Medicaid Management Information System that will be implemented July 1, 2013 .

	FY 13-14		FY 14-1	
54 Hospital Outpatient Payments at 70% of Costs Reduces interim outpatient payments to hospitals to reflect the impact of reducing the settlement to 70% of costs effective January 1, 2014. Hospitals are currently paid for outpatient services at 80% of costs. This will result in $17.1 million less spending for outpatient services in FY 2013-14 and $35.6 million in FY 2014-15. The Hospital GAP plan allows hospitals to receive supplemental payments to increase the overall payments for hospital outpatient services to 100% of costs. The reduction in the outpatient patient percentage will result in an increase in the hospital assessment, of which the State will retain 15.6% of the increase assessment, totaling $3.2 million in FY 2013-14 and $6.6 million in FY 2014-15.	($20,294,954)	R	($42,132,325)	R
55 Shared Savings Payment Plan Establishes a 4% withhold on selective services effective July 1, 2013. Services subject to the withhold include inpatient hospital, physician (excluding primary care physicians until January 1, 2015), dental, optical services and supplies, podiatry, chiropractors, hearing aids, personal care services, nursing homes, adult care homes and drugs. DHHS will work with providers to develop a shared savings plan that will be implemented by January 1, 2015 that will include incentives to provide effective and efficient care that results in positive outcomes for Medicaid recipients. In FY 2013-14 the State share of the amount withheld will be $24.8 million. This represents a total impact of $70.9 million in provider payments, including both the State and federal shares. In FY 2014-15 the State share of the withhold will be $49.5 million, providers will be eligible for shared savings that are projected to total $14.9 million and the impact of the shared savings plan on expenditures is projected to be $27.5 million.	($31,643,177)	R	($50,742,748)	R
56 Prescribed Drugs- Payment Based on Invoice Cost Implements a payment system for all medications based on an invoice cost that will be established through quarterly surveys to determine the actual cost of drugs to pharmacies effective January 1, 2014. Currently, brand drugs are paid a Wholesale Acquisition Cost (WAC) plus 6% and generic drugs are paid at 195% of the State Medicaid Average Costs (SMAC). The change to invoice pricing will reduce expenditures for drugs by $27 million and $55 million in FY 2014-15. Effective January 1, 2014, dispensing fees will be increased to an average payment of $9.87 for all drugs. The payment system for dispensing fees will retain a $2 incentive differential for generic drugs and those on the preferred drug list. This will increase expenditures by $9 million in FY 2013-14 and $18 million in FY 2014-15.	($18,498,384)	R	($36,996,767)	R
57 Private Duty Nursing Limitation Limits adult Private Duty Nursing (PDN) to a cost not to exceed $432 per day, effective January 1, 2014.	($5,001,351)	R	($5,001,351)	R
58 Rehabilitation Services Limitation Limits adult rehabilitative services for set up and training to three visits per year, effective January 1, 2014 .	($2,748,350)	R	($5,651,495)	R

	FY 13-14		FY 14-15	
59 Exchange Premiums for Selected Medicaid Eligibles Reduces funds by purchasing insurance on the Health Benefits Exchange (HBE) for selected Medicaid recipients that are between 133% and 185% of the Federal Poverty Level effective January 1, 2014. Providers providing services to these recipients will be reimbursed through the insurance product the individual purchases and not from Medicaid funding.	($4,089,627)	R	($20,735,543)	R
60 Physician Office Visits Limitation Reduces the limit on office visits for adults from 22 visits a year to 10 visits a year effective January 1, 2014. Prior authorization will be required for medically necessary visits in excess of 10 per year. Recipients with chronic conditions will be exempted from this limitation.	($3,676,525)	R	($7,560,122)	R
61 Rate Freeze for Services Subject to Automatic Increases Freezes rates for hospital outpatient services, nursing home services and other rates that contain an inflation or increase factor not specifically approved by the General Assembly at the rate in effect June 30, 2013. Hospital outpatient services percentage of cost will be adjusted to compensate for expected inflation for which hospitals would be eligible. The cost settlement will be limited to that percentage. Nursing direct care services will not receive case mix index increases after June 30, 2013 until reinstated. Federally Qualified Health Centers, Rural Health Centers, State Operated services, Hospice, Part B and D Premiums, third party and HMO premiums, drugs and MCO capitation payments are excluded.	($18,332,670)	R	($28,027,681)	R
62 Medicaid Rate Methodologies Modification for Acquired Providers Modifies Medicaid rate methodologies to ensure that rates paid to hospital or physician providers that were acquired, merged, leased or managed after December 31, 2011 will not exceed rates that would have been paid if the provider had not been acquired, merged, leased or managed.				
63 Non-emergency Fee for Emergency Services Establishes a triage fee for non-emergency services provided in a hospital-owned and operated emergency department on parity with similar services provided in a physician's office. The fee will be effective January 1, 2014.	($1,198,401)	R	($2,464,298)	R
64 Additional Personal Care Services for Qualified Individuals Establishes an increased limit of up to130 hours per month for qualified recipients with Alzheimer's Disease and other memory disorders in Special Care Units in Adult Care Homes (ACH). DHHS will implement an additional savings component that addresses the higher acuity level for Alzheimer's/memory care recipients in Adult Care Homes. The unit rate for all Personal Care Services will be reduced to $14.12.	$0	R	$0	R

	FY 13-14		FY 14-1	
65 Medicaid Rebase Provides Medicaid funding for the continuation of the program at the current level, adjusted for changes in enrollment, mix of enrollment, consumption, new service and new policy. Additionally, the rebase includes the impact of changes in federal match (FMAP), annualization of reductions not fully implemented during FY 2012-13, the extension of Medicaid to the former foster care children until age 26 beginning January 1, 2014, contracts and settlements.	$434,000,000	R	$607,000,000	R
66 Provider Cost Settlements Increases funding for Medicaid cost settlements to provide for the growth in Medicaid recipients and the cost of serving Medicaid recipients for those providers whose payments are cost settled after the providers fiscal year. Providers that are cost settled include hospitals, skilled nursing facilities, and Intermediate Care for the Mentally Retarded facilities (ICF-MRs).	$18,000,000	R	$18,000,000	R
67 Contracts Provides funding for Medicaid contracts that ensure the appropriate level of medical service is provided, including contracts that provide prior authorization, utilization reviews and assessments of individuals receiving medical care. This increase is due to estimated increases in the Medicaid population being served. Funding is also provided for the asset verification contract which will ensure Medicaid recipients are within the asset limit for eligibility determination purposes.	$11,000,000	R	$11,000,000	R
68 "Woodwork" and Affordable Care Act Provides funding for expenditures for new Medicaid recipients. Even though North Carolina has decided not to expand Medicaid eligibility under the Affordable Care Act (ACA) effective January 1, 2014, 69,683 new enrollees are expected to join Medicaid in FY 2013-14 and 72,426 are expected to join in FY 2014-15 as a result of provisions contained in the ACA related to penalties for non-coverage and outreach efforts.	$49,684,791	R	$114,119,120	R
69 Transfer of Health Choice Children Transfers all children under 133% of the Federal Poverty Level beginning January 1, 2014 in accordance with the Affordable Care Act which requires they be covered under Medicaid instead of Health Choice. Provides funding for the increase in costs that will be incurred as a result of these recipients being eligible for broader benefits under Medicaid than they had when covered under Health Choice. In FY 2013-14 there will be about 51,000 recipients impacted. The State will retain the State Children's Health Insurance Program federal match instead of the traditional Medicaid federal match. There is a partial offset in Health Choice for this amount.	$22,080,000	R	$46,080,000	R
70 MMIS Implementation Costs Provides funding to implement manual processes to ensure the appropriate payment of claims by hiring temporary staff or through external contracts. The new Medicaid Management Information System (MMIS) for the adjudication of claims is scheduled to be implemented July 1, 2013. The new system will not contain all of the functionality of the current MMIS.	$4,828,664	NR		

	FY 13-14		FY 14-15	
71 Community Care Of North Carolina Study Provides funding for a study to determine whether the Community Care of North Carolina model saves money and improves health outcomes. This was recommended by the State Auditor in the January 2013 performance audit of the Medicaid Program. Total funding available for the study is $200,000 as the State funds may be used to match federal Medicaid administrative funds.	$100,000	NR		
(12.0) NC Health Choice				
72 Mental Health Drug Management Reduces funds for prescription drugs. Mental health drugs will subject to prior authorization to ensure appropriate use and clinical outcomes, effective January 1, 2014. This will put mental health drugs on parity with all other medications paid for by Health Choice.	($254,504)	R	($356,861)	R
73 Transfer of Health Choice Children Reduces funds by transferring children to Medicaid. Beginning January 1, 2014 the Affordable Care Act requires all children under 133% of the Federal Poverty Level be covered under Medicaid instead of Health Choice. In FY 2013-14 there will be about 51,000 recipients impacted and the State will retain the State Children's Health Insurance Plan federal match instead of the traditional Medicaid federal match.	($12,348,000)	R	($25,480,000)	R
74 Contract Budget Adjustment Reduces Health Choice contract expenditures to actual amounts.	($2,800,000)	R	($2,800,000)	R
75 Rates Freeze for Services Subject to Automatic Increases Freezes rates for hospital outpatient services, nursing home services and other rates that contain an inflation or increase factor not specifically approved by the General Assembly at the rate in effect June 30, 2013. Hospital outpatient services percentage of cost will be adjusted to compensate for expected inflation for which hospitals would be eligible. Cost settlement will be limited to that percentage. Nursing direct care services will not receive case mix index increases after June 30, 2013 until reinstated. Federally Qualified Health Centers, Rural Health Centers, State Operated services, Hospice, Part B and D Premiums, third party and HMO premiums, drugs and MCO capitation payments are excluded.	($1,265,912)	R	($1,405,614)	R
76 Shared Savings Payment Plan Establishes a 4% withhold on selective services effective January 1, 2014. Services subject to the withhold include inpatient hospital, physician services (excluding primary care until January 1, 2015), dental, optical services and supplies, podiatry, chiropractors, hearing aids, personal care services, nursing homes, adult care homes and drugs. DHHS will collaborate with providers to develop and implement a shared savings plan that will be implemented by January 1, 2015 to provide incentives for effective and efficient care that results in positive outcomes for Medicaid recipients.	($1,175,520)	R	($2,383,942)	R

	FY 13-14		FY 14-1	
77 Non-emergency Fee for Emergency Services Establishes a triage fee for non-emergency services provided in a hospital-owned and operated emergency department on parity with similar services provided in a physician's office. The fee will be effective January 1, 2014.	($88,796)	R	($183,809)	R
78 Prescribed Drugs- Payment Based on Invoice Costs Implements a payment system for all medications based on an invoice cost that will be established through quarterly surveys to determine the actual cost of drugs to pharmacies effective January 1, 2014. Currently, brand drugs are paid a Wholesale Acquisition Cost (WAC) plus 6% and generic drugs are paid at 195% of the State Medicaid Average Costs (SMAC). The change to invoice pricing will reduce expenditures for drugs by $1.2 million and $2.5 million in FY 2014-15. Effective January 1, 2014, dispensing fees will be increased to an average payment of $9.87 for all drugs. The payment system for dispensing fees will retain a $2 incentive differential for generic drugs and those on the preferred drug list. This will increase expenditures by $401,633 in FY 2013-14 and $803,265 in FY 2014-15.	($832,236)	R	($1,664,473)	R
79 Physician Expenditures Adjusted to Appropriately Report CCNC Payments Establishes a separate budget for per member per month payments to the North Carolina Community Care Network for care management activities and to Community Care North Carolina (CCNC) physicians for CCNC activities for reporting and tracking purposes. The respective amounts are	$2,557,144	R	$2,699,001	R

	Total Requirements	State Funds
FY2013-14		
CCNC Care Management	$5,800,000	$1,400,000
Provider Payments	$4,500,000	$1,100,000
FY 2014-15		
CCNC Care Management	$6,100,000	$1,500,000
Provider Payments	$4,700,000	$1,200,000

80 Physician Expenditures Adjustment to Appropriately Report CCNC Payments Establishes a separate budget for per member per month payments to the North Carolina Community Care Network for care management activities and to Community Care North Carolina (CCNC) physicians for CCNC activities for reporting and tracking purposes. The respective amounts are	($2,557,144)	R	($2,699,001)	R

	Total Requirements	State Funds
FY2013-14		
CCNC Care Management	($5,800,000)	($1,400,000)
Provider Payments	($4,500,000)	($1,100,000)
FY 2014-15		
CCNC Care Management	($6,100,000)	($1,500,000)
Provider Payments	($4,700,000)	($1,200,000)

Senate Subcommittee on Health and Human Services	FY 13-14		FY 14-15	
81 Health Choice Rebase Provides Health Choice funding to continue of the program at the current level, adjusted for changes in enrollment, mix of enrollment, consumption, new services and new policy. Additionally, the rebase includes the impact of changes in federal match (FMAP), annualization of reductions not fully implemented during FY 2012-13.	$6,176,522	R	$11,178,930	R
82 Cost Settle Hospital Outpatient Services to 70% of Cost Reduces interim outpatient payments to hospitals to reflect the impact of reducing the settlement to 70% of costs effective January 1, 2014. Hospitals are currently paid for outpatient services at 80% of costs.	($365,239)	R	($753,852)	R
Total Legislative Changes	**$346,843,739**	**R**	**$486,434,451**	**R**
	$22,246,476	**NR**	**$25,915,401**	**NR**
Total Position Changes	-657.03		-817.03	
Revised Budget	**$4,984,960,590**		**$5,142,910,388**	

SENATE SERGEANT-AT-ARMS

COMMITTEE: **SENATE APPROPRIATIONS ON**

HEALTH AND HUMAN SERVICES

DATE: 05/20/13 ROOM: 643

1. STEVE WILSON
2. ROBERT YOUNG
3. KEN KIRBY
4. _____
5. _____
6. _____

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN SERVICES SUBCOMMITTEE
(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pam Kilpatrick	OSBM
Emila Sutton	NC HFA
Cher McDowell	RECA
Elizabeth Hodgins	CFTF
Daphne Lynn	OSBM
Wanda Mitchell	OSBM
Matt Sheffield	BIPI
Zane Yates	Centene
Doug Miskiew	BCG
C Weintz	Staff
David Brown	OSBM
David Alon	KFA
Mike McKinney	Centene
Chris Hill	NC Justice Center
Wayne Williams	OSBM
[illegible]	NCMMC

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN SERVICES SUBCOMMITTEE
(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	CSS
Thomas Moore	FWW
Connie Wilson	[illegible]
Will Raney-Hill	NCHFA
Leah Powers	Governor's office
Reston Jones	Gov's office
Andrew Mecher	Capstrat
BRUCE THOMPSON	PARKER POE
Alex Copley	Parker Poe
[signature] Harrison	NCSNA
KAREN GILLESPIE	DMS
Townes Maxwell	PSG
[signature]	NCACC
[signature]	NCACC
Jaime King Fuquay	NCEL
MATT GUMMERT	NCACC
[signature]	AOPCNC

09-21-201

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN SERVICES SUBCOMMITTEE
(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Wolfe	MWC LCC
Mary Bethune	AARP-NC
Alex Millin	KLG
Ken Melvin	Benchmarks
Andy Chase	KMA
Julia Adams	ARC
Adam Linker	NC Justice Center
Claire Hermann	NCAAN
Lisa Hazirjian	NCAAN
[illegible]	SEANC
[illegible]	NCACC
Alan Briggs	A NC FOOD BANKS
TJ Bryhee	NP
George Smith	NP
Matt Wolfe	PPNAB
TRACY GLVARD	AHHC
Ruby Emanuelson	NMSS-NC

09-21-201

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN SERVICES SUBCOMMITTEE
(Committee Name)

____
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathlin Rothecker	Brubaker + Assoc.
Sarah Rothecker	Brubaker & Assoc.
John DelGiorno	Brubaker & Assoc.
Angie Hauser	Ward & Smith
[illegible]	AGP
Bill Rustin	AGP
Emily Carmody	NC Coalition to End Homelessness
Juri Schur	GARD
[illegible]	[illegible]
Alex Badger	CSS
[illegible]	GSK
Jay Perens	CSS
P.J. [illegible]	[illegible]
[illegible]	NCEMA
Andy Walsh	SAS
Michelle Frazier	Manning and Fulton
[illegible]	NC ALTCF

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN SERVICES SUBCOMMITTEE

(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel VanLiere	Vidant Health
Matthew McConnell	Carolinas HealthCare
Jim Johnson	BSA
Joel Maynard	NCAFP
Nancy Pelosi	WHS House
Cody Hand	NCHA
Amy Whited	NC Med Soc
John Metcalf	Policy Group
Allison Waller	Nelson Mullins
Payton Maynard	[illegible]
[illegible]	NCNS
Chris McClure	Brooks Pierce
[illegible]	NCMM
Matt Gross	NCPC
[illegible]	MUC
Joanne Stevens	NC Nurses Assoc.
[illegible] Robinson	NCRMA

09-21-201

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN SERVICES SUBCOMMITTEE
(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lorri Ann Harris	LRA
Debbie Hughes	KCG
Jody C Tyson	NC Education Lottery
JASON SOPER	NC DOT

09-21-201

VISITOR REGISTRATION SHEET

SENATE HEALTH & HUMAN SERVICES SUBCOMMITTEE
(Committee Name)

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jon Carr	Jordan Price Wall
Ashley Perkinson	Perkinson Law

09-21-201

SENATE APPROPRIATIONS ON HEALTH AND HUMAN SERVICES COMMITTEE
May 21, 2014 at 11:00 a.m.
Room 1027/1228, Legislative Bldg.

AGENDA

Senator Louis Pate, Presiding	**Welcome, Opening Remarks**
Proposed revised Community Services Block Grant State Plan for FY 2014 & FY 2015	**Adam Sholar**
Adjourn	

Senate Committee on Appropriations on Health and Human Services
Wednesday, May 21, 2014 at 11:00 AM
Room 1027 of the Legislative Building

MINUTES

The Senate Committee on Appropriations on Health and Human Services met at 11:00 a.m. on May 21, 2014 in Room 1027 of the Legislative Building. Five members were present. This meeting was called to serve as a legislative public hearing on the Community Services Block Grant to satisfy a federal requirement that we hold such a hearing once every three years.

Senator Louis Pate, Chair, presided.

Senator Pate recognized the following Sergeants-at-Arms: Donna Blake, Steve Wilson, Ed Kesler, Giles Jeffreys and Anderson Meadows. He then recognized the Pages assigned to the Committee: Isaiah Roberts of Charlotte, Camden Diggs or Norwood, Maggie Shafer of Clinton, Rose Tucker of Greensboro, D. J. Jacobs of Durham, Corbin Robinson of Spring Lake; Jennifer Matthews of Winston-Salem, and Nick Corn, IV of Rocky Mount.

Senator Pate opened the meeting/public hearing by welcoming everyone and explaining the reason for this meeting was to satisfy a federal requirement that we hold such a hearing once every three years. He then called on Adam Sholar from DHHS to speak relative to this requirement and to introduce Ms. Verna Best, Director of the Office of Economic Opportunity with DHHS, to explain the Proposed Revised Community Services Block Grant State Plan for FY 2014 and 2015.

After a brief introduction and explanation, Mr. Sholar turned the meeting/hearing over to Ms. Best who explained in detail the NC Plan for Administering the Community Services Block Grant Program in Fiscal Years 2014-2015 (as amended – copy attached).

Senator Pate opened the floor for the public as well as members to have a brief question and answer time.

The meeting adjourned at 11:55 a.m.

Louis M Pate J.
Senator Louis Pate, Chair
Presiding

Edna Pearce
Edna Pearce, Committee Clerk

ATTENDANCE

SENATE COMMITTEE ON HHS APPROPRIATIONS

DATES	5/21/14															
CHAIRS:																
Sen. Ralph Hise, Co-Chair																
Sen. Louis Pate, Co-Chair	✓															
SENATE:																
Sen. Austin Allran																
Sen. Tamara Barringer	✓															
Sen. Floyd McKissick	✓															
Sen. Gladys A. Robinson	✓															
Sen. Van Duyn	✓															
STAFF:																
Ryan Blackledge																
Jennifer Hillman																
Susan Jacobs																
Joyce Jones																
Denise Thomas																
Lisa Wilks																
Brandon Greife																
Kristi Huff																
Susan Fanning																
Edna Pearce																

Edna Pearce (Sen. Louis Pate)

From:	Edna Pearce (Sen. Louis Pate)
Sent:	Tuesday, May 20, 2014 07:53 AM
To:	Edna Pearce (Sen. Louis Pate)
Subject:	<NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Wednesday, May 21, 2014 at 11:00 AM - CORRECTED #2
Attachments:	Add Meeting to Calendar_LINC_.ics

Principal Clerk ____
Reading Clerk ____

Corrected #2: Room Change

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	May 21, 2014	11:00 AM	1027/1128 LB

The Senate HHS Appropriations Committee will hold a Legislative Public Hearing on the Community Services I Grant per federal requirements.

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

SENATE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

May 21, 2014
Legislative Building – Room 1027/1128
11:00 a.m.

Senator Louis Pate, Presiding	Welcome, Opening Remarks
Community Services Block Grant – Legislative Hearing	Verna Best, Director Office of Economic Opportunity, DHHS
Questions From Members	
Adjourn	

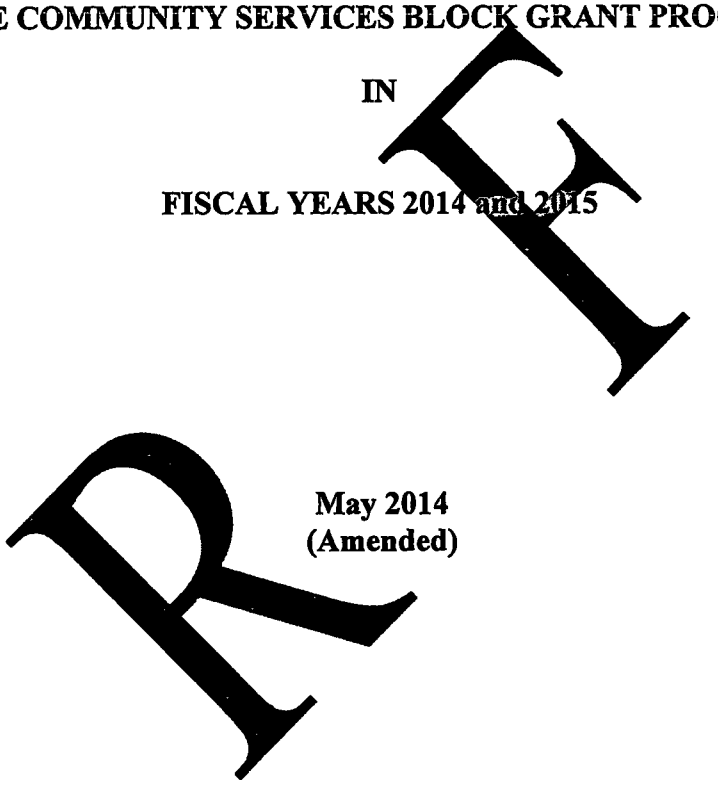
THE NORTH CAROLINA PLAN

FOR ADMINISTERING

THE COMMUNITY SERVICES BLOCK GRANT PROGRAM

IN

FISCAL YEARS 2014 and 2015



May 2014
(Amended)

North Carolina Department of Health and Human Services
Department of Social Services, Family and Economic Services Section
Office of Economic Opportunity
2420 Mail Service Center
Raleigh, North Carolina 27699-2420
(919) 527-6250 [phone]
(919)-334-1265 [fax]
http://www.ncdhhs.gov/oeo/

Statement on Poverty and the Community Services Block Grant (CSBG) in North Carolina

According to the 2011 U.S. Census Bureau Small Area Income Poverty Estimates, 17.8% of North Carolinians live in poverty with a child poverty rate of 25.4%. According to the U.S. Census Bureau 2007-2011 American Community Survey 5-Year Estimates, 10.3% of individuals aged 65 and older live in poverty. For the purpose of North Carolina's Community Services Block Grant (CSBG) State Plan, poverty is defined as economic insufficiency or lack of resources to attain basic needs such as food, clothing, shelter, transportation and healthcare. Additionally, it is acknowledged that the causes and resolutions of poverty are associated with personal responsibility, availability of community resources and opportunities for individuals to access resources. The CSBG State Plan seeks to outline a strategic approach to effective administration, outcome-based performance management and optimal accountability for this funding.

CSBG is the federal, anti-poverty block grant which in North Carolina funds the operations of the state's administrative oversight office and the network of local non-profit Community Action Agencies (CAA), governmental and Limited Purpose Agencies (LPAs) for the primary purpose of reducing poverty. Most agencies in the CSBG network are Community Action Agencies (CAAs), created through the Economic Opportunity Act, a predecessor of CSBG. In North Carolina, the impact of CAAs dates back to 1963 with the development of a public/private partnership known as the North Carolina Fund. The network continues to expand with CAAs currently designated to serve 96 of North Carolina's 100 counties and LPAs serving special populations statewide. These agencies are delivering responsive and effective services by mobilizing public and private resources to move low-income families from poverty into economic independence.

Two trademarks of CSBG are the tripartite board requirement for eligible entities and the National Results Oriented Management and Accountability (ROMA) model. CSBG requires agencies to have a tripartite board structure which serves as an opportunity for shared leadership, accountability and integrity between representatives of low-income, elected public officials and leaders from the private sector. Being active in the administration of the program moves low-income individuals from a posture of being 'subject to' available anti-poverty programming to 'shared governance in' available anti-poverty programming. Such values and traits are essential for fostering law-abiding, contributing and upstanding community members. A second trademark of CSBG is the National ROMA model which serves as the primary training and reporting framework for the North Carolina CSBG network. Additionally, the National ROMA model drives accountability and performance management in areas of family stability, community revitalization and agency capacity.

With the eminent impact of sequestration and other budget constraints that threaten to adversely affect CSBG funding and low-income individuals who receive CSBG services, North Carolina still faces the reality that the state's poverty rate exceeds the national average. As such, all efforts will be channeled towards ensuring that these limited but essential resources are maximized through leveraging the community resources and human capital required to combat the central causes of poverty that persist in our state.

TABLE OF CONTENTS

VI. Administrative Certifications

Certification Regarding Lobbying
Certification Regarding Debarment, Suspension and Other Responsibility Matters
Certification Regarding Drug-Free Workplace Requirements
Certification Regarding Environmental Tobacco Smoke

VII. Appendices

To be added in final amended plan

Insert Transmittal Letter

II. Federal Fiscal Years Covered by State Plan

The North Carolina Plan for Administering the Community Services Block Grant Program in Fiscal Years 2014 and 2015 serves as North Carolina's application to the Department of Health and Human Services, Office of Community Services for funding for federal fiscal years 2014 and 2015. This application document was prepared in accordance with requirements of the Act and the Office of Community Services.

IV. Executive Summary

The major goal of the North Carolina Community Services Block Grant Program is to provide funding to Community Action Agencies and Limited Purpose Agencies to carry out activities that will enable low-income families to move out of poverty.

This grant program is administered by the Department of Health and Human Services, Division of Social Services, Economic and Family Services Section, Office of Economic Opportunity.

A. CSBG State Legislation

The North Carolina State Executive Budget Act, General Statute 143-16.1, requires that the Secretary of the Department of Health and Human Services report to the General Assembly on the administration of the Community Services Block Grant Program. The report must include, but is not limited to a delineation of the proposed dollar amount of allocations by activity and by category, including dollar amounts to be used for administration costs and a comparison of the proposed funding with two prior years' program budgets. The State's CSBG Block Grant Plan was presented [to be added post legislative hearing]

B. Designation of Lead State Agency to Administer CSBG Program
(see next page)

C. Public Hearing Requirement

(1) Public Hearing: to be added post public hearing

(2) Legislative Hearing: to be added post legislative hearing

(2) Public Inspection of State Plan: to be added at conclusion of public inspection

Governor Letter to be inserted

IV. Statement of Federal and CSBG Assurances

As part of the annual or biannual application and plan required by Section 676 of the Community Services Block Grant Act, as amended, (42 U.S. C. 9901 et seq.) (The Act), the designee of the chief executive of the State hereby agrees to the Assurances in Section 676 of the Act –

A. Programmatic Assurances

(1) Funds made available through this grant or allotment will be used:

(a) To support activities that are designed to assist low-income families and individuals, including families and individuals receiving assistance under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.), homeless families and individuals, migrant or seasonal farmworkers, and elderly low-income individuals and families to enable the families and individuals to:

(i) remove obstacles and solve problems that block the achievement of self-sufficiency (including self-sufficiency for families and individuals who are attempting to transition off a State program carried out under part A of title IV of the Social Security Act);

(ii) secure and retain meaningful employment;

(iii) attain an adequate education, with particular attention toward improving literacy skills of the low-income families in the communities involved, which may include carrying out family literacy initiatives;

(iv) make better use of available income;

(v) obtain and maintain adequate housing and a suitable living environment;

(vi) obtain emergency assistance through loans, grants, or other means to meet immediate and urgent family and individual needs; and

(vii) achieve greater participation in the affairs of the communities involved, including the development of public and private grassroots partnerships with local law enforcement agencies, local housing authorities, private foundations, and other public and private partners to document best practices based on successful grassroots intervention in urban areas, to develop methodologies for widespread replication; and strengthen and

improve relationships with local law enforcement agencies, which may include participation in activities such as neighborhood or community policing efforts;

(b) To address the needs of youth in low-income communities through youth development programs that support the primary role of the family, give priority to the prevention of youth problems and crime, and promote increased community coordination and collaboration in meeting the needs of youth, and support development and expansion of innovative community-based youth development programs that have demonstrated success in preventing or reducing youth crime, such as programs for the establishment of violence-free zones that would involve youth development and intervention models (such as models involving youth mediation, youth mentoring, life skills training, job creation, and entrepreneurship programs); and after-school child care programs; and

(c) To make more effective use of, and to coordinate with, other programs (including State welfare reform efforts); ['676(b)(1)]

(2) To describe how the State intends to use discretionary funds made available from the remainder of the grant or allotment described in section 675C(b) of the Act in accordance with the Community Services Block Grant Program, including a description of how the State will support innovative community and neighborhood-based initiatives related to the purposes of the Community Services Block Grant Program; ['676(b)(2)]

(3) To provide information provided by eligible entities in the State, including:

(a) a description of the service delivery system, for services provided or coordinated with funds made available through grants made under section 675C(a) of the Act, targeted to low-income individuals and families in communities within the State;

(b) a description of how linkages will be developed to fill identified gaps in services, through the provision of information, referrals, case management, and follow-up consultations;

(c) a description of how funds made available through grants made under section 675C(a) will be coordinated with other public and private resources; and

(d) a description of how local entities will use the funds to support innovative community and neighborhood-based initiatives related to the purposes of the Community Services Block Grant, which may include

fatherhood initiatives and other initiatives with the goal of strengthening families and encouraging effective parenting. ['676(b)(3)

(4) To ensure that eligible entities in the State will provide, on an emergency basis, for the provision of such supplies and services, nutritious foods, and related services, as may be necessary to counteract conditions of starvation and malnutrition among low-income individuals. ['676(b)(4)]

(5) That the State and eligible entities in the State will coordinate, and establish linkages between, governmental and other social services programs to assure the effective delivery of such services to low-income individuals and to avoid duplication of such services, and the State and the eligible entities will coordinate the provision of employment and training activities in the State and in communities with entities providing activities through statewide and local workforce investment systems under the Workforce Investment Act of 1998. ['676(b)(5)]

(6) To ensure coordination between antipoverty programs in each community in the State, and ensure, where appropriate, that emergency energy crisis intervention programs under title XXVI (relating to low-income home energy assistance) are conducted in such communities. ['676(b)(6)]

(7) To permit and cooperate with Federal investigations undertaken in accordance with section 678D of the Act. ['676(b)(7)]

(8) That any eligible entity in the State that received funding in the previous fiscal year through a community services block grant under the Community Services Block Grant Program will not have its funding terminated under this subtitle, or reduced below the proportional share of funding the entity received in the previous fiscal year unless, after providing notice and an opportunity for a hearing on the record, the State determines that cause exists for such termination or such reduction, subject to review by the Secretary as provided in section 678C(b) of the Act. ['676(b)(8)]

(9) That the State and eligible entities in the State will, to the maximum extent possible, coordinate programs with and form partnerships with other organizations serving low-income residents of the communities and members of the groups served by the State, including religious organizations, charitable groups, and community organizations. ['676(b)(9)]

(10) To require each eligible entity in the State to establish procedures under which a low-income individual, community organization, or religious organization, or representative of low-income individuals that considers its organization, or low-income individuals, to be inadequately represented on the board (or other mechanism) of the eligible entity to petition for adequate representation. ['676(b)(10)]

(11) To secure from each eligible entity in the State, as a condition to receipt of funding, a community action plan (which shall be submitted to the Secretary, at the request of the Secretary, with the State plan) that includes a community-needs assessment for the community served, which may be coordinated with community-needs assessment conducted for other programs. ['676(b)(11)]

(12) That the State and all eligible entities in the State will, not later than fiscal Year 2001, participate in the Results Oriented Management and Accountability System, another performance measure system for which the Secretary facilitated development pursuant to Section 678E(b) of the Act. ['676(b)(12)]

(13) To provide information describing how the State will carry out these assurances. ['676(b)(13)]

B. Administrative Assurances

The State further agrees to the following, as required under the Act:

(1) To submit an application to the Secretary containing information and provisions that describe the programs for which assistance is sought under the Community Services Block Grant Program that is prepared in accordance with and containing the information described in Section 676 of the Act. ['675A(b)]

(2) To use not less than 90 percent of the funds made available to the State by the Secretary under Section 675A or 675B of the Act to make grants to eligible entities for the stated purposes of the Community Services Block Grant Program and to make such funds available to eligible entities for obligation during the fiscal year and the succeeding fiscal year, subject to provisions regarding recapture and redistribution of unobligated funds outlined below. ['675C(a)(1) and (2)]

(3) In the event that the State elects to recapture and redistribute funds to an eligible entity through a grant made under Section 675C(a)(1) when unobligated funds exceed 20 percent of the amount so distributed to such eligible entity for such fiscal year, the State agrees to redistribute recaptured funds to an eligible entity, or require the original recipient of the funds to redistribute the funds to a private, nonprofit organization, located within the community served by the original recipient of the funds, for activities consistent with the purposes of the Community Services Block Grant Program. ['675C(a)(3)]

(4) To spend no more than the greater of $55,000 or 5 percent of its grant

received under Section 675A or the State allotment received under section 675B for administrative expenses, including monitoring activities. ['675C(b)(2)]

(5) In states with a charity tax credit in effect under state law, the State agrees to comply with the requirements and limitations specified in Section 675(c) regarding use of funds for statewide activities to provide charity tax credits to qualified charities whose predominant activity is the provision of direct services within the United States to individuals and families whose annual incomes generally do not exceed 185 percent of the poverty line in order to prevent or alleviate poverty among such individuals and families. ['675(c)]

(6) That the lead agency will hold at least one hearing in the State with sufficient time and statewide distribution of notice of such hearing, to provide to the public an opportunity to comment on the proposed use and distribution of funds to be provided through the grant or allotment under Section 675A or '675B for the period covered by the State plan. ['676(a)(2)(B)]

(7) That the chief executive officer of the State will designate an appropriate State agency for purposes of carrying out State Community Services Block Grant Program activities. ['676(a)(1)]

(8) To hold as least one legislative hearing every three years in conjunction with the development of the State plan. ['676(a)(3)]

(9) To make available for the public inspection each plan or revised State plan in such a manner as will facilitate review of and comment on the plan. ['676(e)(2)]

(10) To conduct the following reviews of eligible entities:

(a) a full onsite review of each such entity at least once during each three-year period;

(b) an onsite review of each newly designated entity immediately after the completion of the first year in which such entity receives funds through the Community Service Block Grant Program;

(c) follow-up reviews including prompt return visits to eligible entities, and their programs, that fail to meet the goals, standards, and requirements established by the State;

(d) other reviews as appropriate, including reviews of entities with programs that have had other Federal, State or local grants (other than assistance provided under the Community Services Block Grant Program) terminated for cause. ['678B(a)]

(11) In the event that the State determines that an eligible entity fails to comply with the terms of an agreement or the State plan, to provide services under the Community Services Block Grant Program or to meet appropriate standards, goals, and other requirements established by the State (including performance objectives) the State will comply with the requirements outlined in Section 678C of the Act, to:

(a) inform the entity of the deficiency to be corrected;

(b) require the entity to correct the deficiency;

(c) offer training and technical assistance as appropriate to help correct the deficiency, and submit to the Secretary a report describing the training and technical assistance offered or stating the reasons for determining that training and technical assistance are not appropriate;

(d) at the discretion of the State, offer the eligible entity an opportunity to develop and implement, within 60 days after being informed of the deficiency, a quality improvement plan and to either approve the proposed plan or specify reasons why the proposed plan cannot be approved;

(e) after providing adequate notice and an opportunity for a hearing, initiate proceedings to terminate the designation of or reduce the funding to the eligible entity unless the entity corrects the deficiency. ['678(C)(a)]

(12) To establish fiscal controls, procedures, audits and inspections, as required under Sections 678D(a)(1) and 678D(a)(2) of the Act.

(13) To repay to the United States amounts found not to have been expended in accordance with the Act, or the Secretary may offset such amounts against any other amount to which the State is or may become entitled under the Community Services Block Grant Program. ['678D(a)(3)]

(14) To participate, by October 1, 2001, and ensure that all-eligible entities in the State participate in the Results-Oriented Management and Accountability (ROMA) System. ['678E(a)(1)]

(15) To prepare and submit to the Secretary an annual report on the measured performance of the State and its eligible entities, as described under '678E(a)(2) of the Act.

(16) To comply with the prohibition against use of Community Services Block Grant funds for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than low-cost residential

weatherization or other energy-related home repairs) of any building or other facility, as described in Section 678F(a) of the Act.

(17) To ensure that programs assisted by Community Services Block Grant funds shall not be carried out in a manner involving the use of program funds, the provisions of services, or the employment or assignment of personnel in a manner supporting or resulting in the identification of such programs with any partisan or nonpartisan political activity or any political activity associated with a candidate, or contending faction or group, in an election for public or party office; any activity to provide voter or prospective voters with transportation to the polls or similar assistance with any such election, or any voter registration activity. ['678F(b)]

(18) To ensure that no person shall, on the basis of race, color, national origin or sex be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with Community Services Block Grant Program funds. Any prohibition against discrimination on the basis of age under the Age Discrimination Act of 1975 (42 U.S.C 6101 et seq.) or with respect to an otherwise qualified individual with a disability as provided in Section 504 of the Rehabilitation Act of 1973 (29 U.S.C 12131 et seq.) shall also apply to any such program or activity. ['678F(c)]

(19) To consider religious organizations on the same basis as other non-governmental organizations to provide assistance under the program so long as the program is implemented in a manner consistent with the Establishment Clause of the first amendment to the Constitution; not to discriminate against an organization that provides assistance under, or applies to provide assistance under the Community Services Block Grant Program on the basis that the organization has a religious character, and not to require a religious organization to alter its form of internal government except as provided under Section 678B or to remove religious art, icons, scripture or other symbols in order to provide assistance under the Community Services Block Grant Program. ['679]

C. Other Administrative Certifications

The State also certifies the following:

(1) To provide assurances that cost and accounting standards of the Office of Management and Budget (OMB Circular A-110 and A-122) shall apply to a recipient of Community Services Block Grant Program funds.

(2) To comply with the requirements of Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly or the

provision of health, day care, education, or library services to children under the age of 18 if the services are funded by a Federal grant, contract, loan or loan guarantee. The State further agrees that it will require the language of this certification be included in any sub-awards, which contain provisions for children's services and that all sub-grantees shall certify accordingly.

NAME OF APPLICANT	PR/AWARD NUMBER AND/OR PROJECT NAME
N.C. Department of Health and Human Services	Community Services Block Grant Program
PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE	
Aldona Z. Wos, M.D., NC DHHS Secretary	
SIGNATURE	DATE
X	

V. The Narrative State Plan

A. Administrative Structure

(1) State Administrative Agency

(a) The mission of the North Carolina Department of Health and Human Services, Division of Social Service's Office of Economic Opportunity is to administer grant programs that provide opportunities for low-income individuals and families to become self-sufficient through the provision of financial resources to Community Action Agencies, and Limited Purposes Agencies, for programs that will substantially reduce the number of citizens in our state who are living in poverty. The responsibilities of the Office of Economic Opportunity are to plan and administer the Community Services Block Grant Program in conformance with federal and state regulations; to provide a broad range of technical assistance and training to the staff and governing bodies of grant recipients; and to give priority to mobilization and coordination of anti-poverty resources at the state level.

(b) The goals and objectives of the Office of Economic Opportunity are to:

(i) Increase the number of families attaining economic self-sufficiency (income above the poverty level based on household size).

(ii) Improve the administrative efficiency of the Office through staff training and development and integration of the use of automation technology in all aspects of office operations.

(iii) Build grantee and community capacity to plan, develop and deliver services.

(iv) Develop partnerships and collaborate with Departmental Divisions, other state agencies, public and private human service organizations to promote more effective utilization of existing resources.

(v) Ensure results-based performance management through monitoring, assessment and evaluation standards

(vi) Identify and pursue funding from public and private sources to improve and enhance programs operated by local grantees.

(2) Eligible Entities: (reference the list provided on the next two pages)

FISCAL YEARS 2014 AND 2015 COMMUNITY SERVICES BLOCK GRANT PROGRAM
LISTING OF ELIGIBLE ENTITIES AND GEOGRAPHIC AREAS SERVED

Alamance County Community Services, Inc.
Alamance County

Blue Ridge Community Action, Inc.
Burke, Caldwell and Rutherford Counties

Blue Ridge Opportunity Commission, Inc.
Alleghany, Ashe, and Wilkes Counties

Catawba County Social Services
Catawba County

Charlotte Area Fund, Inc.
Mecklenburg County

Choanoke Area Development Association, Inc.
Hertford, Bertie, Halifax, and Northampton Counties

Coastal Community Action, Inc.
Carteret, Craven, Jones and Pamlico Counties

Community Action Opportunities, Inc.
Madison, Buncombe and McDowell Counties

Cumberland Community Action Program, Inc.
Cumberland and Sampson Counties

Davidson County Community Action, Inc.
Davidson County

Eastern Carolina Human Services Agency, Inc.
Onslow, Duplin and New Hanover Counties

Economic Improvement Council, Inc.
Camden, Chowan, Currituck, Dare, Gates, Hyde, Pasquotank, Perquimans, Tyrrell and Washington Counties

Experiment in Self-Reliance, Inc.
Forsyth County

Iredell Community Action Research and Evaluation, Inc.
Alexander and Iredell and Counties

Johnston-Lee-Harnett Community Action, Inc.
Johnston, Lee and Harnett Counties

Joint Orange-Chatham Community Action, Inc.
Orange, Chatham and Randolph Counties

Macon Program For Progress, Inc.
Macon County

Martin Community Action, Inc.
Beaufort, Martin and Pitt Counties

Mountain Projects, Inc.
Haywood and Jackson Counties

Nash Edgecombe Economic Development, Inc.
Edgecombe, Nash, and Wilson Counties

Operation Breakthrough, Inc.
Durham County

Passage Home
Wake County

Salisbury-Rowan Community Action, Inc.
Cabarrus and Rowan Counties

Sandhills Community Action Program, Inc.
Anson, Montgomery, Moore and Richmond Counties

Union County Community Action, Inc.
Union County

W.A.M.Y. Community Action, Inc.
Watauga, Avery, Mitchell, and Yancey Counties

Four-County Community Services, Inc.
Bladen, Brunswick, Hoke, Robeson, Columbus, Pender, and Scotland Counties

Four Square Community Action, Inc.
Cherokee, Clay, Graham, and Swain Counties

Franklin-Vance-Warren Opportunity, Inc.
Franklin, Granville, Vance and Warren Counties

Gaston Community Action, Inc.
Cleveland, Gaston, Lincoln and Stanly Counties

Greene Lamp, Inc.
Greene and Lenoir Counties

Wayne Action Group For Economic Solvency, Inc.
Wayne County

Welfare Reform Liaison Project, Inc.
Guilford County

Western Carolina Community Action, Inc.
Henderson, Transylvania and Polk Counties

Yadkin Valley Economic Development District, Inc.
Davie, Stokes, Surry, and Yadkin Counties

See also Appendices for state map.

(3) Distribution and Allocation of Funds

A. Planned Distribution of Funds for Fiscal Years 2014 and 2015

Distribution Category	% Distribution	FY 2014 ALLOCATION	FY 2015 PROJECTED ALLOCATION
Eligible Entities	90%	$22,402,724	$14,922,404
Limited Purpose Agencies/ Discretionary	5%	$1,244,596	$829,023
State Administration	5%	$1,244,596	$829,023
Total	100%	$ 24,891,916	$16,580,450

B. Description of Criteria and Distribution Formula

FY 2014 and 2015 CSBG Programs will be allocated as follows:

(1) Ninety percent of the funds allocated to North Carolina under the Community Services Block Grant Program will be distributed to eligible entities as described in the Act as follows:

(a) Funds shall be allocated based on the ratio (percentage of poverty) in the county or counties served by the eligible agency as compared to the number of persons in poverty in the total area (counties served by all eligible agencies). Starting State Fiscal Years 2014 and 2015, North Carolina will utilize the most current U.S. Census Small Area Income Poverty Estimates (SAIPE) as the source for documenting the number of persons in poverty. In prior years, the Decennial Census was utilized; however, the Decennial Census no longer provides

county level poverty estimates. Utilizing SAIPE will allow the state administering office and local agencies to be more timely in acknowledging and responding to the changing demographics across North Carolina.

(b) However, no eligible agency shall receive less than:

i) An allocation of one hundred twenty thousand dollars, or

ii) Eighty percent of the eligible agency's Federal Fiscal Year 1982 allocation whichever is higher.

(2) Five percent of the funds will be used by the Office for administration of the CSBG Program.

(3) The remaining five percent of the funds will be used to make grants to Limited Purpose Agencies who were funded by the Community Services Administration in Federal Fiscal Year 1981 for the purpose of operating projects for a specific target population, such as American Indian, or for a specific program area, such as housing and which were funded by the Office in Fiscal Year 1982 to carry out similar specific and limited projects. Pending exploration of modifications to the North Carolina Administrative Code, these funds may be awarded to other agencies that address the effects and causes of poverty in North Carolina.

**Note: In accordance with provisions of the Act, the state allows funds unexpended by an eligible entity at the end of a fiscal year to remain available for use by that entity for an additional period of one year. In order to expend funds remaining from a previous year, an eligible entity is required to submit for the State's review, an audit of the prior year's expenditures along with a request detailing the planned use of the unexpended funds.

C. Description of Distribution and Use of Restricted Funds (planned for FY 2014 and FY 2015). **Note: This is subject to change based on sequestration and federal budget authorization.

GRANTEE	FY 2014 ALLOCATION	FY 2015 PROJECTED ALLOCATION	SERVICES/ PROJECTS
Alamance County Community Services Agency, Inc.	$325,411	$235,500	Self-Sufficiency
Blue Ridge Community Action, Inc.	$597,081	$431,516	Self-Sufficiency Information and Referral (Linkages)
Blue Ridge Opportunity Commission, Inc.	$292,594	$213,718	Self-Sufficiency Emergency Assistance
Catawba County Social Services	$285,613	$195,129	Youth Education
Charlotte Area Fund, Inc.	$1,618,236	$1,411,495	Self-Sufficiency Nutrition
Choanoke Area Development Association, Inc.	$548,270	$272,351	Self-Sufficiency
Coastal Community Action, Inc.	$462,067	$274,702	Self-Sufficiency
Community Action Opportunities, Inc.	$724,313	$492,259	Self-Sufficiency
Cumberland Community Action Program, Inc.	$1,133,889	$664,001	Self-Sufficiency
Davidson County Community Action, Inc.	$324,093	$209,896	Self-Sufficiency
Eastern Carolina Human Services Agency, Inc. * additional $655,547 planned for future contracting due to New Hanover County Designation December 22, 2013	$570,983	$644,648	Self-Sufficiency
Economic Improvement Council, Inc.	$462,123	$255,170	Self-Sufficiency
Experiment in Self-Reliance, Inc.	$760,046	$570,690	Self-Sufficiency
Four-County Community Services	$1,614,709	$974,301	Self-Sufficiency
Four Square Community Action, Inc.	$187,135	$120,000	Information & Referral (Linkages)
Franklin-Vance-Warren Opportunity, Inc.	$504,476	$307,551	Self-Sufficiency
Gaston Community Action, Inc.	$1,024,606	$658,990	Self-Sufficiency
Greene Lamp, Inc.	$287,835	$176,060	Self-Sufficiency
Iredell Community Action Research and Evaluation, Inc.	$334,697	$248,831	Self-Sufficiency
Johnston-Lee-Harnett Community Action, Inc.	$788,479	$523,932	Self-Sufficiency
Joint Orange-Chatham Community Action, Inc.	$745,946	$456,951	Self-Sufficiency
Macon Program for Progress, Inc.	$140,099	$120,000	Self-Sufficiency
Martin Community Action, Inc.	$866,201	$510,015	Self-Sufficiency
Mountain Projects, Inc.	$244,837	$161,399	Information & Referral (Linkages)
Nash-Edgecombe Economic Development, Inc.	$769,699	$463,356	Self-Sufficiency
Operation Breakthrough, Inc.	$780,751	$457,564	Self-Sufficiency
Passage Home	$1,145,354	$936,832	Self-Sufficiency & Youth

Salisbury-Rowan Community Action Agency,	$538,160	$431,409	Self-Sufficiency
ıdhills Community Action Program, Inc.	$561,757	$338,142	Self-Sufficiency
Union County Community Action, Inc.	$237,014	$191,049	Self-Sufficiency
W.A.M.Y Community Action, Inc.	$307,153	$191,341	Self-Sufficiency
Wayne Action Group for Economic Solvency, Inc.	$343,513	$233,806	Self-Sufficiency
Welfare Reform Liaison Project	$1,073,327	$803,530	Self-Sufficiency/ Employment
Western Carolina Community Action, Inc.	$293,841	$201,301	Self-Sufficiency
Yadkin Valley Economic Development District, Inc.	$437,015	$306,861	Self-Sufficiency
Undesignated Counties			Designation Pending
Caswell	$71,419	$38,758	TBD
Person	$95,226	$62,899	TBD
Rockingham	$249,144	$136,451	TBD
Total	$22,402,724	$14,922,404	

D. Description of Distribution and Use of Discretionary Funds
**Note: This is subject to change based on sequestration and federal budget authorization. The North Carolina Administrative Code is under review for updates/ revisions related to the use of discretionary funding.

Five percent of the CSBG Program allocation will be used to fund four Limited Purpose Agencies as shown in the following table or may be awarded to agencies that address the effects and causes of poverty pending modifications to the North Carolina Administrative Code.

GRANTEE	FY 2014 ALLOCATION	FY 2015 PROJECTED ALLOCATION	SERVICES/PROJECTS
Telamon, Inc.	$158,633	$105,665	Education: provides services to assist youth of migrant and seasonal farmworkers ages 16-24 with remaining in high school or attaining their General Education Diploma (GED).
The Affordable Housing Group of North Carolina	$190,423	$126,840	Housing: provides technical assistance to community-based organizations for the purpose of developing or restoring safe/ affordable housing. Provides Housing Counseling to community-based organizations.
Western Economic Development Organization	$119,481	$79,586	Employment: provides marketing services to increase the income of residential substance abuse program participants.
North Carolina Commission of Indian Affairs	$53,264	$35,479	Education: provides services to low-income American Indian students to assist them with remaining in college and maintaining a minimum Grade Point Average (GPA) of 2.0.
Discretionary	$722,795	$481,452	NC Administrative Code review needed to determine specific use of funds.
Total	$1,244,596	$829,023	

E. Description of Use of Administrative Funds

Five percent of the FY 2014 and 2015 CSBG Program allocation will be used for administration. No CSBG Program funds will be used for the Charity Tax Credit Program.

FY 2014 and 2015 Proposed Administrative Funds Usage
**Note: This is subject to change based on sequestration and federal budget authorization.

DISTRIBUTION	FY 2014 ALLOCATION	FY 2015 PROJECTED/ ALLOCATION
State Office Administration- funds used by the N.C. Department of Health and Human Services – Division of Social Services Office of Economic Opportunity to provide whole-health agency monitoring and training/technical assistance to program grantees to ensure compliance with federal rules and regulations and department level support for the coordination of integrated service delivery for anti-poverty and human service programs.	$1,244,596	$829,023
Total	$1,244,596	$829,023

F. State Community Services Program Implementation

(1) Program Overview

(a) The Service Delivery System:

The CSBG Program service delivery system is currently composed of thirty-five CAAs, and four LPAs. Thirty-four of the CAAs are private non-profit organizations and one is a public agency. This service delivery system is being expanded though the designation process for the three North Carolina counties (Caswell, Person and Rockingham) not presently receiving CSBG funding and New Hanover County due to the previous designee relinquishing the CSBG designation. The four LPAs were recipients of funding from the Community Service Administration in FFY 1981and provide services to a specific population or in a specific service category.

In an effort to assure that the voice of low-income persons is heard, the tripartite board structure has a sector that is designated for low-income representation and active engagement in all CAAs (eligible entities). The unique board composition offers opportunity for the low-income population to participate in the oversight, development and evaluation of agency programs.

Most CAAs implement a comprehensive service delivery system to assist individuals and families with moving from poverty to economic independence. These agencies provide an array of services to families within their agency or in partnership with other human service agencies. Head Start, Workforce Investment Act, Weatherization and Section 8 Rental Assistance are among the federal programs operated by most North Carolina CAAs. North Carolina CAAs also operate federal/state funded projects inclusive of but not limited to employment, nutrition, youth development, senior services and housing. Multi-county CAAs operate with a central office and neighborhood centers located throughout the service area. Many agencies work closely with community organizations and neighborhood groups to achieve effective outreach and to stimulate involvement in local affairs.

In-keeping with the National Results Oriented Management and Accountability (ROMA) goals and best practices, North Carolina encourages CSBG grantees to embrace and execute a Self-Sufficiency (comprehensive case management) concept to better mobilize CSBG funding for direct service provision to low-income families while also leveraging these dollars with other agency and community resources. While this approach in some regards is vastly different from the way other states

administer CSBG, North Carolina believes it affords us a methodology to demonstrate 1) CSBG's effectiveness of changing people's lives by moving them from poverty based on 100% of the Federal Poverty Guidelines to economic stability and into independence, 2) allows us to scale participants' progress from In-Crisis to Thriving to demonstrate CSBG's incremental effectiveness, 3) provides subgrantee agencies with an effective framework for creating meaningful collaborations, producing optimal partnerships and generating additional funding to further the agencies goals for CSBG in response to identified poverty problems within their communities and 4) permits the usage of CSBG for direct services provision to participants not for administrative purposes only. Although this is currently the preferred approach in North Carolina, it should be noted that in addition to Self-Sufficiency, North Carolina's sub-grantee agencies have the flexibility to administer Employment, Housing, Education, Nutrition, Emergency Assistance, Information and Referral and Income Management projects with CSBG funding. Since the early 2000's, it has been North Carolina's philosophy that all eligible projects and CSBG funding uses could be best coordinated within the Self-Sufficiency framework to better address and alleviate the causes of poverty.

(b) Linkages

Strategies utilized to develop linkages to fill identified gaps in services by local entities include:

- participation on local human service councils where representatives from human service agencies meet regularly to identify solutions to specific problems being experienced by low-income families,
- cross referrals between partners in local Job Link Centers,
- the pursuit of funding from public and private agencies (state government, local government, United Ways, foundations, corporations),
- recruitment of volunteers from faith-based organizations, correctional institutions, high schools, and colleges, and
- participation in county-wide electronic data sharing networks.

(c) Coordination with Other Public and Private Resources

A major component of the strategic plan completed by all grantees is the resource analysis, which identifies all public and private community resources that are available to solve an identified poverty problem. Agencies responsible for these resources are identified partners in the grantees' plan for action on the identified poverty problem and coordination activities are identified and listed in the agency work plan.

(d) Innovative Community and Neighborhood-based Initiatives

Strategies local grantees use to foster innovative community and neighborhood-based initiatives often inclusive of fatherhood initiatives with the goal of strengthening families and encouraging effective parenting are:

- collaborative efforts with Head Start programs,
- the provision of small seed grants to community and neighborhood groups for special projects,
- providing funding for consultant/training on special topics in target neighborhoods,
- providing funds for community residents to attend workshops, conferences or training on selected topics.
- North Carolina recognizes the increased focus on innovative practices as it relates to performance efficiencies and will encourage additional innovative approaches as specifically as state and federal guidance becomes available relative to discretionary funding.

(2) Community Needs Assessments:

As a part of North Carolina's CSBG funding application, each eligible entity is required to submit a Community Anti-Poverty Plan. The plan must include a community needs assessment for the counties served which may be coordinated with community needs assessments conducted by other sources.

(3) Tripartite Boards

North Carolina Administrative Rules require that:

(a) Each eligible private grant recipient must have a board of directors consisting of at least 15 members and not more than 51 members.

(b) The board of directors of private grant recipients shall be constituted so as to assure that:

(i) one-third of the members of the board are elected public officials, holding office on the date of selection, or their representatives, except that if the number of such elected officials reasonably available and willing to serve is less than one-third of the membership of the board, membership on the board of appointive public officials or their representatives may be counted in meeting such one-third requirement;

(ii) not fewer than one-third of the members are persons chosen in accordance with democratic selection procedures adequate to assure that they are representative of low-income individuals and families in the neighborhood served; reside in the neighborhood served; and are able to participate actively in the development, planning, implementation, and evaluation of the program to serve low-income communities; and

(iii) the remainder of the members are officials or members of business, industry, labor, religious, law enforcement, education, or other major groups and interests in the community served.

(c) All committees of the board of directors of private grant recipients shall fairly reflect the composition of the board.

(d) Each eligible public organization must administer the program through:

(i) a tripartite board, which shall have members selected by the organization and shall be composed so as to assure that not fewer than 1/3 of the members are persons chosen in accordance with democratic selection procedures adequate to assure that these members:

(a) are representative of low-income individuals and families in the neighborhood served;

(b) reside in the neighborhood served; and

(c) are able to participate actively in the development, planning, implementation, and evaluation of programs funded under this subtitle; or

(ii) another mechanism specified by the State to assure decision making and participation by low-income individuals in the development, planning, implementation, and evaluation of programs funded.

North Carolina's administering agency monitors board requirements by collecting board membership/composition rosters, inclusive of committees, during the annual application process. Board member profiles sheets are submitted to the Office as new members are seated. The process by which members are selected as well as engaged is assessed through review of board minutes and board member files during onsite and desktop monitoring. Attempts are made to meet with board members during onsite monitoring visits or when requested. In addition, North

Carolina requests and encourages board members to attend the annual Contractors' Training Conference which includes specific workshops and training sessions for Boards/Administration.

(4) State Charity Tax Program:

Provisions of the State Charity Tax Program are not applicable to the North Carolina Community Services Block Grant Program.

G. Programmatic Assurances

(1) The administering agency assures that CSBG funds will be used:

(a) To support activities that are designed to assist low-income families and individuals, including families and individuals receiving assistance under part A of title IV of the Social Security Act (42 U.S.C 601 et seq.), homeless families and individuals, migrant or seasonal farmworkers, and elderly low-income individuals and families to enable families and individuals to:

(i) remove obstacles and solve problems that block the achievement self-sufficiency (including self-sufficiency for families and individuals who are attempting to transition off a State program carried out under part A of title IV of the Social Security Act);

(ii) secure and retain meaningful employment;

(iii) attain an adequate education, with particular attention toward improving literacy skills of the low-income families in the communities involved, which may include carrying out family literacy initiatives;

(iv) make better use of available income;

(v) obtain and maintain adequate housing and a suitable living environment;

(vi) obtain emergency assistance through loans, grants, or other means to meet immediate and urgent family and individual needs, and

(vii) achieve greater participation in the affairs of the communities involved, including the development of public and private grassroots partnerships with local law enforcement agencies, local housing authorities, private foundations, and other public

and private partners to document best practices based on successful grassroots intervention in urban areas, to develop methodologies for widespread replication; and strengthen and improve relationships with local law enforcement agencies, which may include participation in activities such as neighborhood or community policing efforts.

(b) To address the needs of youth in low-income communities through youth development programs that support the primary role of the family, give priority to the prevention of youth problems and crime, and promote increased community coordination and collaboration in meeting the needs of youth, and support development and expansion of innovative community-based youth development programs that have demonstrated success in preventing or reducing youth crime, such as programs for the establishment of violence-free zones that would involve youth development and intervention models (such as models involving youth mediation, youth mentoring, life skills training, job creation, and entrepreneurship programs) and after-school child care programs; and

(c) To make more effective use of, and to coordinate with, other programs (including State welfare reform efforts).

Grantee applications for funding that meet all applicable conditions and include eligible activities such as those listed above will be approved. Applications should be developed to address the poverty conditions identified in each agency's community needs assessment. This information becomes the basis for each agency's annual or multi-year strategic plan. Grantees will be required to describe in their funding applications how they will:

(i) describe how the agency will establish linkages between governmental and other social services programs to assure the effective delivery of such services to low-income individuals, to avoid the duplication of such services and to fill identified gaps in services, through the provision of information, referrals, case management and follow-up consultations.

(ii) address the needs of youth in low-income communities through youth development programs, that support the primary role of the family, give priority to the prevention of youth problems and crime, and promote increased community coordination and collaboration in meeting the needs of youth, and support development and expansion of innovative community-based youth development programs that have demonstrated success in prevention or reducing youth crime, such as programs for the

establishment of violence-free zones that would involve youth development and intervention models (such as models involving youth mediation, youth mentoring, life skills training, job creation, and entrepreneurship programs); and after-school child care programs; and

(iii) Make more effective use of, and coordinate with, other programs (including state welfare reform efforts).

The strategic plans developed by grantees in response to their community needs assessment and resource analysis will result in the formulation of goals and objectives that involve activities listed in Section 676(b)(1) of the Act.

(2) Assurance 676(b)(4): Emergency Foods Needs

As a result of their community needs assessment grantees may select activities that will provide, on an emergency basis, for the provision of such supplies and services, nutrition foods, and related services as may be necessary to counteract conditions of starvation and malnutrition among low-income individuals. Strategies being utilized by North Carolina CSBG Program grantees to assist families with emergency food needs include the operation of regional food banks, sponsoring supplemental food programs for seniors, and coordinating/sponsoring emergency food box/voucher programs.

(3) State Assurances 676(b)(5) Coordinate and Establish Linkages

Community Services Block Grant grantees are required to include in their funding applications information that describes how they will coordinate and establish linkages between government and other social services programs to assure the effective delivery of such services to low-income individuals and to avoid duplication of such services. Current and previous year's efforts by grantees to meet coordination objectives and to reduce duplication include:

- participation on county-wide coordinating and planning councils and committees
- utilizing cross referrals among, local human service agencies; and
- participating in electronic networks for social service agencies.

North Carolina CSBG grantees actively engage in activities of the Workforce Investment Act through serving as contracted partners in the State's Job Link Centers, members of local Workforce Development Boards and operators of Job Link Centers.

(4) Assurance 676(b)(6) Anti-poverty Program Coordination

Coordination of its programs with other anti-poverty programs is required to be described in the funding application of each CSBG program grantee. Grantees are required to describe how they coordinate locally with the emergency energy crisis intervention program under Title XXVI.

(5) Assurance 676(b)(9) Coordination and Partnerships with Groups/ Organizations

CSBG Program grantees identify other organizations that they coordinate with and form partnerships with in their funding applications. Most grantees coordinate programs and form partnerships with religious organizations, charitable groups and community organizations that have representation on their Board of Directors. Applications for CSBG funds will include a description of how the grantee will coordinate and form partnerships with other organizations serving low-income residents of the community and members of the groups served by the State, including religious organizations, charitable groups, and community organizations.

The State ensures coordination of programs with and the formation of partnerships with organizations serving low-income residents including, religious organizations, charitable groups, and community organizations by encouraging their participation in State level planning and program implementation by having representatives serve on councils, committees, work groups and by providing funding to projects operated by such groups.

H. Fiscal Controls and Monitoring

(1) State Program Monitoring

Monitoring activities of the state administering agency will include reviews of eligible entities, as required under Section 676B (a) of the Act

(a) a full onsite review of each such entity at least once during each 3-year period;

(b) an onsite review of each newly designated entity immediately after the completion of the first year in which such entity receives funds through the Community Services Block Grant Program;

(c) follow-up reviews including prompt return visits to eligible entities, and their programs, that fail to meet the goals, standards, and requirement established by the State;

(d) other reviews as appropriate, including reviews of entities with programs that have had other Federal, State or local grants (other than assistance provided under the Community Services Block Grant Program) terminated for cause. Monitoring procedures for the CSBG program begin with the annual funding application processes and continue through the closeout of each grant year. Major monitoring activities include: Application Review, Risk Assessment, Monthly Expenditure Reviews, Quarterly or Semi-Annual Performance Reviews, Desk-Top Reviews and On-site Monitoring.

(e) the audit of the Community Services Block Grant Program for the period July 1, 2011 through June 30, 2012 was completed as a part of the State of North Carolina's annual audit and released by the North Carolina Office of State Auditor on April 9, 2013. The State Auditor has conducted field work for the Department of Health & Human Services annual audit for year ending June 30, 2012. The Single Audit Report is accessible at: http://www.ncauditor.net/EPSWeb/Reports/Financial/FSA-2012-8730.pdf.

(2) Corrective Action, Termination and Reduction of Funding

If the State determines, on the basis of a final decision in a review pursuant to section 678B, that an eligible entity fails to comply with the terms of an agreement, or the State Plan, to provide services under this subtitle or to meet appropriate standards, goals, and other requirements established by the State (including performance objectives), the State shall;

(a) when a sub-recipient has areas of non-compliance and/or deficiencies, a Corrective Action Plan will be required.

(b) The process for corrective actions includes:

(i) Identification of deficiencies through monitoring;
(ii) Inform the entity of the deficiency to be corrected;
(iii) Require the entity to correct the deficiency through the development of a Corrective Action Plan;
(iv) Offer training and technical assistance as appropriate to help correct the deficiency, and submit to the Secretary a report describing the training and technical assistance offered or stating the reasons for determining that training and technical assistance are not appropriate
(v) Formal acceptance of the Sub-Recipient's Corrective Action Plan; and
(v) Follow-up to ensure Corrective Action Plan has sufficiently been implemented

(c) the requirement of the entity to correct the deficiency may include;

(i) State offers training and technical assistance, if appropriate, to help correct the deficiency, and prepare and submit to the Secretary a report describing the training and technical assistance offered; or

(ii) if the State determines that such training and technical assistance are not appropriate, prepare and submit to the Secretary a report stating the reasons for the determination;

(d) (i) at the discretion of the State (taking into account the seriousness of the deficiency and the time reasonably required to correct the deficiency), allow the entity to develop and implement, within 60 days after being informed of the deficiency, a quality improvement plan to correct such deficiency within a reasonable period of time, as determined by the State: and

(ii) not later than 30 days after receiving from an eligible entity a proposed quality improvement plan pursuant to subparagraph (A), either approve such proposed plan or specify the reasons why the proposed plan cannot be approved; and

(e) after providing adequate notice and an opportunity for a hearing, initiate proceedings to terminate the designation of or reduce the funding under this subtitle of the eligible entity unless the entity corrects the deficiency. When efforts to remedy deficiencies are unsuccessful, the administering office will implement actions as outlined in 10A NCAC 97B .1103 REMEDIES in conjunction with guidance from the Office of Community Services. The Office will also work to implement a process for interim service delivery provision when an area ceases to be served due to extended periods of funding suspension and/or termination.

(3) Fiscal Controls, Audits and Withholding:

State established procedures for fiscal control and fund accounting will be followed to assure the proper disbursal of and accounting for CSBG funds. The established procedures are monitored by the State Office of Budget and Management and funds expended are audited annually by the State Auditor's Office. Additionally, CSBG grantees are required to meet specific standards of fiscal control as part of the grant agreement, including cost and accounting standards of the Office of Management and Budget. Grantees are required to submit an annual agency audit completed in accordance with provisions of OMB circular A-133 or A-128.

The State will make appropriate books, documents, papers and records available to the Secretary of the Comptroller General of the United States, or any of their duly authorized representatives for examination, copying, or mechanical reproduction on or off the premises of the appropriate entity upon a reasonable request for the items.

(4) Assurances

(a) The Assurance 676(b)(7): Cooperation with Federal Investigations

The State will permit and cooperate with federal investigations as required. All CSBG grant agreements stipulate that grantees will make appropriate books, documents, papers and records relevant to the grant available for inspection by the State and appropriate federal officials. Further, the grantee is required to assure that its employees and agents cooperate in such efforts.

(b) The Assurance 676(b)(8): Funding Termination

N.C. Administrative Rules for CSBG require that no previously funded grantee will have its funding terminated or reduced below the proportional share of funding it received in the previous fiscal year, unless after notice, and opportunity for hearing on the record, the State determines that cause existed for termination or reduction subject to the procedures and review by the Secretary of Health and Human Services.

(c) The Assurance 676(b)(10): Petition for Representation

The bylaws of each eligible entity were reviewed prior to the initial receipt of funding to insure that procedures were in place to allow low-income individuals, community organizations, or religious organizations, or representatives of low-income individuals that consider its organization(s) or low-income individuals, to be inadequately represented on the board (or other mechanism) of the eligible entity to petition for adequate representation.

I. Accountability and Reporting Requirements

(1) Results Oriented Management and Accountability

The National Results Oriented Management and Accountability (ROMA) model was created by a task force of Federal, state, and local community action officials. The National ROMA model serves as the primary framework for training, reporting and accountability for all eligible entities in North

Carolina. All North Carolina eligible entities are afforded ongoing training to fully participate in the ROMA model.

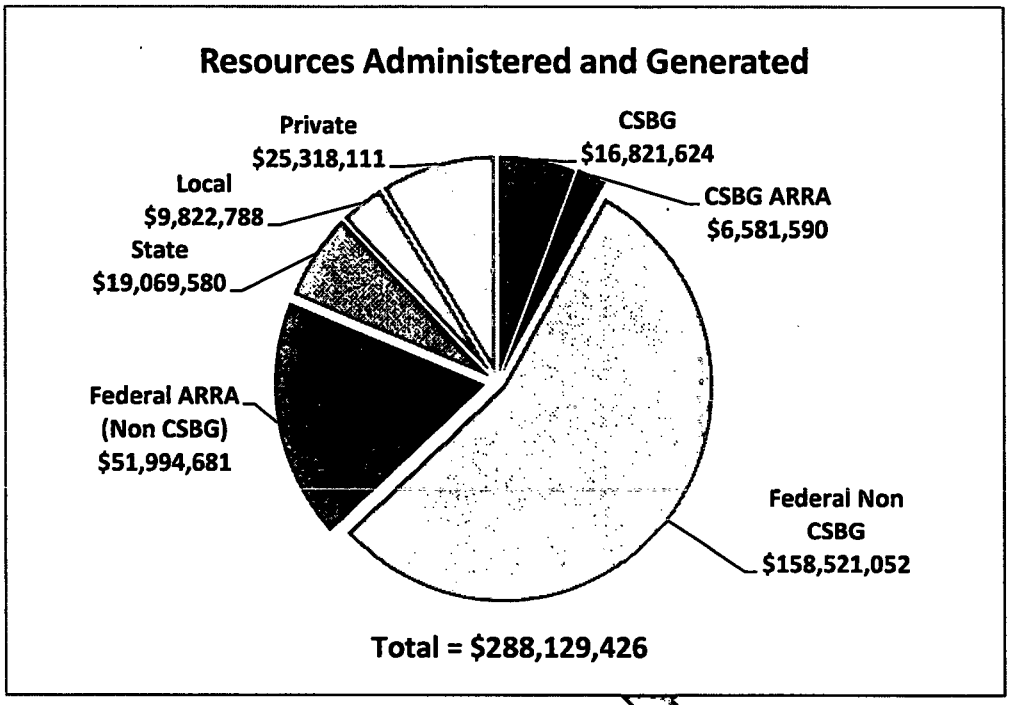
The six National Goals are:

1. Low-income people become more self-sufficient
2. The conditions in which low-income people live are improved
3. Low-income people own a stake in their community
4. Partnerships among supporters and providers of services to low-income people are achieved
5. Agencies increase their capacity to achieve results
6. Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other support systems.

(2) CSBG Annual Reporting

The Community Services Block Grant Information System (CSBG/IS) Report is a federally required report completed annually by each eligible entity and the state's administrative office. The CSBG/IS collects detailed funding and performance information. This report serves as a state and national tool to demonstrate outcomes aligned with the six National Goals and measure how eligible entities promote self-sufficiency, family stability and community revitalization. North Carolina's most recent (FY 2012) CSBG/IS was submitted to the National Association for State Community Services Programs on March 26, 2013 and is under review.

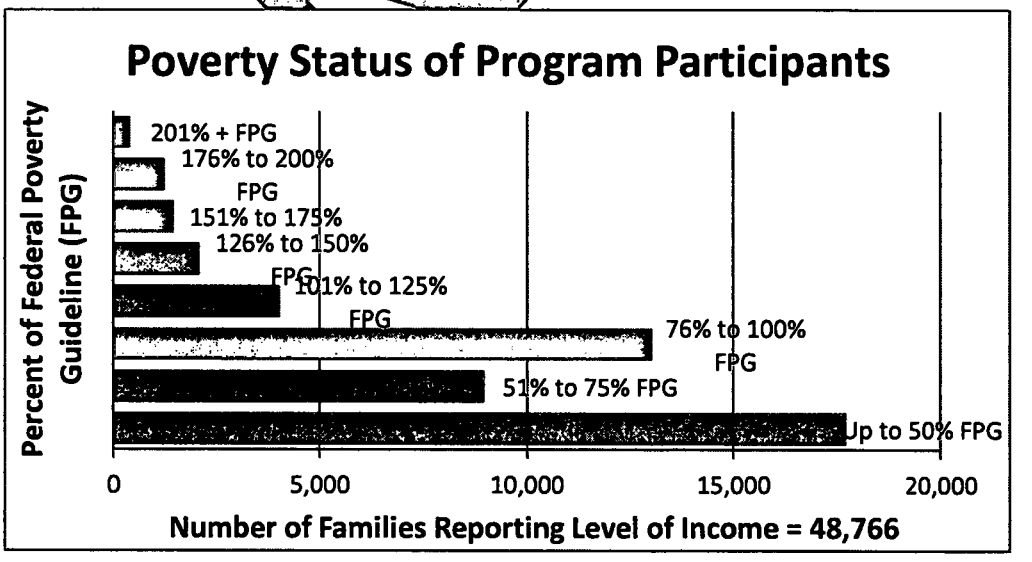
All eligible entities that received CSBG funds in FY 2011 provided information through the CSBG/IS Survey on the funding level, funding sources, uses of funding administered, program activities, the results of program activities, and the number and demographics of individuals and families served. North Carolina's eligible entities reported serving 114,033 unduplicated persons and 53,642 unduplicated families in FY 2011. Additional information related to resources, demographics of individuals/ families served, and outcomes are presented in the tables and charts below. The information presented was reported in the FY 2011 CSBG/IS submission.



Additional Resources Generated through Volunteerism

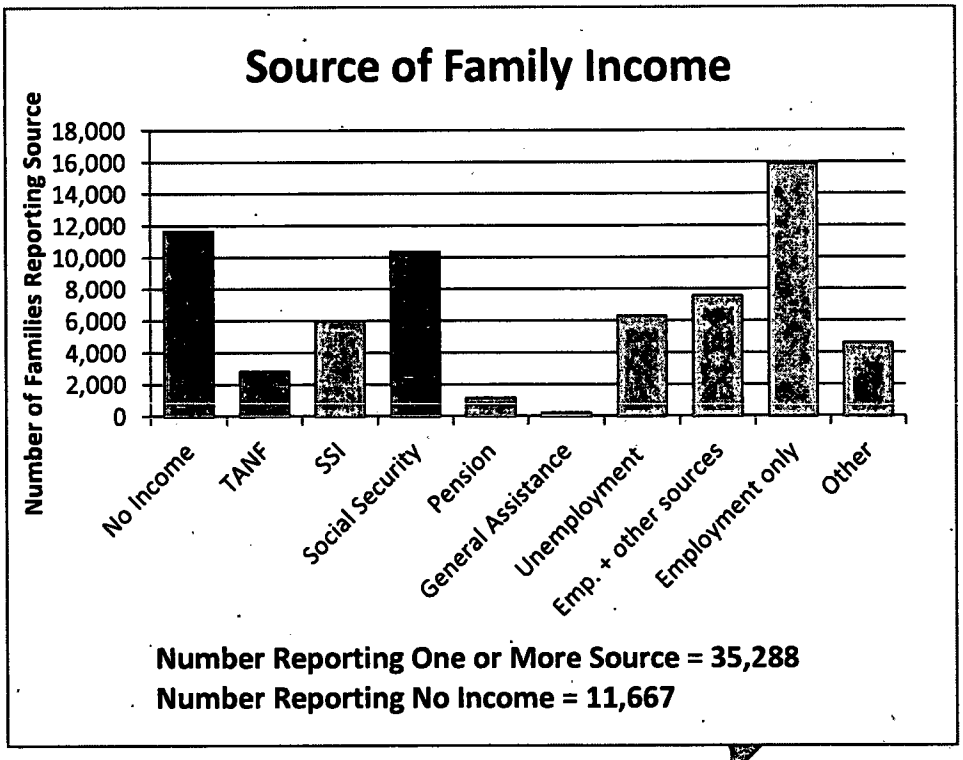
- 1,794,300 hours of services were donated to the efforts of North Carolina Community Action Agencies at a value of $13,008,675 based on the federal minimum wage level.
- 3,005 low-income individuals owned a stake in their community through participation in formal community organizations, government, boards or councils that provide input into decision-making and policy-setting though North Carolina Community Action efforts. A total of 1,542,589 hours were donated by individuals who were low-income.

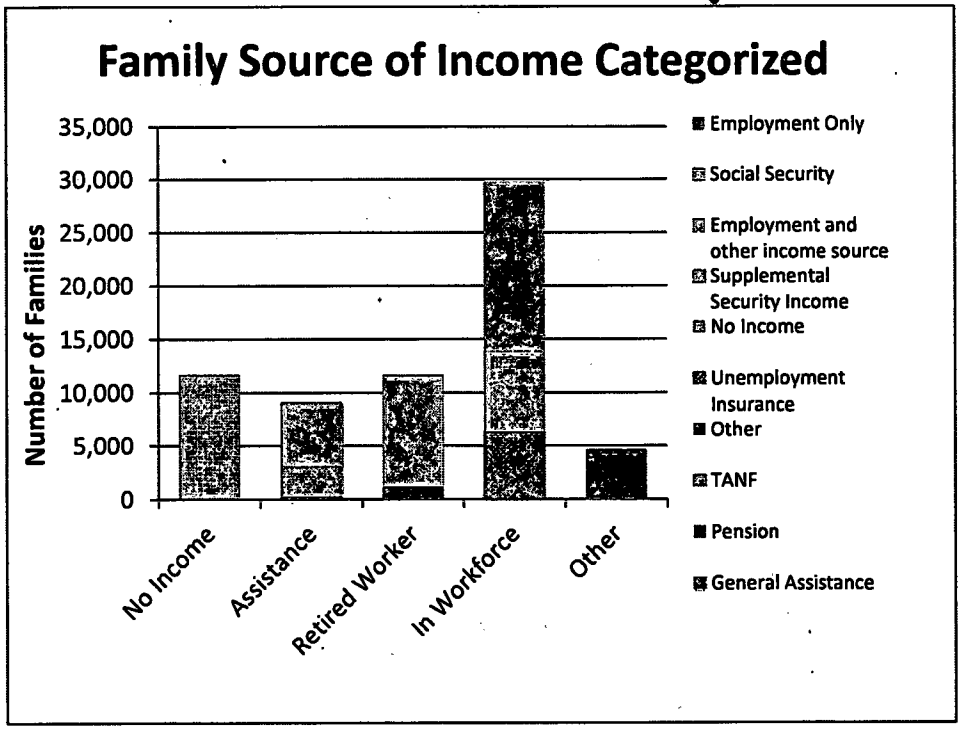
Select Demographic Information of Families and Individuals Served



- 81% of families reporting level of income were at or below 100% of the FPG.
- 36% of families reporting level of income were at or below 50% of the FPG.

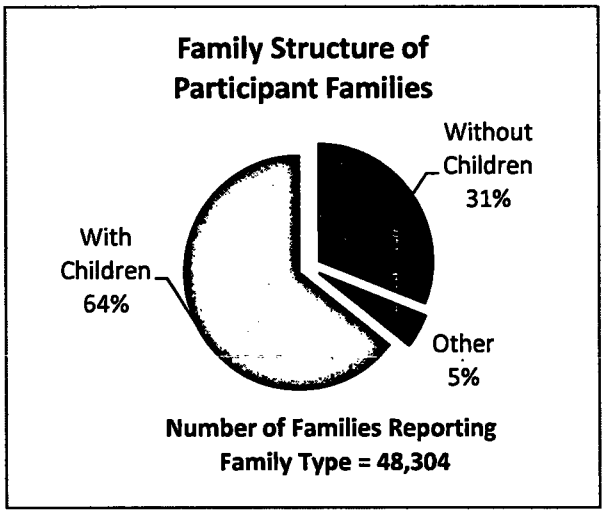
Select Demographic Information of Families and Individuals Served (Cont.)

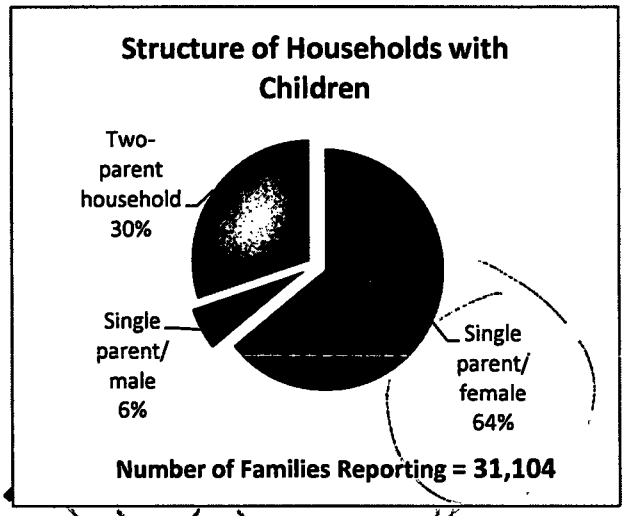


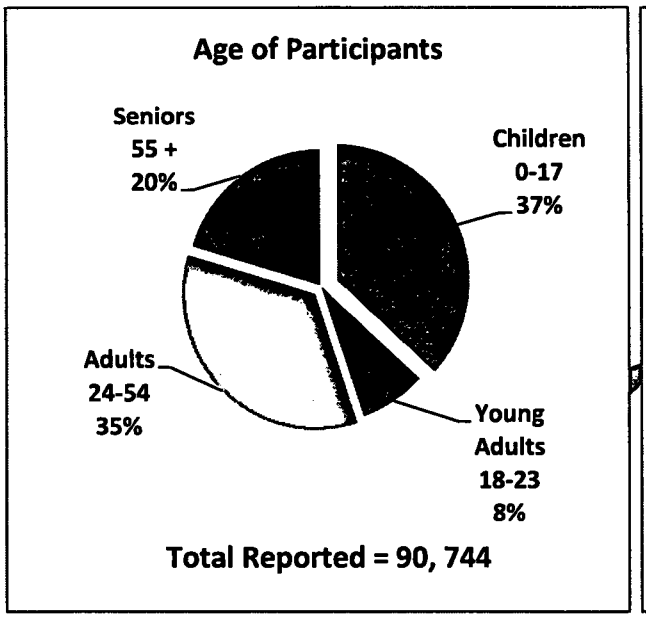


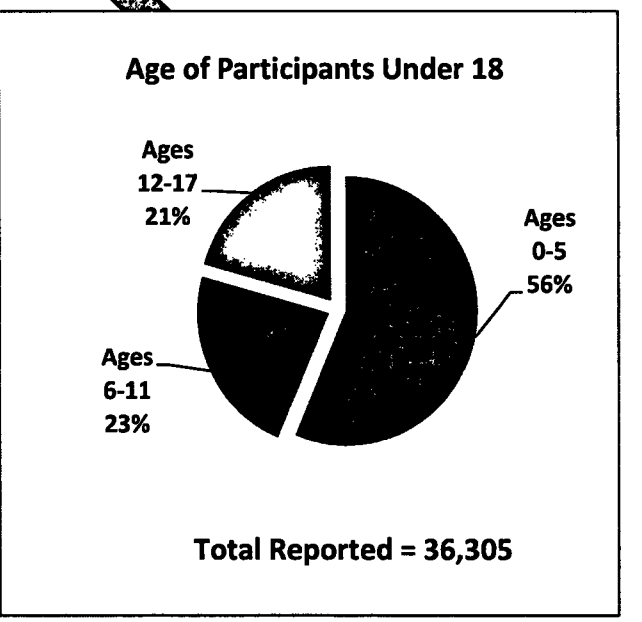
- 71.5% of those reporting an income source are in the workforce

Select Demographic Information of Families and Individuals Served (Cont.)

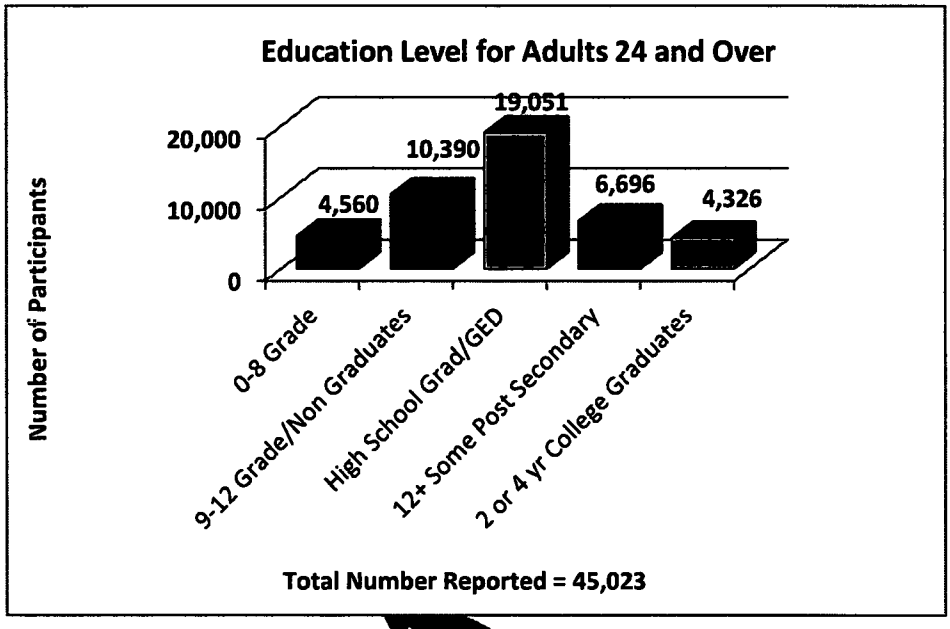








Select Demographic Information of Families and Individuals Served (Cont.)



Select National Performance Indicators

Note: *National Performance Indicators for the CSBG IS 20[illegible]cludes American Recovery and Reinvestment Act (ARRA) programming.*

National Goal 1: Low-income people become more self-sufficient.

National Performance Indicator 1.1 **Employment** The number and percentage of low-income participants in Community Action employment initiatives who get a job or become self-employed	# of Participants Achieving Outcome
Unemployed and obtained a job	2,427
Employed and obtained an increase in employment income and/or benefits	1,356

National Goal 1: Low-income people become more self-sufficient. (cont.)

National Performance Indicator 1.2 **Employment Supports** The number of low-income participants for whom barriers to initial or continuous employment are reduced or eliminated through assistance from Community Action	# of Participants Achieving Outcome
Obtained skills/competencies required for employment	2,737
Completed ABE/GED and received certificate or diploma	472
Completed post-secondary education program and obtained certificate or diploma	1,018
Enrolled children in before or afterschool programs	1,031
Obtained care for child or other dependent	4,758
Obtained access to reliable transportation and/or driver's license	3,127
Obtained health care services for themselves and/or a family member	2,881
Obtained and/or maintained safe and affordable housing	5,584
Obtained food assistance	10,490

National Performance Indicator 1.3 **Economic Asset Enhancement and Utilization** The number of low-income households that achieve an increase in financial assets and/or financial skills as a result of Community Action assistance and the aggregated amount of those assets	# of Participants Achieving Outcome	Aggregated Dollar Amounts (Payments, Credits or Savings)
Number of participants in tax preparation programs who qualified for any type of Federal or State tax credit and the expected aggregated dollar amount of credits	5,906	$3,430,379
Number of participants who obtained court-ordered child support payments and the expected annual aggregated dollar amount of payments	534	$129,518
Number of participants enrolled in telephone lifeline and/or energy discounts and the expected aggregated dollar amount of savings	973	$43,569
Number demonstrating ability to complete and maintain a budget for over 90 days	4,661	N/A
Number of participants opening who increased their savings through an Individual Development Account (IDA) or other savings account and increased savings and the aggregated amount of savings	366	$184,983

National Goal 2: The conditions in which low-income people live are improved.

National Performance Indicator 2.1 **Community Improvement and Revitalization** Increase in, or safeguarding of, threatened opportunities and community resources or services for low-income people in the community as a result of community action projects/ initiatives or advocacy with other public and private agencies, as measured by one or more of the following:	# of Opportunities and/or Community Resources Preserved or Increased
Safe and affordable housing units created in the community	853
Safe and affordable housing units in the community preserved or improved through construction, weatherization or rehabilitation achieved by Community Action activity or advocacy	4,300
Accessible safe and affordable health care services/facilities for low-income people created, or saved from reduction or elimination	3,399
Accessible new or expanded transportation resources, or those that are saved from reduction or elimination, that are available to low-income people, including public or private transportation	1,994

National Performance Indicator 2.2 **Community Quality of Life and Assets** The quality of life and assets in low-income neighborhoods are improved by community action initiative or advocacy	# of Community Assets, Services, or Facilities Preserved or Increased
Increase in the availability or preservation of community services to improve public health and safety	2,241
Increase or preservation of neighborhood quality-of-life resources	2,004

National Goal 3: Low-income people own a stake in their community.

National Performance Indicator 3.2 **Community Empowerment Through Maximum Feasible Participation** The number of low-income people mobilized as a direct result of Community Action initiatives to engage in activities that support and promote their own well-being and that of their community	Total # of Low-Income People
Number of low-income people participating in formal community organizations, government, boards or councils that provide input to decision-making and policy setting through Community Action efforts	3,005
Number of low-income people engaged in non-governance community activities or groups created or supported by Community Action	3,377

National Goal 4: Partnerships among supporters and providers of services to low-income people are achieved

National Performance Indicator 4.1 **Expanding Opportunities Through Community-Wide Partnerships**	# of Organizational Partnerships
The number of partnerships, both public and private, community action actively works with to expand resources and opportunities in order to achieve family and community outcomes	7,962

National Goal 5: Agencies increase their capacity to achieve results

National Performance Indicator 5.1 **Broadening the Resource Base** The number of human capital resources available to Community Action that increase agency capacity to achieve family and community outcomes	Resources in Agency
Number of Certified Community Action Professionals	3
Number of Nationally Certified ROMA Trainers	6
Number of Family Development Trainers	132
Number of Child Development Trainers	405
Number of Staff Members Attending Training/Hours of Staff Member Training	3,618 staff members / 165,784 training hours
Number of Board Members Attending Training/Hours of Board Member Training	546 board members / 7,201 training hours

National Goal 6: Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other supportive environments.

National Performance Indicator 6.1 **Independent Living** The number of vulnerable individuals receiving services from Community Action who maintain an independent living situation as a result of those services:	# of Vulnerable Individuals Living Independently
Senior Citizens (seniors can be reported twice, once under Senior Citizens and again if they are disabled under individuals with Disabilities 55 and over)	12,649
Individuals with Disabilities	
0-17	340
18-54	1,497
55-over	3,129
Age data not collected	204
Total number of individuals with disabilities	5,170

National Goal 6: Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other supportive environments. (cont.)

National Performance Indicator 6.2 **Emergency Assistance** The number of low-income individuals or families served by Community Action that received emergency assistance	# Receiving Assistance
Food	11,598
Fuel or utility payments funded by LIHEAP or other public and private funding sources	6,104
Rent or Mortgage Assistance	4,168
Car or Home Repair (i.e. structural, appliance, heating system, etc.)	428
Temporary Shelter	96
Medical Care	1,924
Protection from Violence	1,421
Legal Assistance	404
Transportation	1,352
Disaster Relief	24
Clothing	1,590

National Performance Indicator 6.3 **Child and Family Development** The number of all infants, children, youth, parents, and other adults participating in developmental or enrichment programs who achieve program goals	# of Participants Achieving Outcome
Infants and children obtain age-appropriate immunizations, medical, and dental care	14,432
Infant and child health and physical development are improved as a result of adequate nutrition	14,158
Children participate in pre-school activities to develop school readiness skills	13,436
Children who participate in pre-school activities are developmentally ready to enter Kindergarten or 1st Grade	7,013
Youth improve health and physical development	839
Youth improve social/emotional development	1,600
Youth avoid risk-taking behavior for a defined period of time	874
Youth have reduced involvement with criminal justice system	241
Youth increase academic, athletic, or social skills for school success	1,560
Parents and other adults learn and exhibit improved parenting skills	7,133
Parents and other adults learn and exhibit improved family functioning skills	6,930

(3) Self-Sufficiency and Accountable Results For Community Action (AR4CA)

Since the early 2000's there has been a focus on utilizing CSBG funds to implement the Self-Sufficiency (case management) program model in North Carolina. The Self-Sufficiency program model serves as a framework for responsiveness to the wide spectrum of barriers individuals may experience when living in poverty (i.e. education, employment, housing, income management, nutrition and linkages to community resources). Additionally, the program model encourages grantees to maximize CSBG's impact through direct service delivery, referrals, collaboration and leveraging community resources while also encouraging participants to take personal responsibility in identifying barriers, establishing goals and achieving economic independence.

In addition to completing the federally required CSBG/IS Report which provides information on the entire agency, grantees operating Self-Sufficiency projects utilize the AR4CA database for tracking activities and reporting outcomes specific to CSBG funds. The state administering office requires quarterly and annual reporting as an additional measure of accountability and program effectiveness specific to CSBG funds. The chart below provides outcomes reported in the AR4CA Year-End Report for SFY 2011-12 by CSBG grantees operating Self-Sufficiency programs.

Summary of Key Self-Sufficiency CSBG Project Outcomes (SFY 2011-12)

**Note: Key CSBG Project Outcomes for SFY 2011-12 are based on information reported on self-sufficiency project models only (other eligible projects' outcomes are not included in this report). The outcomes below reflect outcomes of CSBG standard only, they do not include outcomes of CSBG/ARRA funding.

The number of families participating in and/or receiving comprehensive services designed to remove them from poverty	5,745
The number of low-income families rising above the poverty level	688
The number of participants obtaining employment	830
The number of participants obtaining better employment	218
The average change in annual income	$9,487
The participant average wage rate	$9.02
The number of participants obtaining jobs with medical benefits	225
The number of participants completing education/training programs	930
The number of participants securing standard housing	297
The number of participants provided emergency assistance	990

SENATE SERGEANT-AT-ARMS

COMMITTEE: Senate Appropriations on Health + Human Services

DATE: 5/21/14 ROOM: 1027

1. Donna Blake
2. Steve Wilson
3. Ed Kesler
4. Giles Jeffreys
5. Anderson Meadows
6. _____

SENATE PAGES ATTENDING

COMMITTEE: Appropriations on Health Serv ROOM: 1027 544

DATE: 5-21 TIME: 11 AM

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!....*or else!*

Page Name	Hometown	Sponsoring Senator
1. Isaiah Roberts	Charlotte	Graham
2. Camden Diggs	Norwood	Mclaurin
3. Maggie Shafer (Maggie Shafer)	Clinton	Berger
4. Rose Tucker (Rose Tucker)	Greensboro	Robinson
5. DJ Jacobs	Durham	McKissick
6. Corbin Robinson	Spring Lake	Rabin
7. Jennifer Matthews	Winston-Salem	Parmon
8. Nick Corn IV	Rocky Mount	Newton
9.		
10.		

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

Legislative Public Hearing on the Community Services Block Grant

May 21, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Laurie McDaniel	HomeCare Mgt. Corp. 315 Willesboro Blvd. NE Ste. 2A Lenoir, NC 28645
Jennifer Moore	HomeCare Management Corp 7208 James B White Hwy N Whiteville NC 28472
Chuck Hill	RHA 984 Cloverleaf Plaza, Kannapolis, NC 28083
Glenn Barnes	NEED, Inc. 200 N. Church St. Rocky Mt., N.C. 27802
Belinda Williams	NEED, INC 200 N. Church St. Rocky Mount
Mary Davis	NEED, Inc. P.O. Box 2346 - 200 N. Church St. Rocky Mt., NC 27802
Roslyn Kee	NEED Inc. 200 N Church ST Rocky Mount, NC
Debbie Wiggins	NEED, Ins 200 N. Church St. Rocky Mount NC. 27804
Kathy Finch	603 E Nash St Wilson NC 27893
Gloria Wilson	200 N Church St Rocky Mt NC 27804
Emily Parkman	NC Alliance of YMCAs
Meredith Glickman	League of Women Voters
william Stirling	Brubaker and Associates
Ann Rodriguez	NC Council of Community Programs
Will Richardson	North Carolina League of Municipalities
Eric Gabriel	NC Provider Cncl / RHA
Kay Castillo	NASW-NC

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

Legislative Public Hearing on the Community Services Block Grant

May 21, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

Legislative Public Hearing on the Community Services Block Grant

May 21, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Melvin C. Powers	Roanoke Area Development P.O. Box 530 Rich Square, NC 27869
Brian Duncan	ICARE, Inc. 1415 Shelton Ave. Statesville, NC 28677
SHARON C. GOODSON	NC COMMUNITY ACTION ASSOC. 4428 LOUISBURG RD, STE 101 RALEIGH, NC 27616
Marlee Ray	WAGES Community Action Action 601 Royall Ave Goldsboro NC 27534
Amy Whited	NCMS
Joanna Spruill	NCAPP
Kerra Bolton	WTM
John McMillan	MF&S
Kathy Neal	CCME Cary, NC
Beth Winstead	Martin Community Action, Inc 314 E. Ray St. Williamston, NC 27892
Connie A. Newton	Martin Community Action Inc 314 E. Ray St. Williamston NC 27892
Doris ATKINSON	Visitor
Robert ATKINSON	J-L-H Comm Action Sanford, NC
Roy Moore	Martin Community Action INC. 314 E. Ray St. Williamston, N.C. 27892
Beverly Albritton	Martin Community Action, Inc. 901 Staton Rd Greenville NC 27834
Dura Rodgers	Martin Community Action 314 E. Ray St. Williamston, NC 27892

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

Legislative Public Hearing on the Community Services Block Grant

May 21, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

Legislative Public Hearing on the Community Services Block Grant

May 21, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Jan Herring	RHA Health Services 2248 Wingate Rd Fayetteville NC 28304
Sarah Bass	RHA Behavioral Health 211 S. Centennial, High Point, 27260
Grey Grays	NCAFP
Alan Briggs	NC Food Banks
Belivia Spaulding	NC DHHS
John Schmidt	ODC League of Women Voters
Carol Hammett	Alliance Behavioral Healthcare
Bob Robinson	Alliance BHC
Annaliese Dolph	DL
Yvonne Schmidt	ODC League of Women Voters
Sheryl Zerbe	Community Alternatives Charlotte, NC
Brenda Hyde Rogers	League of Women Voters - ODC Chapel Hill NC
Dee Pankey	BHA Autism Supports
Ben Coley	Higher Ed Works
Paige Worsham	NC Center for Public Policy Research
Shelton Moore	I-CARE, Inc. 1415 Shelton Ave/ PO Box 7049 Statesville NC 28687
B. Angelo Burch Sr.	Operation Breakthrough Inc 500 N Mangum St 27702 P.O. Box 1450

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

Legislative Public Hearing on the Community Services Block Grant

May 21, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Richard Anderson	RHA Howell Care Centers, Inc. 3738 Howell Day Care Rd., LaGrange, NC 28511
Amanda Honaker	Troutman Sanders
Scott Gremillion	Brody School of Medicine
Julie Barrett	Brody School of Medicine/NCAFP
Hayes Griggs	CCNC
Robin Correll	RHA Health Services, Inc.
Kandy John	RHA Howells. 1508 Gatewood Ave Greensboro, NC 27410
Sam Hedrick	RHA Howell Raleigh
Jeffrey Gallagher	Rha Howell Raleigh
Tammy Cox	Rha Howell Goldsboro
Marie Wright	I-CARE, INC
Darlene Kent	I care, Inc
Amy Howard	MCA, INC
Bridgette Dobson	MCA, INC
Carlos Scott	RHA Health Services 2527 E. Lyon Station Rd. Creedmoor NC 27522
Michelle Robertson	RHA Health Services, Inc 190 Commerce Blvd Statesville, NC 28625
Mark Ovokaitys	Brody Sch of Medicine / NCAFP

SENATE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

June 17, 2014
Legislative Office Building – Room 643
8:30 a.m.

Senator Louis Pate, Presiding	Welcome, Opening Remarks
Comparison Document – House and Senate Budget Differences	Committee Staff
Questions From Members	
Adjourn	

Senate Committee on Appropriations on Health and Human Services
Tuesday, June 17, 2014 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Appropriations on Health and Human Services met at 8:30 AM on June 17, 2014 in Room 643 of the Legislative Office Building. Six members were present. This meeting was called in order for the Senate to compare the House and Senate Budget Differences.

Senator Louis Pate, Chair, presided.

Senator Pate recognized the following Sergeants-at-Arms: Donna Blake, Anderson Meadows and Steve Wilson. He then recognized the Pages assigned to the Committee: Quinton Beale of Raleigh, Rachel Figard of Davidson, Jackson Carr of Dunn, Justin Perkins of Apex and Trey Jones of Tabor City.

Senator Pate opened the meeting by welcoming everyone and explaining the rules to be followed by the Committee regarding this particular budget meeting. Staff would explain each portion of the Budget where differences occurred. After completion of explanation of the entire document, questions would be accepted and answered by staff. Ms. Susan Jacobs opened the explanation by giving a comparison overview of the budget differences, and then called on staff for their designated portions.

Upon completion of the explanations, Senator Pate opened the floor for a brief question and answer time. Due to time constraints, Senator Pate explained that it would be necessary to adjourn and reconvene at 1:30 p.m.

The meeting adjourned at 9:50 a.m. and reconvened at 1:30 p.m. with seven members present.

Senator Pate called the meeting to order at 1:30 p.m. and restated the rules for the budget comparison process. Following the presentations by staff, the floor was opened for a brief question and answer session.

The meeting adjourned at 2:55 p.m.

Louis M Pate Jr.
Senator Louis Pate, Chair
Presiding

Edna Pearce
Edna Pearce, Committee Clerk

ATTENDANCE

SENATE COMMITTEE ON HHS APPROPRIATIONS

DATES	5/21/14	6/17/14														
CHAIRS:																
Sen. Ralph Hise, Co-Chair		✓														
Sen. Louis Pate, Co-Chair		✓														
SENATE:																
Sen. Austin Allran																
Sen. Tamara Barringer		✓														
Sen. Floyd McKissick		✓														
Sen. Gladys Robinson		✓														
Sen. Bob Rucho		✓														
Sen. Terry Van Duyn		✓														
STAFF:																
Susan Jacobs		✓														
Denise Thomas		✓														
Lisa Wilks																
Brandon Greife		✓														
Kristi Huff		✓														
Susan Fanning		✓														
Edna Pearce		✓														

Edna Pearce (Sen. Louis Pate)

From: Susan Fanning (Sen. Ralph Hise)
Sent: Friday, June 13, 2014 01:09 PM
To: Susan Fanning (Sen. Ralph Hise)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Tuesday, June 17, 2014 at 8:30 AM
Attachments: Add Meeting to Calendar_LINC_.ics

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Tuesday	June 17, 2014	8:30 AM	643 LOB

Review of differences between House and Senate budgets.

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Tuesday	June 17, 2014	1:30 PM	643 LOB

Continuation of Budget Comparison

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

FRD ESTIMATE NOTES

WHAT WE DON'T KNOW

1) Claims backlog - there is no mechanism to validate legitimate claims submitted and rejected due to system issues. DHHS has referenced provider surveys and meetings but provided no hard data. Antidotal information from providers and Associations indicate there still problems with legitimate claims that providers can not process.
2) OMMIS has indicated there are over 11,000 tickets relating to provider billing issues, but have not provided requested information on type, provider group or issues category
3) Enrollment - we have no consistent accurate information on the number of people enrolled in Medicaid by program aid category that is trended over time to allow any comparison or analytics
4) Enrollment backlog - the only information we have is the data collected from NCFast and EIS on traditional or health insurance exchange referred enrollment. DHHS has referred to DSS surveys but have provided no hard data.
5) Recipient data - there has been one attempt to provide recipient data, but there were acknowledged issues.
6) Validation that extra 21,000 children shifted from Health Choice as appropriate.

RISK FACTORS

1) No way to determine actual value of backlog
2) No way to truly assess impact of woodwork
3) No way to assess utilization changes or trends
4) No way to assess impact of SFY 2013-14 budget reduction items
5) No way to assess whether presumptive eligibility is impacting expenditures

KEY ASSUMPTIONS

	Senate Budget	House Budget
SFY 2013-14 Backlog	$ 407,000,000	$ 215,000,000
Annualize impact of achieved reductions	Included	Included
Annualize Woodwork impact	Included	Included
Annualize shift of Health Choice children to Medicaid	Included	Included
Annualize shift of additional children from Health Choice	Included	Included
Annualize impact of Presumptive Eligibility	Included	Non Included
Enrollment and Utilization growth of 5.3%	Included	Included
Change in Mix of Enrollment	Included	Included
Provider Churn to offset reductions	Included	Not Included
Increased FMAP factor	Included	Included

MEDICAID SUMMARY OF SFY 2013-14 SHORTFALL

	SENATE Budget	*HOUSE* Budget
MEDICAID		
Claims, Utiliization and Growth	$ 149,700,000	$ 149,700,000
Budget Reduction Items	(63,600,000)	(63,600,000)
Presumptive Eligibility	(13,200,000)	(13,200,000)
MAGI Recertification Delay	(2,800,000)	(2,800,000)
Additional Children Shifted From Health Choice	(8,700,000)	(8,700,000)
PCS Services	(12,400,000)	(12,400,000)
Settlements	(8,200,000)	(8,200,000)
POTENTIAL MEDICAID CASH SURPLUS SFY 2013-14	$ 40,800,000	$ 40,800,000
HEALTH CHOICE		
Budget Reduction Items	(2,100,000)	$ (2,100,000)
Additional Children Shifted From Health Choice	5,100,000	5,100,000
Other	6,100,000	6,100,000
POTENTIAL HEALTH CHOICE CASH SURPLUS SFY 2013-14	$ 9,100,000	$ 9,100,000
POTENTIAL NET CASH SURPLUS SFY 2013-14	$ 49,900,000	$ 49,900,000
CLAIM AND ENROLLMENT BACKLOG	(143,800,000)	(75,250,000)
ESTIMATED NET SHORTFALL SFY 2013-14	$ (93,900,000)	$ (25,350,000)

SFY 2013-14 Shortfall Notes:

1) House estimate uses Governor's backlog for claims and enrollment of $215,000,000, instead of $407,000,000 in Senate and FRD Original

MEDICAID SUMMARY OF SFY 2014-15 REBASE

	SENATE *Budget*	*HOUSE* *Budget*
MEDICAID		
Claims, Utiliization and Growth	$ (114,100,000)	$ (27,300,000)
Budget Reduction Items	(90,400,000)	(90,400,000)
Presumptive Eligibility	(5,500,000)	
MAGI Recertification Delay	-	-
Additional Children Shifted From Health Choice	(9,400,000)	(9,400,000)
Increase in FMAP	14,600,000	14,500,000
PCS Services	(100,000)	(4,100,000)
Settlements	(1,100,000)	(1,100,000)
POTENTIAL MEDICAID REBASE SFY 2014-15	$ (206,000,000)	$ (117,800,000)
HEALTH CHOICE		
Budget Reduction Items	$ (2,900,000)	$ (2,900,000)
Additional Children Shifted From Health Choice	7,500,000	7,500,000
Other	9,900,000	9,900,000
POTENTIAL HEALTH CHOICE CASH SURPLUS SFY 2014-15	$ 14,500,000	$ 14,500,000
POTENTIAL NET REBASE SFY 2014-15	$ (191,500,000)	$ (103,300,000)
CLAIM AND ENROLLMENT BACKLOG	-	-
ESTIMATED NET REBASE SFY 2014-15	$ (191,500,000)	$ (103,300,000)

SFY 2014-15 Rebase Notes

1) House budget utilizes the SFY 2013-14 base assuming the Governor's lower backlog of $215,000,000
2) House budget assumes no impact for presumptive eligibility
3) House budget assumes no churn impact
4) House budget reflects the impact of additional 50 PCS hours approved 5/19/14 w/o a rate reduction to offset any portion of additional costs

SENATE APPROPRIATIONS

ON

HEALTH AND HUMAN SERVICES

COMPARISON REPORT ON HOUSE AND SENATE CONTINUATION AND EXPANSION BUDGETS

Senate Bill 744

June 17, 2014

House/Senate Comparison Report

Health and Human Services

(Items in Controversy are Shaded)

		House FY 14-15	Senate FY 14-15
(1.0) Division of Central Management and Support			
1	**Compensation Increase Reserve** Provides a $1,000 annual recurring salary increase (~$1,236 salary and benefit increase) for permanent full-time employees.	$7,519,877	
2	**Compensation Increase Reserve Department-Wide** Provides a $1,000 annual recurring salary and benefit increase ($809 salary increase) for permanent full-time employees department-wide.		$6,011,140
3	**State Retirement System Contributions** Increases the State's contribution to the Teachers' and State Employees' Retirement System to fund the Annual Required Contribution and provide a 1.44% cost-of-living adjustment to retirees. Total General Fund appropriation across all sections in the committee report is $60.3 million.	$1,852,169	
4	**State Retirement System Contributions Department-Wide** Increases the State's contribution to the Teachers' and State Employees' Retirement System to fund the Annual Required Contribution and provide a 0.8% cost-of-living adjustment department-wide to retirees. Total General Fund appropriation across all sections in the committee report is $37 million.		$1,135,828
5	**Contracts and Vacant Positions Department-Wide (1119)** Reduces funds for vacant positions and contracts across the department. The Department has the flexibility to achieve this reduction through the elimination of vacant positions and elimination or reduction of contract costs.	($8,000,000)	($16,000,000)
6	**Maintenance - Cost Allocation (1120)** Allocates allowable federal funds for maintenance expenses in the Division of Child Development and Early Education.	($120,000)	($120,000)

		House FY 14-15	Senate FY 14-15
	NC TRACKS (2413,1122)	$0	$0
	Provides funding for continued system development by using prior-year earned revenue in the nonrecurring amount of $5,223,975 in FY 2014-15. The total FY 2014-15 budget for development costs is $10.7 million and the budget for ongoing operations and maintenance is an additional $10.7 million.		
8	**NC FAST (2411)**	$0	$0
	Provides funding to support the continued development and implementation of the Eligibility Information System for the Child Care, Low Income Energy Assistance and Crisis Intervention Programs, and Federally-Facilitated Exchange Interoperability. The funding will be provided from prior-year earned revenue in the nonrecurring amount of $4,138,002 in FY 2014-15. These projects are funded with 90% federal funds until December 31, 2015. The FY 2014-15 total budget for this project is $55.6 million.		
9	**Competitive Block Grant Transfers (1910)**	($600,223)	($600,223)
	Transfers funds from the competitive block grant to the appropriate Divisions. Funds for maternity homes are transferred to the Division of Social Services in the amount of $375,000. Funds for traumatic brain injury are transferred to the Division of Mental Health, Developmental Disability Services and Substance Abuse Services in the amount of $225,223. Combined with item 8, the competitive block grant is reduced by 2.4% to $9,303,911 recurring.		
10	**Competitive Block Grant Additional Funds (1910)**		$375,000
	Provides recurring funds to increase the competitive block grant. Designates $375,000 in FY 2014-15 for the Big Brothers Big Sisters of the Triangle, Inc. In FY 2015-16 the scope of the competitive block grant is expanded to allow for this organization to apply for funding. Combined with item 7 the competitive block grant is reduced by 2.4% to $9,303,911 recurring.		
11	**Competitive Block Grant Additional Funds (1910)**	$375,000	
	Provides recurring funds to increase the competitive block grant.		
12	**Actuary Positions (1120)**	$170,000 1.00	$170,000 1.00
	Creates two actuary positions in the Office of the Secretary for the Medicaid Program. The total cost of the positions is $340,000. Federal Medicaid receipts will be used to cover 50% of the cost of each position, therefore the State will fund effectively 1 net FTE.		

Health and Human Services

(Items in Controversy are Shaded)

		House FY 14-15	Senate FY 14-15
13	**Health Information Exchange (1910)** Provides State matching funds to support the Health Information Exchange.	$4,000,000	$4,000,000
14	**Supplemental Short-Term Assistance for Group Homes** Provides fund for one year for group home residents who were determined to be ineligible for Medicaid personal care services on or after January 1, 2013. The maximum monthly payment is set at $464.30 and is based on providing 33 hours of service per eligible recipient. Group homes may only use these funds to provide supervision and medication management to residents who meet the required eligibility criteria. Funds for this purpose are capped at maximum amount of $2,000,000 and will end upon depletion of the funds or June 30, 2015, whichever is earlier.	$2,000,000 NR	

House Only

(2.0) Division of Aging and Adult Services

15	**Senior Center** Provides nonrecurring General Fund appropriation for Senior Center capital projects.	$100,000 NR	
16	**Home Care and Community Block Grant Reduction (1370,1451)** Reduces General Fund appropriation for the Home Care and Community Block Grant (HCCBG) by 3%, leaving a balance of $31,808,889.		($969,549)

House Only

Senate Only

(3.0) Division of Child Development and Early Education

17	**TANF Funds for PreK (1330)** Replaces General Fund appropriation for the PreK program with Temporary Assistance for Needy Families block grant funds on a nonrecurring basis. Combined with item 19, there is a decrease of 3.3% in General Fund appropriation to $62.8 million and a 3.6% increase in total funding for PreK.		($7,195,807) NR
18	**TANF Funds for PreK (1330)** Replaces General Fund appropriation for the PreK program with Temporary Assistance for Needy Families block grant funds and Temporary Assistance for Needy Families Emergency Contingency Funds on a nonrecurring basis.	($15,842,334) NR	

Health and Human Services

(Items in Controversy are Shaded)

		House FY 14-15	Senate FY 14-15
	PreK Lottery Funds	($49,168,368)	
	Replaces General Fund appropriation with Lottery receipts for the PreK program. This brings the total Lottery receipts for the PreK program to $124.7 million.		
20	**Administrative Savings due to Efficiencies and Cost Allocation**	($1,893,496) -1.00	($1,893,496) -1.00
	Reduces General Fund appropriation budgeting overrealized receipts, and replacing General Fund appropriation with Child Care and Development Fund for Child Care Regulation. Additionally the Division's administrative costs have been reduced due to the move to the Dorothea Dix campus, including the elimination of one position.		
	#60038615 - Administrative Asst. II - $37,659		
21	**Child Care Subsidy Block Grant Swap Out (1380)**		($13,982,425) NR
	Replaces General Fund appropriation for the Child Care Subsidy program with Child Care Development Fund and Temporary Assistance For Needy Families Emergency Contingency block grant funds on a nonrecurring basis. Both block grants have increased availability for FY 2014-15. Combined with items 15, 16, 17 and 18, General Fund appropriation is reduced by 22% to $49.7 million due to the replacement of State funds with federal funding. Total funding for Child Care Subsidy is unchanged.		
22	**Child Care Subsidy Block Grant Swap Out (1380)**	($13,982,425) NR	
	Replaces General Fund appropriation for the Child Care Subsidy program with Child Care Development Fund and Temporary Assistance For Needy Families Emergency Contingency block grant funds on a nonrecurring basis. Both block grants have increased availability for FY 2014-15. Combined with items 16, 17, 18, 19, and 20 General Fund appropriation is reduced by 34% to $27.1 million due to the replacement of State funds with federal funding. Total funding for Child Care Subsidy is unchanged.		
23	**Child Care Subsidy Eligibility Changes (1380)**		($11,000,000)
	Changes eligibility for Child Care Subsidy from 75% of State Median Income to 200% of Federal Poverty Level (FPL) for children age 0-5 and children with special needs. Children who are age 6-12 are eligible at 133% of FPL. This change is effective September 1, 2014. This change in eligibility reduces funding needs by $22 million; half of these funds, $11 million, will be used to reduce the waiting list by 2,300 eligible children. Combined with items 14, 16, 17, and 18, General Fund appropriation is reduced by 22% to $49.7 million due to the replacement of State funds with federal funding in item 14. Total funding for Child Care Subsidy is unchanged.		

Health and Human Services (Items in Controversy are Shaded)	House FY 14-15	Senate FY 14-15
24 **Child Care Subsidy Eligibility Changes (1380)** Changes eligibility for Child Care Subsidy from 75% of State Median Income to 200% of Federal Poverty Level (FPL) for children age 0-5 and children with special needs. Children who are age 6-12 are eligible at 133% of FPL. This change is effective October 1, 2014. Children currently receiving assistance will have their income eligibility determined according to the new income standards at their next redetermination after October 1, 2014. Combined with items 15,17,18,19 and 20 General Fund appropriation is reduced by 34% to $27.1 million due to the replacement of State funds with federal funding in item 15. Total funding for Child Care Subsidy is unchanged.	($7,670,393)	
25 **Child Care Subsidy Co-Payments Set at 10% of Income (1380)** Sets co-payments at 10% of income for all households that are required to pay a co-payment effective September 1, 2014. This does not change who pays a co-payment; children receiving child care subsidy through Child Welfare, Child Protective Services and Foster Care will continue to be exempt from the co-payment requirement. This reduction does not change the slot availability for child care subsidy as the amount paid by the Child Care Subsidy Program will be reduced due to the increased co-payment. The co-payment is paid to the child care provider. There were 40,000 children whose families paid a co-payment based on 8% or 9% of their family income out of 110,000 children whose families paid a co-payment in FY 2012-13. Combined with items 14, 15, 17, and 18 General Fund appropriation is reduced by 22% to $49.7 million due to the replacement of state funds with federal funding in item 14. Total funding for Child Care Subsidy is unchanged.		($1,812,687)
26 **Child Care Subsidy Co-Payments Set at 10% of Income** Sets co-payments at 10% of income for all households that are required to pay a co-payment effective October 1, 2014. This does not change who pays a co-payment; children receiving child care subsidy through Child Welfare, Child Protective Services and Foster Care will continue to be exempt from the co-payment requirement. This reduction does not change the slot availability for child care subsidy as the amount paid by the Child Care Subsidy Program will be reduced due to the increased co-payment. The co-payment is paid to the child care provider. There were 40,000 children whose families paid a co-payment based on 8% or 9% of their family income out of 110,000 children whose families paid a co-payment in FY 2012-13. Combined with items 15, 16, 18, 19, and 20 General Fund appropriation is reduced by 34% to $27.1 million due to the replacement of state funds with federal funding in item 15. Total funding for Child Care Subsidy is unchanged.	($1,631,418)	

related to item 23

		House FY 14-15	Senate FY 14-15
	Child Care Subsidy Co-Payment No Longer Prorated for Part-time Care (1380)		($2,359,965)
	Eliminates the proration of co-payments for part-time care effective September 1, 2014. This reduction does not result in any loss of child care slots. The increased co-payment will reduce the amount paid to child care providers by the Child Care Subsidy program. Providers collect the co-payment from the parents. There were 26,000 children whose families paid a reduced co-payment due to part-time care out of 110,000 children whose families paid a co-payment in FY 2012-13. Combined with items 14, 15, 16, and 18, General Fund appropriation is reduced by 22% to $49.7 million due to the replacement of State funds with federal funding in item 14. Total funding for Child Care Subsidy is unchanged.		
28	**Child Care Subsidy Co-Payment No Longer Prorated for Part-Time Care (1380)**	($2,123,968)	
	Eliminates the proration of co-payments for part-time care effective October 1, 2014. This reduction does not result in any loss of child care slots. The increased co-payment will reduce the amount paid to child care providers by the Child Care Subsidy program. Providers collect the co-payment from the parents. There were 26,000 children whose families paid a reduced co-payment due to part-time care out of 110,000 children whose families paid a co-payment in FY 2012-13. Combined with items 15, 16, 17, 19 and 20 General Fund appropriation is reduced by 34% to $27.1 million due to the replacement of State funds with federal funding in item 15. Total funding for Child Care Subsidy is unchanged.		
29	**Child Care Subsidy Waiting List (1380)**	$523,333	
	Provides funding to reduce the Child Care Subsidy waiting list from the net savings of the actions in 15, 16, 17, 18, and 20. When the actions in these items are annualized, this will provide funding to reduce the Child Care Waiting List by 2,250. Combined with items 15, 16, 17, 18, and 20, General Fund appropriation is reduced by 34% to $27.1 million due to the replacement of State funds with federal funding in item 15. Total funding for Child Care Subsidy is unchanged.		
30	**Child Care Subsidy Waiting List (1380)**		$15,172,652
	Provides funding to reduce the Child Care Subsidy waiting list by an estimated 3,200 children. Combined with items 14, 15, 16, and 17, General Fund appropriation is reduced by 22% to $49.7 million due to the replacement of State funds with federal funding in item 14. Total funding for Child Care Subsidy is unchanged.		

31	**Child Care Market Rates (1380)** Provides funding to increase the child care market rates for the Child Care Subsidy Program effective January 1, 2015, based on the 2013 North Carolina Child Care Market Rate Study. The child care market rates are increased by 40% of the difference between the current child care market rates and the 2013 child care market rates. Combined with items 15, 16, 17, 18, and 19, General Fund appropriation is reduced by 34% to $27.1 million due to the replacement of State funds with federal funding in item 15. Total funding for Child Care Subsidy is unchanged.	$10,902,446	
32	**PreK Expansion (1330)** Provides funds for 1,000 additional PreK slots to serve at-risk 4 year olds in the PreK program. Combined with item 12 which replaces General Fund appropriation with federal block grant funds, there is a decrease of 3.3% in General Fund appropriation to $62.8 million and a 3.6% increase in total funding for PreK.		$5,040,000 NR
33	**PreK (1330)** Provides funding to address the additional average per slot cost increase due to teacher raises and provides funding for additional slots. There is also $4 million in additional Temporary Assistance for Needy Families Emergency Contingency Block Grant funds which brings the total additional funding for PreK to $9 million. This increases the total funding for PreK by 13%.	$5,040,000 NR	

(4.0) Division of Social Services

34	**State/County Special Assistance Caseloads (1570)** Reduces funding for State/County Special Assistance (SA) due to decreasing caseloads. The reduced funding has no impact on assistance for eligible recipients. Combined with item 20, reduces General Fund appropriation for SA by 7.2%, leaving $65.2 million recurring.		($4,215,542)
35	**State-County Special Assistance Caseloads (1570)** Reduces funding for State-County Special Assistance (SA) due to decreasing caseloads. The reduced funding has no impact on assistance for eligible recipients.	($4,215,542)	

	State County Special Assistance Income Eligibility (1570) Changes the income eligibility for the State/County Special Assistance Program from a method that bases income eligibility on the payment rate for the facility type where the recipient resides, to a method based on the federal poverty level for all recipients regardless of where they reside. The SA eligibility level is set at 100% of the Federal Poverty Level. Current recipients of SA are grandfathered in and will continue to receive SA. Combined with item 20, the General Fund appropriation for SA is reduced by 7.2%, leaving $65.2 million recurring.		($807,864) Correct # = ($377,997)
37	**State Funding for County Medicaid Administration Eliminated (1376)** Eliminates funding provided to local departments of social services to offset counties' cost for Medicaid enrollment. The federal match rate is increasing from 50% to 75% for eligibility determination for Medicaid, therefore counties will receive additional federal funds for this activity.	($1,682,806)	($1,682,806)
38	**Adult Care Home Case Management (1453)** Eliminates funding for the Adult Care Home Case Management Service (ACHCM) which ended in June 2013. This service provided funding for county departments of social services workers to perform the assessment and case management for individuals in adult care homes and licensed family homes who were heavy need residents. The Personal Care Services (PCS) Program now uses an independent assessment to determine eligibility for PCS and therefore the Case Management Service is no longer needed.	($856,058)	($856,058)
39	**County Child Protective Services Caseloads (1430)** Provides funding to replace $4.5 million in federal block grant funds utilized to pay for Child Protective Services (CPS) workers that counties lost in FY 2013-14 and provides additional funding to reduce county departments of social services caseloads to an average of 10 families per worker performing Child Protective Services assessments. Combined with items 26 and 27, the General Fund appropriation for Child Protective Services is increased by 101% to $27 million. related to item 40.	$8,326,627	

40	**County Child Protective Services Caseloads (1430)** Provides funding to replace $4.5 million in federal block grant funds utilized to pay for Child Protective Services (CPS) workers that counties lost in FY 2013-14 and provides additional funding to reduce county departments of social services caseloads to an average of 10 families per worker performing Child Protective Services assessments. Combined with items 25 and 26, the General Fund appropriation for Child Protective Services is increased by 101% to $27 million.		$8,326,627
41	**Enhance Oversight of County Child Welfare Services (1430)** Provides funding for nine positions to enhance oversight of child welfare services in local county departments of social services. These positions will monitor, train, and provide technical assistance to the local county departments of social services to ensure children and families are provided services to address safety, permanency and the well-being of children who are served by child welfare services. The funds will increase Division of Social Services staffing for Child Protective Services to 28 positions, an increase of 47%. Combined with items 24 and 26, this General Fund appropriation for Child Protective Services is increased by 101% to $27 million.		$750,000 9.00
42	**Enhance Oversight of County Child Welfare Services (1430)** Provides funding for nine positions to enhance oversight of child welfare services in local county departments of social services. These positions will monitor, train, and provide technical assistance to the local county departments of social services to ensure children and families are provided services to address safety, permanency and the well-being of children who are served by child welfare services. The funds will increase Division of Social Services staffing for Child Protective Services to 28 positions, an increase of 47%. Combined with items 25 and 27, this General Fund appropriation for Child Protective Services is increased by 101% to $27 million.	$750,000 9.00	
43	**Child Welfare In-Home Services Expansion (1430)** Increases General Fund appropriation for Child Welfare In-Home Services. In-Home Services are provided to maintain the safety of the child while helping the parent/caretaker learn more effective parenting practices. In-Home Services provide, arrange for, and coordinate interventions and services, as needed that focus on child safety and protection, family preservation, and the prevention of further abuse or neglect. Combined with items 25 and 26, the General Fund appropriation for Child Protective Services is increased by 101% to $27 million.	$4,500,000	

related to item 39

related to item 44

		House FY 14-15		Senate FY 14-15	
	Child Welfare In-Home Services Expansion (1430)			$4,500,000	
	Increases General Fund appropriation for Child Welfare In-Home Services. In-Home Services are provided to maintain the safety of the child while helping the parent/caretaker learn more effective parenting practices. In-Home Services provide, arrange for, and coordinate interventions and services, as needed that focus on child safety and protection, family preservation, and the prevention of further abuse or neglect. Combined with items 24 and 25, the General Fund appropriation for Child Protective Services is increased by 101% to $27 million.				
45	**Child Protective Services Statewide Evaluation (1430)**				
	Provides funding for an independent, statewide evaluation of Child Protective Services at local departments of social service and the Department of Health and Human Services. The evaluation will assess performance, caseload sizes, administrative structure, funding and worker turnover and include recommendations on improving Child Protective Services.	$700,000	NR	$700,000	NR
46	**Child Protective Services Pilot Program (1430)**				
	Provides funding to develop and implement a pilot program designed to enhance coordination of services and information among agencies to improve the protection and outcomes for vulnerable children served through Child Welfare Services. The agencies included in the pilot are local county departments of social services, local law enforcement, the court system, Guardian Ad Litem programs and other agencies as determined appropriate by the Department of Health and Human Services.	$300,000	NR	$300,000	NR
47	**Foster Care Assistance Payments (1532)**	$5,000,000		$5,000,000	
	Provides funding for Foster Care Assistance Payments due to increasing caseloads. Caseloads increased by 9% from March 2013 to March 2014 and are projected to continue to grow. General Fund appropriation is increased by 18% to a total of $32.2 million.				
48	**State Maternity Home Fund (1110)**	$375,000		$375,000	
	Transfers General Fund Appropriation from the Competitive Block grant in the Division of Central Management to the State Maternity Home Fund in the Division of Social Services. Maternity Homes are removed from the competitive block grant. Individuals experiencing an unplanned pregnancy apply to receive funding from the State Maternity Home Fund. Once the individual is determined eligible, the payment goes to the appropriate Maternity Home. There is no change in funding for the State Maternity Home Fund.				

related to item 43

Health and Human Services

(Items in Controversy are Shaded)

		House FY 14-15	Senate FY 14-15
49	**Work First Drug Testing**	$218,538	
		$125,750 NR	
	Provides funds for the implementation of Part II. Drug Screening and Testing For Work First Program Assistance of S.L. 2013-417.		

House Only

(5.0) Division of Public Health

50	**ADAP - AIDS Drug Assistance Program (1460)**		
	Funds ADAP at the full service level. Increased FY 2013-14 pharmaceutical rebates and other federal receipts will be carried forward into FY 2014-15 and will allow the program to serve all eligible persons up to 300% of the Federal Poverty Level. FY 2014-15 funding is reduced by 8%, with $68.8 million remaining for aid and public assistance.	($5,782,163) NR	($5,782,163) NR
51	**Incubation Project (1161)**	($100,000)	($100,000)
	Eliminates General Fund support for the North Carolina Public Health Incubator Collaborative. Funds are used to support a contract with the UNC Institute of Public Health. The contract will be discontinued, but regional health department collaboratives will continue to develop and disseminate best practices.		
52	**Vector Control Program (1153)**	($185,992)	($185,992)
	Terminates the Vector Control Program, which provided small grants to a limited number of counties for mosquito control.		
53	**Child and Family Support Team (1332)**	($251,788) -2.00	($251,788) -2.00
	Eliminates funding for the Child and Family Support Team. Funds were originally provided as start-up funding to support schools participating in the Child and Family Support Team program. The school-based program is now fully implemented, and start-up resources are no longer needed. Two positions are eliminated effective July 1, 2014. #60037795 - Program Development Coordinator - $66,173 #60037797 - Administrative Asst I - $44,648		
54	**School Nurse Funding Initiative (SNFI) (1332)**		($3,487,500)
	Reduces funding (29%) to local education authorities (LEAs) to eliminate 70 school nurse positions and reallocates the remaining 166 SNFI-funded school nurse positions to Tier 1 counties only. As a result, the number of SNFI-funded nurses in the 35 Tier 1 counties will increase to the recommended school nurse-to-student ratio of 1:750 or less. $8.7 million remains in the FY 2014-15 SNFI budget.		

Senate Only

Operational Efficiencies (1110, 1171, 1261, 1441) — ($298,275) -5.00

Reduces operating funds for the Purchase of Medical Care Unit, State Center for Health Statistics, and the Early Intervention, Physical Activity and Nutrition, and Chronic Disease and Prevention Units. Five positions are eliminated effective July 1, 2014.

#60041103 - Office Assistant IV - $35,891
#60088935 - Processing Asst V - $36,931
* #60041452 – Administrative Asst I – $51,304
#60041171 - Nutrition Program Supervisor - $55,808
#60040661 - Business Officer - $50,200

---

56 **Operational Efficiencies (1110, 1171, 1261, 1441)** — ($298,275) -5.00

Reduces operating funds for the Purchase of Medical Care Unit, State Center for Health Statistics, and the Early Intervention, Physical Activity and Nutrition, and Chronic Disease and Prevention Units. Five positions are eliminated effective July 1, 2014.

#60041103 - Office Assistant IV - $35,891
#60088935 - Processing Asst V - $36,931
* #60041456 – Administrative Officer #3 – $51,304 — tech. adj 4
#60041171 - Nutrition Program Supervisor - $55,808
#60040661 - Business Officer - $50,200

---

57 **Public Health Program Adjustments (1271, 1332)** — ($337,325) — ($337,325)

Eliminates residual funds for Purchase of Medical Care, Early Hearing Detection and Intervention, and Tobacco Prevention and Control programs. The budgets are being modified to actual or anticipated spending levels, with no reduction to public service.

Fund Code 1271: Purchase of Medical Care - ($142,325)
Fund Code 1332: Early Hearing Detection and Intervention - ($131,000)
Fund Code 1271: Tobacco Prevention and Control - ($64,000)

---

58 **Vital Records (1173)** — $350,000

Provides $350,000 recurring for the Vital Records Automation Fund, increasing the projected FY 2014-15 budget to $1,041,024. The funds will be used to modify and enhance the Electronic Birth Records System, to update Vital Records' system equipment and software, and for continuing information technology system maintenance.

related to item 59

59	**Vital Records (1173)** Provides funds for temporary staffing to keep up with the demand for certificate issuance, the relocation of records from the primary vault to a secondary vault due to safety issues, microfilming/daily records management, the adoptions database and certificate issuance, and long term vital events document preservation.	$350,000	
60	**Office of Chief Medical Examiner (1172)** Provides funding to address operational issues in the statewide medical examiner system. The expansion will increase the FY 2014-15 budget by 23% from $4.4 million to $5.4 million.	$1,000,000	$1,000,000
61	**On-Site Water Protection (1153)** Transfers the On-Site Water Protection Unit to the Department of Environment and Natural Resources as a Type I transfer. Additional adjustments that are necessary due to legislative salary increases, retirement and medical adjustments, as well as receipt adjustments and transfers from special funds, may be implemented through a type 11 budget revision.		($1,177,154) -14.00
62	**Well Water Testing Fee (1174)** Budgets increased receipts from fees charged by the State Public Health Laboratory to analyze private well water samples. The fee charged to test samples from newly constructed wells will increase from $55 to $74, (35%), effective July 1, 2014. In addition, the Laboratory will be authorized to analyze water samples from existing private wells for a fee of $74, effective July 1, 2014. The fee change will increase receipts to cover the costs of supplies used to analyze water samples. Requirements $221,548 Receipts $221,548 Net Appropriation $0		
63	**Food Protection Program** Realigns the Food Protection Program budget by reallocating $400,000 from aid to counties for local food and lodging programs to be used for the costs to operate the State elements of this program. Due to an increase in the amount of the counties' share of food and lodging fee receipts enacted in Section 12E.1 of S.L. 2013-360, the counties no longer need to receive this General Fund Appropriation. The Food Protection Program will use these funds to cover State costs related to food and lodging regulation.	$0	

related to item 58

Senate Only

House Only

		House FY 14-15		Senate FY 14-15	
)) Division of Mental Health, Developmental Disabilities, and Substance Abu					
64	**New Broughton Hospital Reserve (1910)** Eliminates reserve funds provided to purchase equipment, furniture, and information technology infrastructure for the new Broughton Hospital. S.L. 2013-360 appropriated the nonrecurring funds for the anticipated December 2014 opening of the new facility. Due to construction issues, the opening of the replacement facility is delayed until May 2016.	($16,598,589)	NR	($16,598,589)	NR
65	**Claims Processing (1110)** Reduces funding by 47% to budget anticipated savings in contracted claims processing costs. In FY 2013-14, the Division began using the NC Tracks system to process community service claims and no longer uses private contractors for this purpose. $2.7 million remains in the FY 2014-15 budget for contractual information technology services.	($2,400,000)		($2,400,000)	
66	**Local Management Entity/Managed Care Organizations (1111)** Reduces the General Fund appropriation for Local Management Entity/Managed Care Organization (LME/MCO) administrative cost allocations by 5.6%. Administrative cost savings will be achieved by merging the nine LME/MCOs operating in FY 2013-14 to seven or fewer by June 30, 2015. Approximately $30 million remains in the FY 2014-15 budget for LME/MCO administration.	($1,800,000)		($1,800,000)	
67	**Central Office Administration (1110)** Reduces the General Fund appropriation for the Division's central offices by 4.5%. Seven vacant positions are eliminated, effective July 1, 2014. Approximately $9.5 million remains in the Division's FY 2014-15 central administration budget. #65006250, Quality Assurance Officer - $70,840 #60043442 Mental Health Prgm Mgr I – $59,962, #60043463, W/A Primary Care Systems Asso - $49,171 #60043400, Processing Assistant V - $48,979 #60043406, W/A Administrative Asst - $29,856 #60043320, Administrative Off III - $54,498 #60043328, Budget Manager - $90,000	($448,876) -7.00			

tech. related to item 68.

Health and Human Services

(Items in Controversy are Shaded)

		House FY 14-15	Senate FY 14-15
68	**Central Office Administration (1110)** Reduces the General Fund appropriation for the Division's central offices by 4.5%. Seven vacant positions are eliminated, effective July 1, 2014. Approximately $9.5 million remains in the Division's FY 2014-15 central administration budget. #65006250, Quality Assurance Officer - $70,840 * #60043367, Mental Health Prgm Mgr I – $59,962, #60043463, W/A Primary Care Systems Asso - $49,171 #60043400, Processing Assistant V - $48,979 #60043406, W/A Administrative Asst - $29,856 #60043320, Administrative Off III - $54,498 #60043328, Budget Manager - $90,000		($448,876) -7.00
69	**LME/MCO General Administration (1111)** Eliminates funds held in reserve for LME/MCO risk management. As required by S.L. 2013-85, the Division has increased responsibilities related to monitoring LME/MCO administrative, operational, actuarial, and financial performance, eliminating the need to maintain a reserve fund.	($6,100,000)	($6,100,000)
70	**Wright School (1546)** Eliminates funding for the Wright School, effective July 1, 2014.		($2,709,912) -38.66
71	**Brain Injury Association of North Carolina (1451)** Continues General Fund appropriation for the Brain Injury Association of North Carolina contract. The association provides information, referral, and training services for persons with traumatic brain injury, their families, and health care professionals.	$225,223	$225,223
72	**Community-Based Crisis Services** Provides funds to be used to increase community-based crisis stabilization services. These services provide alternatives to the use of local hospital emergency departments or inpatient services in State-operated facilities. Crisis services include psychiatric outpatient clinics, 24-hour crisis walk-in clinics, psychiatric urgent care units, facility-based crisis treatment, 23-hour observation, and non-hospital detoxification.	$5,028,677	
73	**Unpaid LME Liabilities** Provides one-time funding for the LME/MCOs to address unpaid liabilities carried forward from prior fiscal years. DMH/DD/SAS had insufficient funds to pay the LME/MCO their State allocations in a timely manner.	$5,255,527 NR	

related to item 67

Senate only

House only

House only

Critical Time Intervention

Hou-On14

Provides funds to support short-term case management services for persons leaving inpatient psychiatric facilities, adult care homes, and other institutions.

$750,000 NR

75 **Assistive Technology**

House On14

Provides funds for assistive technology for persons with mental and other disabilities who are transitioning from institutions to live in community-based settings.

$41,000 NR

(7.0) Division of Vocational Rehabilitation

		House FY 14-15	Senate FY 14-15
76	**Operational Efficiencies (1110, 1452, 1480)**	($575,336) -11.95	($575,336) -11.95

Reduces General Fund appropriation to reflect savings achieved by reducing layers of management and administration. Effective July 1, 2014, 20.75 positions (11.95 full-time equivalents (FTEs) supported by the General Fund), are eliminated from Service Support, Employment Services, and Independent Living Services.

(8.0) Division of Health Service Regulation

	Cost Allocation for Construction Team Inspections (1153)	($263,000)	($263,000)

Allocates the cost for construction team inspections of adult care homes, family homes, and group homes to claim administrative match through Medicaid. The construction teams inspect facilities to ensure compliance with federal licensure standards. The inspection consists of external and internal evaluations, including living quarters, fire safety, electrical and plumbing equipment, to ensure homes and facilities are maintained in a safe living condition.

78	**Health Care Personnel Registry Receipts (1110)**	($25,000)	($25,000)

Budgets over-realized receipts for the Health Care Personnel Registry, a tool for monitoring unlicensed health care personnel. The registry lists nurses and medications aides who have met federal and State educational and competency requirements. Further, it lists unlicensed health care personnel who are being investigated for or have been found to have caused harm to a resident or facility. The cost of maintaining the registry is shared with Medicare. For FY 2012-13, actual expenditures totaled $4.1 million. While budgeting the over-realized receipts ($25,000) will result in a corresponding decrease in appropriation, the FY 2014-15 budget (requirements) of $4.4 million is unchanged.

(9.0) Division of Medical Assistance

---

79 **Provider Assessments for Behavioral Health LME/MCO's (1310)** — ($59,555,995)

Senate Only

Implements a 3.5% assessment on all Behavioral Health LME/MCO's effective July 1, 2014. The State will retain 65% of the total amount assessed to fund Medicaid services. The remaining 35% will be used to increase the capitation rates for the Local Management Entities/Managed Care Organizations (LME/MCO's). In FY 2012-13, Medicaid payments totaled $1.4 billion to LME/MCOs. The FY 2013-14 budget is $2.5 billion and is the first year where all LME/MCOs have been operational for the full year.

---

80 **Mental Health Drug Management (1310, 1331)** — ($6,000,000)

Senate Only

Implements prior authorization of mental health drugs, effective January 1, 2015. This adjustment brings mental health drug policy in line with other drug classes that require prior authorization in the Medicaid program. This represents a 2% reduction in drug spending net of rebates, leaving an estimated budget in FY 2014-15 of $737 million. The amount saved is net of the reduction in drug rebates.

---

81 **Automatic Eligibility for ABD/State County Special Assistance (1310)** — ($28,750,000)

Senate Only

Correction = ($14.3 million)

Eliminates the automatic Medicaid eligibility for Aged, Blind and Disabled/State County Special Assistance recipients effective January 1, 2015. This eligibility standard was established by North Carolina and is not mandated by the federal government. There are currently 11,886 individuals that have Medicaid eligibility as a result of this policy who will lose Medicaid coverage. In FY 2013-14 it is estimated that total spending on this eligibility group will be $167.9 million. Of this amount, $57.5 million are General Fund appropriations.

Correct # = 5,238

---

82 **Medically Needy Eligibility Standards (1310)** — ($3,563,134)

Senate Only

Eliminates eligibility for Medically Needy individuals in family and children and Aged, Blind and Disabled categories effective January 1, 2015. This eligibility group is optional and not mandated by Centers for Medicare and Medicaid Services (CMS). There are currently 3,342 individuals that have Medicaid coverage based on this policy. In FY 2013-14 it is estimated that total spending on this eligibility group will be $20.8 million and $7.1 million in General Fund appropriations.

Medsolutions Contract Renegotiation and Imaging Request for Proposal (1310) — ($5,500,000) — ($5,500,000)

Requires the department to renegotiate their imaging contract with Medsolutions to reduce capitation rates to achieve improved medical loss ratios. The Department is also directed to issue a Request for Proposal (RFP) for high tech imaging services. This represents a 14.9% reduction in spending on the high tech imaging contract, leaving an estimated $90 million in the budget for FY 2014-15.

84 **Nursing Home Case- Mix Index Adjustment (1310)** — ($2,200,000)

Senate Only

Freezes the case-mix index adjustments for direct cost of nursing home rates effective January 1, 2015. Historically, nursing home direct care rates are adjusted quarterly for the change in the average case mix or intensity of care for each facility's residents from the previous quarter. The case mix index adjustments do not apply to the indirect care or fair rental value components of the nursing home per diem rates. Total Medicaid payments for nursing homes is projected to be $1.16 billion in FY 2013-14. This represents a 0.5% reduction in overall spending for nursing homes leaving an estimated $1.2 billion in the Medicaid budget for FY 2014-15.

85 **Average Acquisition Cost for Drug Pricing (1310)** — ($975,000)

Sen. Only

Converts the pricing for drug products from a multiple of Wholesale Acquisition Cost (WAC) for brand medications and State Maximum Allowable Cost (SMAC) for generic medications to an average acquisition cost for all Medicaid drugs. This item also adjusts dispensing fees to more closely align with the cost of dispensing. Total spending for drug product and dispensing fees are projected to be $1.4 billion in FY 2013-14. The amount is offset by drug rebates that are estimated at $678 million in FY 2013-14. This represents a 0.3% reduction in spending for drug costs, net of rebates, leaving an estimated net budget of $737 million in FY 2014-15.

86	**State Retention of Physician Upper Payment Limit (UPL) Plan**	($8,086,028)	
	Implements a new 25.9% retention of the assessment under the University of North Carolina at Chapel Hill (UNC) and East Carolina University (ECU) physician UPL plan effective July 1, 2014. The retention will apply to the total amount assessed and transferred to the Division of Medical Assistance through an intergovernmental transfer or payment by these organizations. The amount not retained will be used to fund the state share of the costs of the supplemental payment under the UPL plan. In FY 2013-14, UNC and ECU transferred $23.1 million to the Division of Medical Assistance for the State share of UPL payments of $66.8 million. The new State retention will increase the amounts transferred from UNC and ECU to approximately $31.1 million, with supplemental payments to the two organizations totaling approximately $66.8 million.		
87	**State Retention of Physician Upper Payment Limit (UPL) Plan (1310)**		($9,380,470)
	Implements a new 28.85% retention of the assessment under the University of North Carolina at Chapel Hill (UNC) and East Carolina University (ECU) physician UPL plan effective July 1, 2014. The retention will apply to the total amount assessed and transferred to the Division of Medical Assistance through an intergovernmental transfer or payment by these organizations. The amount not retained will be used to fund the state share of the costs of the supplemental payment under the UPL plan. In FY 2013-14, UNC and ECU transferred $23.1 million to the Division of Medical Assistance for the State share of UPL payments of $66.8 million. The new State retention will increase the amounts transferred from UNC and ECU to approximately $32.5 million, with supplemental payments to the two organizations totaling approximately $66.8 million.		
88	**State Retention of the Hospital GAP Plan Assessment (1310)**		($15,102,794)
	Increases the State retention on assessments through the hospital GAP plan from 25.9% to 28.85% effective July 1, 2014. The increased retention percentage will apply to the total amount assessed under the GAP plan. The residual amount of assessment will be used to make supplemental equity and upper payment limit payments as defined under the plan. The GAP plan for the year ending September 30, 2014 provides for payments from hospitals totaling $366 million and supplemental payments for outpatient equity and inpatient upper payment limit of $787 million. This change will increase the amount of payments from the hospitals, but will not change the supplement payments the hospitals receive.		

Senate Only

	Personal Care Services (PCS) Rate adjustment (1310)		$0
Sen. Only	Reduces the PCS unit rate so that the approval of 50 additional hours included in the Medicaid Clinical policy approved by the Center for Medicare and Medicaid Services (CMS) in May 2014 is budget neutral.		
90	**Single Base Rate for All Hospitals (1310)**		($10,800,000)
Senate Only	Establishes a single base diagnosis related group (DRG) rate for inpatient hospital services based on the statewide median base rate for all hospitals effective January 1, 2015. This reduces payments for hospital services by $12.4 million and increases the GAP plan retention by $9.2 million on an annual basis. In FY 2013-14 total spending for inpatient hospital services is projected to be $938 million. This represents a 1.8% reduction in spending for inpatient hospital services, leaving an estimated $992 million in the FY 2014-15 budget.		
91	**Provider Rate Reduction (1310)**		($10,803,013)
Senate Only	Reduces provider rates by 2% effective January 1, 2015. This reduction applies to all fee-for-service providers with the exception of drugs, nursing homes, all cost based providers, and services where rates are set by the federal government, negotiated through a managed care contract, or as specified in special provisions.		
92	**Hospital Outpatient Cost (1310)**	($6,078,784)	($6,078,784)
	Reduces the settlement for the University of North Carolina-Chapel Hill (UNC-CH) and Pitt Memorial (ECU) hospitals for outpatient services to 70% of Medicaid costs effective July 1, 2014. Historically, the State has funded the State share of payment to UNC-CH and ECU at 100% of costs, unlike other hospitals which are paid 70% of cost through the claims and settlement processes. The reduction in settlement percentage will be factored into supplemental payments under the Disproportionate Share Hospital (DSH) and hospital GAP payment plans. This represents a 2.1% reduction in overall hospital outpatient Medicaid spending, leaving an estimated $821 million in the budget for outpatient services for all hospitals in FY 2014-15.	Correct = $8,040,967	

Health and Human Services

(Items in Controversy are Shaded)

	House FY 14-15	Senate FY 14-15

93 Medicaid Funds for FY 13-14

$75,250,000 NR

X See Handout

Appropriates nonrecurring funds to address a projected FY 2013-14 Medicaid budget shortfall of $25.4 million. Unachieved S.L. 2013-360 reductions and other unbudgeted items are outlined below:

Medicaid Claims, Utilization and Growth:($81,150,000) X
Budget Reduction Items not Achieved: $63,600,000
Presumptive Eligibility: $13,200,000
MAGI Recertification Delay: $2,800,000
Additional Children Shifted from Heath Choice: $8,700,000
PCS Services: $12,400,000

missing information:
Settlements: $8,200,000
HealthChoice surplus: ($9,100,000)
Medicaid claims + Backlog: $75,250,000
Net Shortfall: $25,400,000

94 Medicaid Funds for FY 13-14

$143,800,000 NR

X See Handout

Appropriates nonrecurring funds to address a projected FY 2013-14 Medicaid budget shortfall of $93.9 million. Unachieved S.L. 2013-360 reductions and other unbudgeted items are outlined below:

Medicaid Claims, Utilization and Growth:($149,700,000) X
Budget Reduction Items not Achieved: $63,600,000
Presumptive Eligibility: $13,200,000
MAGI Recertification Delay: $2,800,000
Additional Children Shifted from Heath Choice: $8,700,000
PCS Services: $12,400,000
Settlements: $8,200,000
Heath Choice Surplus:($9,100,000)
Medicaid Claims and Enrollment Backlog: $143,800,000

Net Shortfall: $ 93,900,000

A projected FY 2013-14 cash surplus of $49.9 million, anticipated due to backlogs of unpaid claims and unprocessed eligibility applications, will revert on June 30, 2014. Therefore, a nonrecurring appropriation of $143.8 million is needed for the liability associated with the unpaid claims and enrollment backlogs that will be paid in FY 2014-15.

95 Paragard Rate

House Only

$62,000 NR

Changes pricing methodology for Paragard IUD's to be consistent with pricing formula for other IUD's.

96 Dispensing Fee Study

House Only

$100,000 NR

Prepares a study of dispensing fees.

Related to item 85

Nursing Homes

House Only

$4,000,000

Restores 3% to nursing home rates effective January 1, 2015 that was reduced as part of the shared savings plan item implemented in SFY 2013-14. The ongoing annual state cost will be $8,000,000.

---

98 **Medicaid Rebase (1310;1331;1320)**

$206,000,000

House Budget includes $117,800,000(R) in the Reserves Section for this purpose. See handout for additional information

Funds the Medicaid rebase for FY 2014-15 that includes 5.3% growth in enrollment and utilization; a change in mix to a more expensive recipient; current year spending trends for Personal Care Services and settlements; the impact of presumptive eligibility as a result of the Affordable Care Act; the impact of an additional 20,000 children shifting from Health Choice to Medicaid; the impact of not meeting all the budget reduction items approved as part of the FY 2013-15 Biennium Budget; and an increase in the federal match rate.

The following chart details the various components of the rebase calculation:

Growth, Claims and Utilization:$114,100,000
Budget Reductions Not Achieved:
- Outpatient to 70% - $25,300,000
- Shared Savings - $10,800,000
- Drug Savings - $9,400,000
- Rehabilitation Visit Limitation - $5,700,000
- Physician Visit Limitation - $7,600,000
- Freeze Rates - $26,600,000
- Copay Increase - $5,000,000

Presumptive Eligibility:$5,500,000
Additional Children Shifted From Health Choice: $9,400,000
Change in FMAP: ($14,600,000)
PCS Services: $100,000
Settlements:$1,100,000

MEDICAID REBASE FY 2014-15: $ 206,000,000

---

99 **Personal Care Services (PCS) Study Optional Program (1102)**

$300,000 NR

Provides funding for the Department to transfer $300,000 to the Legislative Services Commission to contract for a study to define a new limited PCS optional service program. This amount represents the State share of the total funding of $600,000. The remaining source of funding will come from the Medicaid administrative funding from the Centers for Medicare and Medicaid Services (CMS). The report from this study is due December 1, 2015. Additionally, the Department will study and report on Adult Care Home inspections, procedures and processes.

related to item 100.

100	**Personal Care Services (PCS) Study Optional Program (1102)** Provides funding for the Department to transfer $200,000 to the Legislative Services Commission to contract for a study to define a new limited PCS optional service program. This amount represents the State share of the total funding of $400,000. The remaining source of funding will come from the Medicaid administrative funding from the Centers for Medicare and Medicaid Services (CMS). The report from this study is due December 1, 2015.		$200,000	NR
101	**Division of Medical Assistance Reorganization (1101,1102)** Provides funding for consultants, contractors and initial staffing for the development of a new organization for the Division of Medical Assistance.		$4,898,158	NR
102	**Medicaid Reform** Provides funding for consultants, contractors and staff to reform the Medicaid program.	$1,000,000		

related to item 99

(10.0) NC Health Choice

103	**Health Choice Rebase (1310)** Funds the Health Choice rebase for FY 2014-15 that includes a 5.3% growth in enrollment and utilization, the impact of an additional 20,000 children shifting from Health Choice to Medicaid, and the impact of not meeting all the budget reduction items included in the 2013 Appropriations Act. The following chart details the various components of the rebase calculation: Growth, Claims and Utilization: ($9,900,000) Budget Reductions Not Achieved: $2,900,000 Additional Children Shifted From Health Choice: ($7,500,000) HEALTH CHOICE REBASE FY 2014-15 ($14,500,000)	($14,500,000)	($14,500,000)	
104	**Single Base Rate for all Hospitals (1310)** Establishes a single base diagnosis related group (DRG) rate for inpatient hospital services based on the statewide median base rate for all hospitals effective January 1, 2015. This represents a 1.8% reduction in claims spending for inpatient hospital services.		($63,961)	

Senate Only

	House FY 14-15	Senate FY 14-15
Health Choice Administrative Budget Adjustment (1102)	($1,250,000)	($1,250,000)
Adjusts the Health Choice administrative budget to more accurately reflect actual expenditures and anticipated costs in FY 2014-15.		

(11.0) Divisions of Services for the Blind and Services for the Deaf and Hard of

106 **No Action Taken**		
Takes no budget action specific to the Divisions of Services for the Blind and Services for the Deaf and Hard of Hearing.		
Department Totals	($70,045,786) -16.95 $37,818,766 NR	$16,389,971 -69.61 $111,379,174 NR

Health and Human Services

HOUSE AND SENATE BUDGET

ITEMS IN CONTROVERSY

[skipped pages]

Senate and House Differ

Senate Version

HHS COMPETITIVE GRANTS PROCESS REVISIONS

SECTION 12A.1. Section 12A.2 of S.L. 2013-360 reads as rewritten:

"FUNDING FOR NONPROFIT ORGANIZATIONS/ESTABLISH COMPETITIVE GRANTS PROCESS

"SECTION 12A.2.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, the sum of nine million five hundred twenty-nine thousand one hundred thirty-four dollars ($9,529,134) in recurring funds for ~~each year of the 2013-2015 fiscal biennium,~~the 2013-2014 fiscal year and the sum of nine million three hundred three thousand nine hundred eleven dollars ($9,303,911) in recurring funds for the 2014-2015 fiscal year, the sum of three hundred seventeen thousand four hundred dollars ($317,400) in nonrecurring funds for each year of the 2013-2015 fiscal biennium, and the sum of three million eight hundred fifty-two thousand five hundred dollars ($3,852,500) appropriated in Section 12J.1 of this act in Social Services Block Grant funds for each year of the 2013-2015 fiscal biennium shall be used to allocate funds for nonprofit organizations.

...

"SECTION 12A.2.(d) It is the intent of the General Assembly that, beginning fiscal year 2014-2015, the Department implement a competitive grants process for nonprofit funding. To that end, the Department shall develop a plan that establishes a competitive grants process to be administered by the Division of Central Management and Support. The Department shall develop a plan that, at a minimum, includes each of the following:

(1) A request for application (RFA) process to allow nonprofits to apply for and receive State funds on a competitive basis.

(2) A requirement that nonprofits match a minimum of ten percent (10%) of the total amount of the grant award.

(3) A requirement that the Secretary prioritize grant awards to those nonprofits that are able to leverage non-State funds in addition to the grant award.

(4) A process that awards grants to nonprofits ~~dedicated to providing~~that have the capacity to provide services on a statewide basis and that support any of the following State health and wellness initiatives:

a. A program targeting advocacy, support, education, or residential services for persons diagnosed with autism.

~~b. A comprehensive program of education, advocacy, and support related to brain injury and those affected by brain injury.~~

c. A system of residential supports for those afflicted with substance abuse addiction.

d. A program of advocacy and supports for individuals with intellectual and developmental disabilities or severe and persistent mental illness, substance abusers, or the elderly.

e. Supports and services to children and adults with developmental disabilities or mental health diagnoses.

f. A food distribution system for needy individuals.

g. The provision and coordination of services for the homeless.

h. The provision of services for individuals aging out of foster care.

i. Programs promoting wellness, physical activity, and health education programming for North Carolinians.

j. A program focused on enhancing vision screening through the State's public school system.

k. Provision for the delivery of after-school services for mentoring at-risk youth.

l. The provision of direct services for amyotrophic lateral sclerosis (ALS) and those diagnosed with the disease.

m. The provision of assistive information technology services for blind and disabled persons.

(5) Ensures that funds received by the Department to implement the plan supplement and do not supplant existing funds for health and wellness programs and initiatives.

...

"**SECTION 12A.2.(h)** For fiscal year 2014-2015 only, from the sum of nine million three hundred three thousand nine hundred eleven dollars ($9,303,911) referred to in subsection (a) of this section, the Department shall allocate the sum of three hundred seventy-five thousand dollars ($375,000) to the Big Brothers Big Sisters of the Triangle, Inc., for the purpose of mentoring at-risk youth. Big Brothers Big Sisters of the Triangle, Inc., shall be required to seek future funding through the competitive grants process in accordance with subsection (d) of this section."

★ Senate Only

House Version

HHS COMPETITIVE GRANTS PROCESS REVISIONS

SECTION 12A.1. Section 12A.2 of S.L. 2013-360 reads as rewritten:

"**FUNDING FOR NONPROFIT ORGANIZATIONS/ESTABLISH COMPETITIVE GRANTS PROCESS**

"**SECTION 12A.2.(a)** Of the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, the sum of nine million five hundred twenty-nine thousand one hundred thirty-four dollars ($9,529,134) in recurring funds for ~~each year of the 2013-2015 fiscal biennium,~~the 2013-2014 fiscal year and the sum of nine million three hundred three thousand nine hundred eleven dollars ($9,303,911) in recurring funds for the 2014-2015 fiscal year, the sum of three hundred seventeen thousand four hundred dollars ($317,400) in nonrecurring funds for each year of the 2013-2015 fiscal biennium, and the sum of three million eight hundred fifty-two thousand five hundred dollars ($3,852,500) appropriated in Section 12J.1 of this act in Social Services Block Grant funds for each year of the 2013-2015 fiscal biennium shall be used to allocate funds for nonprofit organizations.

...

"**SECTION 12A.2.(d)** It is the intent of the General Assembly that, beginning fiscal year 2014-2015, the Department implement a competitive grants process for nonprofit funding. To that end, the Department shall develop a plan that establishes a competitive grants process to be administered by the Division of Central Management and Support. The Department shall develop a plan that, at a minimum, includes each of the following:

(1) A request for application (RFA) process to allow nonprofits to apply for and receive State funds on a competitive basis.

(2) A requirement that nonprofits match a minimum of ten percent (10%) of the total amount of the grant award.

(3) A requirement that the Secretary prioritize grant awards to those nonprofits that are able to leverage non-State funds in addition to the grant award.

(4) A process that awards grants to nonprofits ~~dedicated to providing~~that have the capacity to provide services on a statewide basis and that support any of the following State health and wellness initiatives:

a. A program targeting advocacy, support, education, or residential services for persons diagnosed with autism.

~~b. A comprehensive program of education, advocacy, and support related to brain injury and those affected by brain injury.~~

c. A system of residential supports for those afflicted with substance abuse addiction.

d. A program of advocacy and supports for individuals with intellectual and developmental disabilities or severe and persistent mental illness, substance abusers, or the elderly.

e. Supports and services to children and adults with developmental disabilities or mental health diagnoses.

f. A food distribution system for needy individuals.

g. The provision and coordination of services for the homeless.

h. The provision of services for individuals aging out of foster care.

i. Programs promoting wellness, physical activity, and health education programming for North Carolinians.

j. A program focused on enhancing vision screening through the State's public school system.

k. Provision for the delivery of after-school services for apprenticeships or mentoring at-risk youth.

l. The provision of direct services for amyotrophic lateral sclerosis (ALS) and those diagnosed with the disease.

m. The provision of assistive information technology services for blind and disabled persons.

n. A comprehensive smoking prevention and cessation program that screens and treats tobacco use in pregnant women and postpartum mothers. } A

(5) Ensures that funds received by the Department to implement the plan supplement and do not supplant existing funds for health and wellness programs and initiatives.

...."

Senate and House Differ

Senate Version

Follows $

FUNDS FOR STATEWIDE HEALTH INFORMATION EXCHANGE

SECTION 12A.2.(a) It is the intent of the General Assembly:

(1) To maximize receipt of federal funds for administration and support of the statewide health information exchange network (HIE Network).

(2) To allow the North Carolina Health Information Exchange (NC HIE), the nonprofit corporation responsible for overseeing and administering the HIE Network, to receive the State's share of available federal funds for administration and support of the HIE Network in order to reduce the operating costs of the HIE Network by an amount sufficient to allow for the elimination or reduction of the participation fee the NC HIE currently imposes on hospitals required to connect to the HIE Network pursuant to G.S. 90-413.3A.

(3) Beginning with the 2015-2016 fiscal year, to make the Department of Health and Human Services, Division of Central Management and Support, responsible for using State funds to draw down available matching federal funds for administration and support of the HIE Network.

SECTION 12A.2.(b) From the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, for the health information exchange for the 2014-2015 fiscal year, the Department shall allocate to the North Carolina Health Information Exchange, a nonprofit corporation, an amount sufficient to represent the State share for the maximum amount of approved federal matching funds for allowable Medicaid administrative costs related to the HIE Network.

Follows $

House Version

FUNDS FOR STATEWIDE HEALTH INFORMATION EXCHANGE

SECTION 12A.2.(a) It is the intent of the General Assembly:

(1) To maximize receipt of federal funds for administration and support of the statewide health information exchange network (HIE Network).

(2) To allow the North Carolina Health Information Exchange (NC HIE), the nonprofit corporation responsible for overseeing and administering the HIE Network, to receive the State's share of available federal funds for administration and support of the HIE Network in order to reduce the operating costs of the HIE Network by an amount sufficient to allow for the elimination or reduction of the participation fee the NC HIE currently imposes on hospitals required to connect to the HIE Network pursuant to G.S. 90-413.3A.

(3) Beginning with the 2015-2016 fiscal year, to make the Department of Health and Human Services, Division of Central Management and Support, responsible for using State funds to draw down available matching federal funds for administration and support of the HIE Network.

SECTION 12A.2.(b) From the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, for the health information exchange for the 2014-2015 fiscal year, the Department shall allocate to the North Carolina Health Information Exchange, a nonprofit corporation, an amount sufficient to represent the State share for the maximum amount of approved federal matching funds for allowable Medicaid administrative costs related to the HIE Network.

SECTION 12A.2.(c) By March 1, 2015, the NC HIE shall report to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, and the Fiscal Research Division on its use of (i) State appropriations allocated to the NC HIE pursuant to this section and (ii) federal matching funds received by the NC HIE for costs related to the HIE Network. The report shall include a detailed, audited report of all State and federal funds received by the NC HIE and all expenditures from these funds.

A House Only

Senate Only

SINGLE SYSTEM OF MEDICAID CLAIM ADJUDICATION FOR ENTITIES UNDER CONTRACT WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

SECTION 12A.3.(a) Section 12A.4(j) of S.L. 2013-360 reads as rewritten:

"**SECTION 12A.4.(j)** The Department shall plan and implement system modifications necessary to enable entities under contract with the Department to perform Medicaid claim adjudication in the replacement MMIS. The Department shall implement these system modifications by the earlier of ~~January 1, 2015,~~ July 1, 2017, or prior to renewing any contract currently in effect with an entity required to perform Medicaid claim adjudication in the replacement MMIS pursuant to this section. Upon implementation of these system modifications, the Department shall require all Medicaid claim adjudication to be performed by the replacement MMIS, including all Medicaid claim adjudication performed by entities under contract with the Department. The Department may require entities under contract with the Department to contract directly with the State's Medicaid fiscal agent to provide technical support for Medicaid claim adjudication performed by the replacement MMIS for these entities, subject to prior approval of contract terms by the Department. The Department may charge entities under contract with the Department a fee not to exceed the amount necessary to cover the full operating cost of Medicaid claim adjudication performed by the replacement MMIS for these entities."

SECTION 12A.3.(b) Section 12A.4(k) of S.L. 2013-360, as amended by Section 4.11 of S.L. 2013-363, reads as rewritten:

"**SECTION 12A.4.(k)** Subsection (j) of this section becomes effective ~~January 1, 2015.~~January 1, 2016."

SECTION 12A.3.(c) The Department of Health and Human Services shall develop a plan to implement a single system of Medicaid claim adjudication compatible with the replacement Medicaid Management Information System (MMIS), to be used by all entities under contract with the Department until the Department implements system modifications necessary to enable these entities to perform Medicaid claim adjudication in the replacement MMIS. The Department shall submit the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than May 1, 2015.

House Only

REPEAL PLANS TO IMPLEMENT SYSTEM MODIFICATIONS TO ENABLE CONTRACT ENTITIES TO PERFORM MEDICAID CLAIM ADJUDICATION IN THE REPLACEMENT MEDICAID MANAGEMENT INFORMATION SYSTEM

SECTION 12A.4.(a) Section 12A.4(j) of S.L. 2013-360 is repealed.

SECTION 12A.4.(b) Section 12A.4(k) of S.L. 2013-360, as amended by Section 4.11 of S.L. 2013-363, is repealed.

House Only

FUNDS FOR REPLACEMENT MEDICAID MANAGEMENT INFORMATION SYSTEM

SECTION 12A.5. Section 12A.4(a) of S.L. 2013-360 reads as rewritten:

"**SECTION 12A.4.(a)** The Secretary of the Department of Health and Human Services may utilize prior year earned revenue received for the replacement MMIS in the amount of nine million six hundred fifty-eight thousand one hundred fifty-two dollars ($9,658,152) for the 2013-2014 fiscal year and in the amount of ~~one million six hundred sixty-six thousand six hundred twenty-five dollars ($1,666,625)~~ six million eight hundred ninety thousand six hundred dollars ($6,890,600) for the 2014-2015 fiscal year. In the event the Department does not receive prior year earned revenues in the amounts authorized by this section, or funds are insufficient to advance the project, the Department may, with prior approval from the Office of State Budget and Management (OSBM), utilize overrealized receipts and funds appropriated to the Department to achieve the level of funding specified in this section for the replacement MMIS."

Follows $

{ Technical / Conforms with Money Report }

House Only

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

SECTION 12A.6. Section 12A.6(a) of S.L. 2013-360 reads as rewritten:

"**SECTION 12A.6.(a)** Funds appropriated in this act in the amount of eight hundred sixty-four thousand six hundred fifty-five dollars ($864,655) for State fiscal year 2014-2015 along with prior year earned revenue in the amount of four million one hundred thirty-eight thousand two dollars ($4,138,002) and the cash balance in Budget Code 24410 Fund 2411 for the North Carolina Families Accessing Services through Technology (NC FAST) project shall be used to match federal funds in fiscal years 2013-2014 and 2014-2015 to expedite the development and implementation of the Eligibility Information System (EIS), Child Care, Low Income Energy Assistance, and Crisis Intervention Programs, and Child Service components of the NC FAST project."

Follows $

{Technical/Conforms with Money Report}

House Only

SUPPLEMENTAL SHORT-TERM ASSISTANCE FOR GROUP HOMES

SECTION 12A.7.(a) Notwithstanding any other provision of law, funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2014-2015 fiscal year for unpaid LME liabilities is reduced by the sum of two million dollars ($2,000,000) in nonrecurring funds, and that amount is instead allocated to the Department of Health and Human Services, Division of Central Management and Support, for the 2014-2015 fiscal year to provide temporary, short-term financial assistance in the form of a monthly payment to group homes on behalf of each resident who meets all of the following criteria:

(1) Was eligible for Medicaid-covered personal care services (PCS) prior to January 1, 2013, but was determined to be ineligible for PCS on or after January 1, 2013, due to Medicaid State Plan changes in PCS eligibility criteria specified in Section 10.9F of S.L. 2012-142, as amended by Section 3.7 of S.L. 2012-145 and Section 70 of S.L. 2012-194.

(2) Has continuously resided in a group home since December 31, 2012.

SECTION 12A.7.(b) These monthly payments shall be subject to all of the following requirements and limitations:

(1) The amount of the monthly payments authorized by this section shall not exceed four hundred sixty-four dollars and thirty cents ($464.30) per month for each resident who meets all criteria specified in subsection (a) of this section.

(2) A group home that receives the monthly payments authorized by this section shall not, under any circumstances, use these payments for any purpose other than providing, as necessary, supervision and medication management for a resident who meets all criteria specified in subsection (a) of this section.

(3) The Department shall make monthly payments authorized by this section to a group home on behalf of each resident who meets all criteria specified in subsection (a) of this section only for the period commencing July 1, 2014, and ending June 30, 2015, or upon depletion of the two million dollars ($2,000,000) in nonrecurring funds appropriated in this act to the Division of Central Management and Support for the 2014-2015 fiscal year for the purpose of this section, whichever is earlier.

(4) The Department shall make monthly payments authorized by this section only to the extent sufficient funds are available from the two million dollars ($2,000,000) in nonrecurring funds appropriated in this act to the Division of Central Management and Support for the 2014-2015 fiscal year for the purpose of this section.

(5) The Department shall not make monthly payments authorized by this section to a group home on behalf of a resident during the pendency of an appeal by or on behalf of the resident under G.S. 108A-70.9A.

(6) The Department shall terminate all monthly payments pursuant to this section on June 30, 2015, or upon depletion of the funds appropriated in this act to the Division of Central Management and Support for the 2014-2015 fiscal year for the purpose of this section, whichever is earlier.

(7) Each group home that receives the monthly payments authorized by this section shall submit to the Department a list of all funding sources for the operational costs of the group home for the preceding two years, in accordance with the schedule and format prescribed by the Department.

SECTION 12A.7.(c) The Department shall use an existing mechanism to administer these funds in the least restrictive manner that ensures compliance with this section and timely and accurate payments to group homes. The Department shall not, under any circumstances, use any portion of the two million dollars ($2,000,000) appropriated in this act to the Division of Central Management and Support for the purpose of this section for any other purpose.

SECTION 12A.7.(d) By no later than April 1, 2015, the Department of Health and Human Services shall submit to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division:

(1) A plan for a long-term solution for individuals residing in group homes who would like to continue residing in this setting and, as a result of an independent assessment, have been determined to need only supervision, medication management, or both.

(2) A list of funding sources for each group home that receives assistance authorized by this section, based on the information provided to the Department pursuant to Section 12A.7(b)(7).

SECTION 12A.7.(e) Nothing in this section shall be construed as an obligation by the General Assembly to appropriate funds for the purpose of this section, or as an entitlement by any group home, resident of a group home, or other person to receive temporary, short-term financial assistance under this section.

SECTION 12A.7.(f) As used in this act, "group home" means any facility that (i) is licensed under Chapter 122C of the General Statutes, (ii) meets the definition of a supervised living facility under 10A NCAC 27G .5601(c)(1) or 10A NCAC 27G .5601(c)(3), and (iii) serves adults whose primary diagnosis is mental illness or a developmental disability but may also have other diagnoses.

SECTION 12A.7.(g) This section expires June 30, 2015. 3*

Senate and House Differ

Senate Version

CHILD CARE SUBSIDY RATES/REVISE CO-PAYMENTS AND ELIGIBILITY CRITERIA

SECTION 12B.1. Section 12B.3 of S.L. 2013-360 reads as rewritten:

"**CHILD CARE SUBSIDY RATES**

"**SECTION 12B.3.(a)** ~~The~~ Beginning September 1, 2014, 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.~~ determined based on a percentage of the federal poverty level as follows:

AGE	INCOME PERCENTAGE LEVEL
0-5	200%
6-12	133%

The eligibility for any child with special needs, including a child who is 13 years of age or older, shall be two hundred percent (200%) of the federal poverty level.

"**SECTION 12B.3.(b)** ~~Fees~~ Beginning September 1, 2014, fees for families who are required to share in the cost of care shall be established based on ~~a~~ ten percent (10%) of gross family ~~income and adjusted for family size. Fees shall be determined as follows:~~ income. Co-payments shall not be prorated for part-time care:

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

"**SECTION 12B.3.(b1)** No later than January 1, 2015, the Department of Health and Human Services, Division of Child Development and Early Education, shall revise its child care subsidy policy to include in the policy's definition of "income unit" the following:

(1) A stepparent and the stepparent's child, if applicable.

(2) A nonparent relative caretaker, and the caretaker's spouse and child, if applicable, when the parent of the child receiving child care subsidy does not live in the home with the child.

...

"**SECTION 12B.3.(h)** Payment for subsidized child care services provided with ~~Work First~~ Temporary Assistance for Needy Families Block Grant funds shall comply with all regulations and policies issued by the Division of Child Development for the subsidized child care program.

...."

House Version

CHILD CARE SUBSIDY RATES/REVISE CO-PAYMENTS AND ELIGIBILITY CRITERIA

SECTION 12B.1. Section 12B.3 of S.L. 2013-360 reads as rewritten:

"**CHILD CARE SUBSIDY RATES**

"**SECTION 12B.3.(a)** ~~The~~ Beginning October 1, 2014, 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.~~ determined based on a percentage of the federal poverty level as follows:

AGE	INCOME PERCENTAGE LEVEL
0-5	200%
6-12	133%

The eligibility for any child with special needs, including a child who is 13 years of age or older, shall be two hundred percent (200%) of the federal poverty level.

"**SECTION 12B.3.(a1)** A child receiving child care subsidy based on seventy-five percent (75%) of the State median income shall continue to receive subsidy based on seventy-five percent (75%) of the State median income until the child's next eligibility redetermination by the Department, and at that redetermination, the child's income eligibility shall be based on the eligibility criteria set forth in subsection (a) of this section.

"**SECTION 12B.3.(b)** ~~Fees~~ Beginning October 1, 2014, fees for families who are required to share in the cost of care shall be established based on ~~a~~ ten percent (10%) of gross family ~~income and adjusted for family size. Fees shall be determined as follows:~~ income. Co-payments shall not be prorated for part-time care.

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

"**SECTION 12B.3.(b1)** No later than January 1, 2015, the Department of Health and Human Services, Division of Child Development and Early Education, shall revise its child care subsidy policy to include in the policy's definition of "income unit" the following:

(1) A stepparent and the stepparent's child, if applicable.

(2) A nonparent relative caretaker, and the caretaker's spouse and child, if applicable, when the parent of the child receiving child care subsidy does not live in the home with the child.

...

"**SECTION 12B.3.(h)** Payment for subsidized child care services provided with ~~Work First~~ Temporary Assistance for Needy Families Block Grant funds shall comply with all regulations and policies issued by the Division of Child Development for the subsidized child care program.

...."

Follows $

* House Only

Senate and House Differ

Senate Version

EARLY CHILDHOOD EDUCATION AND DEVELOPMENT INITIATIVES ENHANCEMENTS/CODIFY TANF MAINTENANCE OF EFFORT REQUIREMENT

SECTION 12B.2. G.S. 143B-168.15(g) reads as rewritten:

"(g) Not less than thirty percent (30%) of the funds spent in each year of each local partnership's direct services allocation shall be used to expand child care subsidies. To the extent practicable, these funds shall be used to enhance the affordability, availability, and quality of child care services as described in this section. The North Carolina Partnership may increase this percentage requirement up to a maximum of fifty percent (50%) when, based upon a significant local waiting list for subsidized child care, the North Carolina Partnership determines a higher percentage is justified. Local partnerships shall spend an amount for child care subsidies that provides at least fifty-two million dollars ($52,000,000) for the Temporary Assistance to Needy Families (TANF) maintenance of effort requirement and the Child Care Development Fund and Block Grant match requirement."

House Version

EARLY CHILDHOOD EDUCATION AND DEVELOPMENT INITIATIVES ENHANCEMENTS/REQUIRE FUND-RAISING ASSISTANCE/CODIFY TANF MAINTENANCE OF EFFORT REQUIREMENT

SECTION 12B.2.(a) Section 12B.9 of S.L. 2013-360 is amended by adding the following new subsection to read:

"**SECTION 12B.9.(i)** The North Carolina Partnership for Children, Inc., (Partnership) shall include in its assistance to local partnerships training and assistance with fund-raising activities. From funds available to the Partnership, the Partnership shall hire a staff of three individuals who are qualified in the areas of grant writing and fund-raising to assist local partnerships in raising non-State funds, particularly regarding private donations. The staff hired pursuant to this subsection shall be located regionally and be accessible to participate in the various local partnerships' activities."

* House Only

SECTION 12B.2.(b) G.S. 143B-168.15(g) reads as rewritten:

"(g) Not less than thirty percent (30%) of the funds spent in each year of each local partnership's direct services allocation shall be used to expand child care subsidies. To the extent practicable, these funds shall be used to enhance the affordability, availability, and quality of child care services as described in this section. The North Carolina Partnership may increase this percentage requirement up to a maximum of fifty percent (50%) when, based upon a significant local waiting list for subsidized child care, the North Carolina Partnership determines a higher percentage is justified. Local partnerships shall spend an amount for child care subsidies that provides at least fifty-two million dollars ($52,000,000) for the Temporary Assistance to Needy Families (TANF) maintenance of effort requirement and the Child Care Development Fund and Block Grant match requirement."

Senate and House Differ

Senate Version

STUDY CHILD CARE SUBSIDY FOR 11- AND 12-YEAR OLDS

SECTION 12B.3.(a) The Department of Health and Human Services, Division of Child Development and Early Education, shall study child care subsidy for 11- and 12-year olds. The Division shall study (i) available options for 11- and 12- year olds for before and after school care, (ii) available resources other than child care subsidy to pay for before and after school care, and (iii) the average cost of care for 11- and 12- year olds.

SECTION 12B.3.(b) The Division shall report its findings and recommendations to the Joint Legislative Committee on Health and Human Services and the Fiscal Research Division no later than November 30, 2014.

House Version

STUDY CHILD CARE SUBSIDY FOR 11- AND 12-YEAR OLDS

SECTION 12B.3.(a) The Department of Health and Human Services, Division of Child Development and Early Education, shall study child care subsidy for 11- and 12-year olds. The Division shall study (i) available options for 11- and 12- year olds for before and after school care, (ii) available resources other than child care subsidy to pay for before and after school care, and (iii) the average cost of care for 11- and 12- year olds.

SECTION 12B.3.(b) The Division shall report its findings and recommendations to the Joint Legislative Committee on Health and Human Services and the Fiscal Research Division no later than November 30, 2014. The report shall include separate findings and recommendations for 11- and 12-year olds.

Senate and House Differ

Senate Version

REVISE CHILD CARE ALLOCATION FORMULA

SECTION 12B.4. Section 12B.4 of S.L. 2013-360 reads as rewritten:

"**CHILD CARE ALLOCATION FORMULA**

"**SECTION 12B.4.(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%) North Carolina Partnership for Children, Inc., 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%) North Carolina Partnership for Children, Inc., 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.~~the applicable federal poverty level percentage set forth in Section 12B.3(a) of this act, as amended.

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

(3) For fiscal years 2013-2014 and 2014-2015, the Division of Child Development and Early Education shall base the formula identified in subdivision (1) of this subsection on the same data source used for the 2012-2013 fiscal year.

(4) The Department of Health and Human Services shall allocate to counties all State funds appropriated for child care subsidy and shall not withhold funds during the 2013-2014 and 2014-2015 fiscal years.

"**SECTION 12B.4.(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 North Carolina Partnership for Children, Inc., funds within a county. Beginning with any funding reallocated in the 2013-2014 fiscal year, reallocated funds shall become part of a county's allocation formula in future fiscal years and, beginning with the 2014-2015 fiscal year, shall apply to both increased and decreased allocations."

* Senate Only

House Version

REVISE CHILD CARE ALLOCATION FORMULA

SECTION 12B.4. Section 12B.4 of S.L. 2013-360 reads as rewritten:

"**CHILD CARE ALLOCATION FORMULA**

"**SECTION 12B.4.(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%) North Carolina Partnership for Children, Inc., 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%) North Carolina Partnership for Children, Inc., 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.~~the applicable federal poverty level percentage set forth in Section 12B.3(a) of this act, as amended.

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

(3) For fiscal years 2013-2014 and 2014-2015, the Division of Child Development and Early Education shall base the formula identified in subdivision (1) of this subsection on the same data source used for the 2012-2013 fiscal year.

(4) The Department of Health and Human Services shall allocate to counties all State funds appropriated for child care subsidy and shall not withhold funds during the 2013-2014 and 2014-2015 fiscal years.

"**SECTION 12B.4.(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 North Carolina Partnership for Children, Inc., funds within a county.

"**SECTION 12B.4.(c)** When implementing the formula under subsection (a) of this section, the Department of Health and Human Services, Division of Child Development and Early Education, shall include the market rate increase in the formula process, rather than running these increases outside of the formula process. Additionally, the Department shall do the following:

(1) Beginning fiscal year 2014-2015, use one-third implementation of the new Census data allocation formula every two years, provided the following applies regarding increases to a county's allocation:

a. For the 2014-2015 fiscal year allocations, a county that did not have a child care subsidy waiting list during the 2013-2014 fiscal year shall not receive an increase in its allocation due to the new allocation formula directed in this subdivision.

b. Beginning fiscal year 2015-2016, a county whose spending coefficient is below ninety-five percent (95%) in the previous fiscal year shall not receive an increase in its allocation in the following fiscal year. The Division may waive this requirement and allow an increase if the spending coefficient is below ninety-five percent (95%) due to extraordinary circumstances, such as a State or federal disaster declaration in the affected county. By October 1st of each year, the Division shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division the counties that received a waiver pursuant to this sub-subdivision and the reasons for the waiver.

★ House Only

(2) Effective immediately following the next new Census data release, use one-third biennial implementation, which reflects a six-year phase-in approach for each Census cycle thereafter going forward."

House Only

CHILD CARE MARKET RATE ADJUSTMENTS

SECTION 12B.5. By January 1, 2015, the Department shall implement an adjustment to child care market rates based upon the 2013 Child Care Market Rate Study. Three- to five-star rated child care centers and three- to five-star rated child care homes shall receive forty percent (40%) of the recommended rate adjustments as defined in the 2013 Child Care Market Rate Study.

House Only

NC PRE-K AUDITS

SECTION 12B.6. Section 12B.1 of S.L. 2013-360, as amended by Sections 4.2 and 4.3 of S.L. 2013-363, is amended by adding the following new subsection to read:

"**SECTION 12B.1.(k)** The administration of the NC Pre-K program by local partnerships shall be subject to the biennial financial and compliance audits authorized under G.S. 143B-168.14(b)."

House Only

CHILD CARE LICENSE CERTIFICATION BY DHHS

SECTION 12B.7. The Department of Health and Human Services shall be responsible for certifying individuals and assigning a certification level pursuant to the North Carolina Early Education Certification based on rules adopted by the Commission.

Senate and House Differ

Senate Version

Follows $

CHILD PROTECTIVE SERVICES IMPROVEMENT INITIATIVE

SECTION 12C.1.(a) Findings and Intent. – The General Assembly makes the following findings:

(1) Child Protective Services' policy from the Department of Health and Human Services, Division of Social Services, recommends that the average child protective services caseload be no greater than 10 families at any time for workers performing child protective services assessments and 10 families at any time for staff providing in-home services. However, data suggests that in 43 of the counties in this State, 21 have a caseload size of over 15 cases per worker; and further, in nine of those 21 counties, there is an average caseload size of over 20 cases per worker.

(2) During the 2013-2014 fiscal year, county departments of social services lost federal funding for child protective services under the Temporary Assistance of Needy Families (TANF) Block Grant and Title IV-E funding. However, the number of Child Protective Services investigations has grown by twenty percent (20%) from fiscal year 2002 to fiscal year 2012.

(3) There is no current, statewide data available on the performance of county departments of social services regarding child protective services.

(4) There exists the potential for a conflict of interest to arise when a county department of social services has been appointed as guardian for both (i) a child who is the subject of a report of abuse, neglect, or dependency that would be investigated by Child Protective Services and (ii) for the parent or legal guardian of the child.

It is the intent of the General Assembly to (i) reduce caseload size for Child Protective Services' workers to the recommended standard, (ii) provide adequate resources for county departments of social services to provide child protective services for abused, neglected, and dependent children, (iii) provide for a comprehensive evaluation of various functions and funding regarding child protective services, and (iv) study ways to reduce conflicts of interest regarding guardianship and child protective services. To that end, the General Assembly supports the initiatives and the allocation of funds for child welfare services as described in this section.

SECTION 12C.1.(b) Funds for Child Protective Services. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of eight million three hundred twenty-six thousand six hundred twenty-seven dollars ($8,326,627) shall be allocated to provide additional child protective services workers at county departments of social services to reduce caseloads to the recommended standard.

SECTION 12C.1.(c) Funds for In-Home Services. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of four million five hundred thousand dollars ($4,500,000) shall be allocated for Child Welfare in-home services to provide and coordinate interventions and services that focus on child safety and protection, family preservation, and the prevention of further abuse or neglect.

SECTION 12C.1.(d) Funds for Oversight of Child Welfare Services. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social

Services, the sum of seven hundred fifty thousand dollars ($750,000) shall be allocated to fund nine positions to the Division to enhance oversight of child welfare services in county departments of social services. These positions shall be used to monitor, train, and provide technical assistance to the county departments of social services to ensure children and families are provided services that address the safety, permanency, and well-being of children served by child welfare services.

SECTION 12C.1.(e) Pilot Program. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of three hundred thousand dollars ($300,000) shall be used to establish and implement a child protective services pilot program. The funds shall be used to enhance coordination of services and information among county departments of social services, local law enforcement agencies, the court system, guardian ad litem programs, and other agencies as deemed appropriate by the Department. The Department shall determine the number of sites that may participate in the pilot program and include regions that are geographically diverse.

The Division shall make a progress report on the pilot program 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 no later than March 1, 2015. The Division shall make a final report of its findings and recommendations on the pilot program to the Joint Legislative Oversight Committee on Health and Human Services no later than March 1, 2016.

SECTION 12C.1.(f) Statewide Evaluation. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of seven hundred thousand dollars ($700,000) shall be used to provide for a comprehensive, statewide evaluation of the State's child protective services system. The Division of Social Services shall contract for an independent evaluation of the system, which evaluation shall include developing recommendations on the following:

(1) The performance of county departments of social services as related to child protective services.
(2) Caseload sizes.
(3) The administrative structure of the child protective services system in the State.
(4) Any funding needs.
(5) Child protective services' worker turnover.
(6) Monitoring and oversight of county departments of social services.

The Division shall report the findings and recommendations from the evaluation to the Joint Legislative Oversight Committee on Health and Human Services no later than January 1, 2016.

SECTION 12C.1.(g) Study Conflicts of Interest/Public Guardianship and Child Protective Services. – The Department of Health and Human Services, Division of Social Services, shall study the issue of conflicts of interest in child welfare cases as related to public guardianship. In conducting the study, the Department shall consider the following regarding addressing potential conflicts of interest:

(1) Creating internal firewalls to prevent information sharing and influence among staff members involved with the conflicting cases.
(2) Creating a formal or an informal "buddy system" allowing a county with a conflict to refer a case to a neighboring county.
(3) Referring the guardianship to a corporate guardian until the child welfare case is resolved.
(4) Having the Department assume responsibility for either the guardianship or the child welfare case.
(5) Recommending legislation to permit the clerk the option to appoint a public agency or official, other than the Director of Social Services, to serve as a disinterested public agent in exceptional circumstances only.

(6) Any other issues specific to this matter the Department deems appropriate.

The Division shall submit a final report of its findings and recommendations 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 no later than February 1, 2015.

Follows $

House Version

CHILD PROTECTIVE SERVICES IMPROVEMENT INITIATIVE

SECTION 12C.1.(a) Findings and Intent. – The General Assembly makes the following findings:

(1) Child Protective Services' policy from the Department of Health and Human Services, Division of Social Services, recommends that the average child protective services caseload be no greater than 10 families at any time for workers performing child protective services assessments and 10 families at any time for staff providing in-home services. However, data suggests that in 43 of the counties in this State, 21 have a caseload size of over 15 cases per worker; and further, in nine of those 21 counties, there is an average caseload size of over 20 cases per worker.

(2) During the 2013-2014 fiscal year, county departments of social services lost federal funding for child protective services under the Temporary Assistance of Needy Families (TANF) Block Grant and Title IV-E funding. However, the number of Child Protective Services investigations has grown by twenty percent (20%) from fiscal year 2002 to fiscal year 2012.

(3) There is no current, statewide data available on the performance of county departments of social services regarding child protective services.

(4) There exists the potential for a conflict of interest to arise when a county department of social services has been appointed as guardian for both (i) a child who is the subject of a report of abuse, neglect, or dependency that would be investigated by Child Protective Services and (ii) for the parent or legal guardian of the child.

It is the intent of the General Assembly to (i) reduce caseload size for Child Protective Services' workers to the recommended standard, (ii) provide adequate resources for county departments of social services to provide child protective services for abused, neglected, and dependent children, (iii) provide for a comprehensive evaluation of various functions and funding regarding child protective services, and (iv) study ways to reduce conflicts of interest regarding guardianship and child protective services. To that end, the General Assembly supports the initiatives and the allocation of funds for child welfare services as described in this section.

SECTION 12C.1.(b) Funds for Child Protective Services. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of eight million three hundred twenty-six thousand six hundred twenty-seven dollars ($8,326,627) shall be allocated to provide additional child protective services workers at county departments of social services to reduce caseloads to the recommended standard.

SECTION 12C.1.(c) Funds for In-Home Services. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of four million five hundred thousand dollars ($4,500,000) shall be allocated for Child Welfare in-home services to provide and coordinate interventions and services that focus on child safety and protection, family preservation, and the prevention of further abuse or neglect.

SECTION 12C.1.(d) Funds for Oversight of Child Welfare Services. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of seven hundred fifty thousand dollars ($750,000) shall be allocated to fund nine positions to the Division to enhance oversight of child welfare services in county departments of social services. These positions shall be used to monitor, train, and provide technical assistance to the county departments of social services to ensure children and families are provided services that address the safety, permanency, and well-being of children served by child welfare services.

SECTION 12C.1.(e) Pilot Program. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of three hundred

thousand dollars ($300,000) shall be used to establish and implement a child protective services pilot program. The funds shall be used to enhance coordination of services and information among county departments of social services, local law enforcement agencies, the court system, guardian ad litem programs, and other agencies as deemed appropriate by the Department. The Department shall determine the number of sites that may participate in the pilot program and include regions that are geographically diverse.

The Division shall make a progress report on the pilot program 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 no later than March 1, 2015. The Division shall make a final report of its findings and recommendations on the pilot program to the Joint Legislative Oversight Committee on Health and Human Services no later than March 1, 2016.

SECTION 12C.1.(f) Statewide Evaluation. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of seven hundred thousand dollars ($700,000) shall be used to provide for a comprehensive, statewide evaluation of the State's child protective services system. The Division of Social Services shall contract for an independent evaluation of the system, which evaluation shall include developing recommendations on the following:

(1) The performance of county departments of social services as related to child protective services.
(2) Caseload sizes.
(3) The administrative structure of the child protective services system in the State.
(4) Adequacy of funding.
(5) Child protective services' worker turnover.
(6) Monitoring and oversight of county departments of social services.

The Division shall report the findings and recommendations from the evaluation to the Joint Legislative Oversight Committee on Health and Human Services no later than January 1, 2016.

SECTION 12C.1.(g) Study Conflicts of Interest/Public Guardianship and Child Protective Services. – The Department of Health and Human Services, Division of Social Services, shall study the issue of conflicts of interest in child welfare cases as related to public guardianship. In conducting the study, the Department shall consider the following regarding addressing potential conflicts of interest:

(1) Creating internal firewalls to prevent information sharing and influence among staff members involved with the conflicting cases.
(2) Creating a formal or an informal "buddy system" allowing a county with a conflict to refer a case to a neighboring county.
(3) Referring the guardianship to a corporate guardian until the child welfare case is resolved.
(4) Having the Department assume responsibility for either the guardianship or the child welfare case.
(5) Recommending legislation to permit the clerk the option to appoint a public agency or official, other than the Director of Social Services, to serve as a disinterested public agent in exceptional circumstances only.
(6) Any other issues specific to this matter the Department deems appropriate.

The Division shall submit a final report of its findings and recommendations 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 no later than February 1, 2015.

Senate and House Differ

Senate Version

Follows $

ELIGIBILITY FOR STATE-COUNTY SPECIAL ASSISTANCE PROGRAM

SECTION 12D.1.(a) G.S. 108A-41(b) reads as rewritten:

"(b) Assistance shall be granted to any person ~~who:~~who meets all of the following criteria:

(1) Meets one of the following:

a. Is 65 years of age ~~and older, is~~ or older.

b. Is between the ages of 18 and 65, and is permanently and totally disabled or is legally blind pursuant to ~~G.S. 111-11; and~~G.S. 111-11.

(2) Meets one of the following:

a. ~~Has~~ Applies for assistance prior to November 1, 2014, and has both (i) insufficient income ~~or~~ and (ii) insufficient other resources to provide a reasonable subsistence compatible with decency and health as determined by the rules and regulations of the Social Services ~~Commission; and~~Commission in effect at the time of application.

b. Applies for assistance on or after November 1, 2014, and has both (i) income at or below one hundred percent (100%) of the federal poverty level guidelines published by the United States Department of Health and Human Services and (ii) insufficient other resources to provide a reasonable subsistence compatible with decency and health as determined by the rules and regulations of the Social Services Commission.

(3) Is one of the following:

a. A resident of North Carolina for at least 90 days immediately prior to receiving this ~~assistance;~~assistance.

~~b. A person coming to North Carolina to join a close relative who has resided in North Carolina for at least 180 consecutive days immediately prior to the person's application. The close relative shall furnish verification of his or her residency to the local department of social services at the time the applicant applies for special assistance. As used in this sub-subdivision, a close relative is the person's parent, grandparent, brother, sister, spouse, or child; or~~

c. A person discharged from a State facility who was a patient in the facility as a result of an interstate mental health ~~compact.~~ compact that requires the State to continue treating the person within the State. As used in this sub-subdivision the term State facility is a facility listed under G.S. 122C-181."

SECTION 12D.1.(b) This section shall not affect the eligibility of State-County Special Assistance applicants approved to receive State-County Special Assistance benefits prior to November 1, 2014.

Technical/ Clarifying Change to existing law

★ Changes to Income Eligibility

★ Changes to Residency Requirements

★ Grandfathers current SA recipients

House Version

CLARIFICATION OF ELIGIBILITY FOR STATE-COUNTY SPECIAL ASSISTANCE PROGRAM

SECTION 12D.1.(a) G.S. 108A-41(b) reads as rewritten:

"(b) Assistance shall be granted to any person ~~who:~~who meets all of the following criteria:

(1) Is one of the following:

a. 65 years of age ~~and older, is between~~or older.

b. Between the ages of 18 and 65, and ~~is~~ permanently and totally disabled or ~~is~~ legally blind pursuant to ~~G.S. 111-11; and~~G.S. 111-11.

(2) Has insufficient income or other resources to provide a reasonable subsistence compatible with decency and health as determined by the rules and regulations of the Social Services ~~Commission; and~~Commission.

(3) Is one of the following:

a. A resident of North Carolina for at least 90 days immediately prior to receiving this ~~assistance;~~assistance.

b. A person coming to North Carolina to join a close relative who has resided in North Carolina for at least 180 consecutive days immediately prior to the person's application. The close relative shall furnish verification of his or her residency to the local department of social services at the time the applicant applies for special assistance. As used in this sub-subdivision, a close relative is the person's parent, grandparent, brother, sister, spouse, or ~~child; or~~child.

c. A person discharged from a State facility who was a patient in the facility as a result of an interstate mental health compact. As used in this sub-subdivision the term State facility is a facility listed under G.S. 122C-181."

Technical / Clarifying Changes
No changes to Eligibity for SA

Senate and House Differ

Senate Version

STATUS REPORTS FILED BY CORPORATIONS OR DISINTERESTED PUBLIC AGENTS SERVING AS GUARDIANS FOR INCOMPETENT WARDS

SECTION 12D.4.(a) G.S. 35A-1202(14) reads as rewritten:

"(14) "Status report" means the report required by G.S. 35A-1242 to be filed by the general guardian or guardian of the person. ~~A status report shall include a report of a recent medical and dental examination of the ward by one or more physicians or dentists, a report on the guardian's performance of the duties set forth in this Chapter and in the clerk's order appointing the guardian, and a report on the ward's condition, needs, and development. The clerk may direct that the report contain other or different information. The report may also contain, without limitation, reports of mental health or mental retardation professionals, psychologists, social workers, persons in loco parentis, a member of a multidisciplinary evaluation team, a designated agency, a disinterested public agent or agency, a guardian ad litem, a guardian of the estate, an interim guardian, a successor guardian, an officer, official, employee or agent of the Department of Health and Human Services, or any other interested persons including, if applicable to the ward's situation, group home parents or supervisors, employers, members of the staff of a treatment facility, or foster parents.~~"

SECTION 12D.4.(b) G.S. 35A-1242 reads as rewritten:

"**§ 35A-1242. Status reports for incompetent wards.**

(a) Any corporation or disinterested public agent that is guardian of the person for an incompetent person, within six months after being appointed, shall file an initial status report with ~~the designated agency, if there is one, or with the clerk.~~ the clerk and submit a copy of the initial status report to the designated agency, if there is one. Such guardian shall file a second status report with ~~the designated agency or~~ the clerk one year after being appointed, and subsequent reports annually thereafter. The clerk may order any other guardian of the person to file status reports. If a guardian required by this section to file a status report is employed by the designated agency, the guardian shall file any required status report with ~~both the designated agency and the clerk.~~ the clerk and submit a copy of the status report to the designated agency.

(a1) Each status report shall include all of the following:

(1) A report of recent medical and dental examinations of the ward by one or more physicians and dentists.

(2) A report on the guardian's performance of the duties set forth in this Chapter and in the clerk's order appointing the guardian.

(3) A report on the ward's residence, education, employment, and rehabilitation or habilitation.

(4) A report of the guardian's efforts to restore competency.

(5) A report of the guardian's efforts to seek alternatives to guardianship.

(6) If the guardian is a disinterested public agent or corporation, a report of the efforts to identify alternative guardians.

(7) The guardian's recommendations for implementing a more limited guardianship, preserving for the ward the opportunity to exercise rights that are within the ward's comprehension and judgment.

(8) Any additional reports or information required by the clerk.

(a2) The guardian may include in each status report additional information pertaining to the ward's best interests.

(b) Each status report shall be filed under the guardian's oath or affirmation that the report is complete and accurate so far as ~~he~~ the guardian is informed and can determine.

(c) A clerk or designated agency that receives a status report shall not make the status report available to anyone other than the guardian, the ward, the court, or State or local human ~~resource~~ services agencies providing services to the ward.

(d) The clerk, on the clerk's own motion, or any interested party, may file a motion in the cause pursuant to G.S. 35A-1207 with the clerk in the county where the guardianship is docketed to request modification of the order appointing the guardian or guardians or for consideration of any matters contained in the status report."

SECTION 12D.4.(c) This section becomes effective October 1, 2014.

House Version

STATUS REPORTS FILED BY CORPORATIONS OR DISINTERESTED PUBLIC AGENTS SERVING AS GUARDIANS FOR INCOMPETENT WARDS

SECTION 12D.4.(a) G.S. 35A-1202(14) reads as rewritten:

"(14) "Status report" means the report required by G.S. 35A-1242 to be filed by the general guardian or guardian of the person. ~~A status report shall include a report of a recent medical and dental examination of the ward by one or more physicians or dentists, a report on the guardian's performance of the duties set forth in this Chapter and in the clerk's order appointing the guardian, and a report on the ward's condition, needs, and development. The clerk may direct that the report contain other or different information. The report may also contain, without limitation, reports of mental health or mental retardation professionals, psychologists, social workers, persons in loco parentis, a member of a multidisciplinary evaluation team, a designated agency, a disinterested public agent or agency, a guardian ad litem, a guardian of the estate, an interim guardian, a successor guardian, an officer, official, employee or agent of the Department of Health and Human Services, or any other interested persons including, if applicable to the ward's situation, group home parents or supervisors, employers, members of the staff of a treatment facility, or foster parents.~~"

SECTION 12D.4.(b) G.S. 35A-1242 reads as rewritten:

"**§ 35A-1242. Status reports for incompetent wards.**

(a) Any corporation or disinterested public agent that is guardian of the person for an incompetent person, within six months after being appointed, shall file an initial status report with ~~the designated agency, if there is one, or with the clerk.~~ the clerk and submit a copy of the initial status report to the designated agency, if there is one. Such guardian shall file a second status report with ~~the designated agency or~~ the clerk one year after being appointed, and subsequent reports annually thereafter. The clerk may order any other guardian of the person to file status reports. If a guardian required by this section to file a status report is employed by the designated agency, the guardian shall file any required status report with ~~both the designated agency and the clerk.~~ the clerk and submit a copy of the status report to the designated agency.

(a1) Each status report shall include all of the following:

(1) A report or [summary] of recent medical and dental examinations of the ward by one or more physicians and dentists. In instances when the guardian has made diligent but unsuccessful attempts to secure this information, the guardian shall include in the status report an explanation and documentation of all actions taken to attempt to secure this information. * House Only

(2) A report on the guardian's performance of the duties set forth in this Chapter and in the clerk's order appointing the guardian.

(3) A report on the ward's residence, education, employment, and rehabilitation or habilitation.

(4) A report of the guardian's efforts to restore competency.

(5) A report of the guardian's efforts to seek alternatives to guardianship.

(6) If the guardian is a disinterested public agent or corporation, a report of the efforts to identify alternative guardians.

(7) The guardian's recommendations for implementing a more limited guardianship, preserving for the ward the opportunity to exercise rights that are within the ward's comprehension and judgment.

(8) Any additional reports or information required by the clerk.

(a2) The guardian may include in each status report additional information pertaining to the ward's best interests.

(b) Each status report shall be filed (i) under the guardian's oath or affirmation that the report is complete and accurate so far as ~~he~~ the guardian is informed and can ~~determine.~~determine or (ii) with the signature of a disinterested, competent witness to a statement by the guardian that the report is complete and accurate so far as the guardian is informed and can determine. Status reports filed with the signature of a disinterested, competent witness shall include the full name, address, and telephone number of the witness.

(b1) The clerk shall make status reports submitted by corporations or disinterested public agents available to the Director, or the Director's designee, of the Division of Aging and Adult Services within the Department of Health and Human Services. The Director, or the Director's designee, shall review the status reports in connection with the Department's regular program of oversight for these categories of guardians.

(c) A clerk or designated agency that receives a status report shall not make the status report available to anyone other than the guardian, the ward, the court, or State or local human ~~resource~~ services agencies providing services to the ward.

(d) The clerk, on the clerk's own motion, or any interested party, may file a motion in the cause pursuant to G.S. 35A-1207 with the clerk in the county where the guardianship is filed to request modification of the order appointing the guardian or guardians or for consideration of any matters contained in the status report."

SECTION 12D.4.(c) This section becomes effective October 1, 2014.

House Only

DEVELOPMENT OF STRATEGIC STATE PLAN FOR ALZHEIMER'S DISEASE

SECTION 12D.5. G.S. 143B-181.1 is amended by adding a new subdivision to read:

"(13) To develop a strategic State plan for Alzheimer's disease. The plan shall address ways to improve at least all of the following with respect to Alzheimer's disease:

a. Statewide awareness and education.
b. Early detection and diagnosis.
c. Care coordination.
d. Quality of care.
e. Health care system capacity.
f. Training for health care professionals.
g. Access to treatment.
h. Home- and community-based services.
i. Long-term care.
j. Caregiver assistance.
k. Research.
l. Brain health.
m. Data collection.
n. Public safety and safety-related needs of individuals with Alzheimer's disease.
o. Legal protections for individuals living with Alzheimer's disease and their caregivers.
p. State policies to assist individuals with Alzheimer's disease and their families."

House Only

REINSTATEMENT OF THE VOLUNTEER DEVELOPMENT PROGRAM AS A SERVICE CATEGORY UNDER THE HOME AND COMMUNITY CARE BLOCK GRANT

SECTION 12D.6. The Department of Health and Human Services, Division of Aging and Adult Services, shall reinstate the Volunteer Development Program as a service category under the Home and Community Care Block Grant. Counties may elect to use this program to provide services to older adults from funds received under the Home and Community Care Block Grant.

Senate and House Differ

Senate Version

CHILDREN'S DEVELOPMENTAL SERVICES AGENCIES

SECTION 12E.1. Section 12E.4 of S.L. 2013-360 reads as rewritten:

"~~**SECTION 12E.4.**~~**SECTION 12E.4.(a)** In order to achieve the reduced amount of State funds appropriated in this act for the Children's Developmental ~~Service~~ Services Agencies (CDSAs) program, the Department of Health and Human Services, Division of Public Health, ~~may~~ shall close ~~up to~~ four State-operated CDSAs, effective ~~July 1, 2014.~~ January 1, 2015. The Department shall retain the CDSA located in the City of Morganton and the CDSAs with the highest caseloads of children residing in rural and medically underserved areas. ~~If the Department elects to close one or more CDSAs pursuant to this section, it~~ The Department shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than ~~March 1, 2014,~~ March 1, 2015, identifying the CDSAs selected for closure.

"**SECTION 12E.4.(b)** For the 2014-2015 fiscal year, the Department shall maintain the same eligibility requirements for the CDSA program that were in effect on June 30, 2013."

House Version

CHILDREN'S DEVELOPMENTAL SERVICES AGENCIES

SECTION 12E.1. Section 12E.4 of S.L. 2013-360 reads as rewritten:

"**SECTION 12E.4.** ~~In~~ The Department of Health and Human Services, Division of Public Health, shall explore all options in order to achieve the reduced amount of State funds appropriated in this act for the Children's Developmental Service Agencies (CDSAs) ~~program, the Department of Health and Human Services, Division of Public Health, may close up to four CDSAs, effective July 1, 2014. The Department shall retain the CDSA located in the City of Morganton and the CDSAs with the highest caseloads of children residing in rural and medically underserved areas. If the Department elects to close one or more CDSAs pursuant to this section, it~~ program. The Department shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than ~~March 1, 2014~~, March 1, 2015, identifying the ~~CDSAs selected for closure.~~ actions implemented by the Department to achieve this reduction."

Senate Only Follows 4

REDIRECTION OF SCHOOL NURSE FUNDING INITIATIVE TO TIER 1 COUNTIES

SECTION 12E.2. Section 12E.3 of S.L. 2013-360 reads as rewritten:

"**SECTION 12E.3.(a)** All funds appropriated in this act for the School Nurse Funding Initiative for the 2014-2015 fiscal year shall be distributed only to local health departments located in counties designated as Tier 1 counties by the North Carolina Department of Commerce. These funds shall be used to supplement and not supplant other State, local, or federal funds appropriated or allocated for this purpose. ~~Communities~~ All Tier 1 counties 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 one and 19 years of age.
(7) Percentage of students with chronic illnesses.
(8) Percentage of county population consisting of minority persons.

"**SECTION 12E.3.(b)** The Division of Public Health shall ensure that school nurses ~~funded with State funds~~ located in counties designated as Tier 1 counties, who are funded by appropriations for the School Nurse Funding Initiative for the 2014-2015 fiscal year (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 healthy 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.

"**SECTION 12E.3.(c)** Section 6.9(b) of S.L. 2011-145, as amended by Section 6.2 of S.L. 2012-142, is repealed."

Senate and House Differ

Senate Version

Follows $

INCREASED FEE FOR PRIVATE WELL-WATER TESTING

SECTION 12E.3.(a) G.S. 130A-5(16) reads as rewritten:

"(16) To charge a fee of up to ~~fifty-five dollars ($55.00)~~ seventy-four dollars ($74.00) for analyzing private well-water samples sent to the State Laboratory of Public Health by local health departments. The fee shall be imposed only for analyzing samples from newly constructed and existing wells. The fee shall be computed annually by the Director of the State Laboratory of Public Health by analyzing the previous year's testing at the State Laboratory of Public Health, and applying the amount of the total cost of the private well-water testing, minus State appropriations that support this effort. The fee includes the charge for the private well-water panel test kit."

SECTION 12E.3.(b) Subsection (a) of this section becomes effective July 1, 2014, and applies to private well-water samples analyzed on or after that date.

House Version Follows $

INCREASED FEE FOR PRIVATE WELL-WATER TESTING

SECTION 12E.3.(a) G.S. 130A-5(16) reads as rewritten:

"(16) To charge a fee of up to ~~fifty-five dollars ($55.00)~~ seventy-four dollars ($74.00) for analyzing private well-water samples sent to the State Laboratory of Public Health by local health departments. The fee shall be imposed only for analyzing samples from newly constructed and existing wells. The fee shall be computed annually by the Director of the State Laboratory of Public Health by analyzing the previous year's testing at the State Laboratory of Public Health, and applying the amount of the total cost of the private well-water testing, minus State appropriations that support this effort. The fee includes the charge for the private well-water panel test kit."

SECTION 12E.3.(b) Subsection (a) of this section becomes effective July 1, 2014, and applies to private well-water samples analyzed on or after that date.

SECTION 12E.3.(c) The Department of Health and Human Services, Division of Public Health, shall, in consultation with local health departments and the Department of Environment and Natural Resources, study options for reducing or waiving the private well-water testing fee established in subsection (a) of this section for households with incomes at or below three hundred percent (300%) of the current federal poverty level. The Department shall report its findings and recommendations, including any recommended legislation, to the Joint Legislative Oversight Committee on Health and Human Services, the Environmental Review Commission, and the Fiscal Research Division by December 1, 2014.

* House Only

Senate Only

TRANSFER OF ON-SITE WATER PROTECTION BRANCH FROM DIVISION OF PUBLIC HEALTH TO DIVISION OF WATER RESOURCES, DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES

SECTION 12E.4.(a) The On-Site Water Protection Branch of the Environmental Section of the Division of Public Health within the Department of Health and Human Services, is hereby transferred to the Division of Water Resources within the Department of Environmental and Natural Resources, by a Type I transfer, as defined in G.S. 143A-6, where it will be known as the On-Site Water Protection Section.

SECTION 12E.4.(b) G.S. 90A-51(2a) reads as rewritten:

"(2a) "Environmental health practice" means the provision of environmental health services, including administration, organization, management, education, enforcement, and consultation regarding environmental health services provided to or for the public. These services are offered to prevent environmental hazards and promote and protect the health of the public in the following areas: food, lodging, and institutional sanitation; on-site wastewater treatment and disposal; public swimming pool sanitation; childhood lead poisoning prevention; well permitting and inspection; tattoo parlor sanitation; and all other areas of environmental health requiring the delegation of authority by the Division of Public Health of the Department of Health and Human Services or the On-Site Water Protection Section of the Division of Water Resources of the Department of Environment and Natural Resources to State and local environmental health professionals to enforce rules adopted by the Commission for Public ~~Health.~~Health or the Environmental Management Commission. The definition also includes local environmental health professionals enforcing rules of local boards of health for on-site wastewater systems and wells."

SECTION 12E.4.(c) G.S. 90A-55(a) reads as rewritten:

"(a) Board Membership. – The Board shall consist of ~~12~~ nine members who shall serve staggered terms: the Secretary of ~~Health and Human Services,~~Environment and Natural Resources or the Secretary's duly authorized representative, one public-spirited citizen, ~~one environmental sanitation educator from an accredited college or university, one local health director,~~ a representative of the Division of Public Health of the Department of Health and Human Services, and ~~seven~~ six practicing environmental health ~~specialists~~ specialists, including one environmental sanitation educator from an accredited college or university, and one local health director, who qualify by education and experience for registration under this ~~Article, six of whom~~Article. The six members who are practicing environmental health specialists shall represent the Western, Piedmont, and Eastern Regions of the State as described more specifically in the rules adopted by the Board."

SECTION 12E.4.(d) Transition of Membership of the Board of Environmental Health Specialist Examiners. –

(1) The terms of all members of the Board of Environmental Health Specialist Examiners as of the effective date of this act shall expire on July 31, 2014. A new Board of nine members shall be appointed consistent with the requirements specified in G.S. 90A-55(a), as amended by subsection (c) of this section.

(2) Notwithstanding the provisions of G.S. 90A-55(b), the initial term of office for the following persons appointed to the Board of Environmental Health Specialist Examiners shall be two years: (i) one public-spirited citizen, (ii) a representative of the Division of Public Health of the Department of Health and Human Services, and (iii) three practicing environmental health specialists. At the end of

these initial two-year appointments, the term of office for their successors shall be four years. The remaining members of the Board shall be appointed for an initial term of four years and the term of office for their successors shall be four years. Initial terms shall begin on August 1, 2014, and expire on July 31 of the year of expiration as set forth in this subdivision.

SECTION 12E.4.(e) G.S. 90A-71(4) reads as rewritten:

"(4) "Department" means the Department of ~~Health and Human Services.~~Environment and Natural Resources."

SECTION 12E.4.(f) G.S. 90A-81(b) reads as rewritten:

"(b) Arbitration. – The Board may establish a voluntary arbitration procedure to resolve complaints concerning a certified contractor or inspector or any work performed by a certified contractor or inspector, or conflicts involving any certified contractor or inspector and ~~the Division of Public Health of~~ the Department or a local health department."

SECTION 12E.4.(g) G.S. 130A-4(c) reads as rewritten:

"(c) The Secretary of Environment and Natural Resources shall administer and enforce the provisions of ~~Articles 9 and 10~~Articles 9, 10, and 11 of this Chapter and the rules of the Commission."

SECTION 12E.4.(h) G.S. 130A-17(b) reads as rewritten:

"(b) The Secretary of Environment and Natural Resources and a local health director shall have the same rights enumerated in subsection (a) of this section to enforce the provisions of ~~Articles 9 and 10~~Articles 9, 10, and 11 of this Chapter."

SECTION 12E.4.(i) G.S. 130A-18(b) reads as rewritten:

"(b) The Secretary of Environment and Natural Resources and a local health director shall have the same rights enumerated in subsection (a) of this section to enforce the provisions of ~~Articles 9 and 10~~Articles 9, 10, and 11 of this Chapter."

SECTION 12E.4.(j) G.S. 130A-19(b) reads as rewritten:

"(b) The Secretary of Environment and Natural Resources and a local health director shall have the same rights enumerated in subsection (a) of this section to enforce the provisions of ~~Articles 9 and 10~~Articles 9, 10, and 11 of this Chapter."

SECTION 12E.4.(k) G.S. 130A-20(b) reads as rewritten:

"(b) The Secretary of Environment and Natural Resources and a local health director shall have the same rights enumerated in subsection (a) of this section to enforce the provisions of ~~Articles 9 and 10~~Articles 9, 10, and 11 of this Chapter."

SECTION 12E.4.(l) G.S. 130A-22(c) reads as rewritten:

"(c) The Secretary of Environment and Natural Resources may impose an administrative penalty on a person who willfully violates Article 11 of this Chapter, rules adopted by the Commission pursuant to Article 11 or any condition imposed upon a permit issued under Article 11. An administrative penalty may not be imposed upon a person who establishes that neither the site nor the system may be improved or a new system installed so as to comply with Article 11 of this Chapter. Each day of a continuing violation shall constitute a separate violation. The penalty shall not exceed fifty dollars ($50.00) per day in the case of a wastewater collection, treatment and disposal system with a design daily flow of no more than 480 gallons or in the case of any system serving a single one-family dwelling. The penalty shall not exceed three hundred dollars ($300.00) per day in the case of a wastewater collection, treatment and disposal system with a design daily flow of more than 480 gallons which does not serve a single one-family dwelling."

SECTION 12E.4.(m) G.S. 130A-23(e) reads as rewritten:

"(e) The Secretary of Environment and Natural Resources shall have all of the applicable rights enumerated in this section to enforce the provisions of ~~Articles 9 and 10~~Articles 9, 10, and 11 of this Chapter."

SECTION 12E.4.(n) G.S. 130A-24(e) reads as rewritten:

"(e) The appeals procedures enumerated in this section shall apply to appeals concerning the enforcement of rules, the imposition of administrative penalties, or any other action taken by the Department of Environment and Natural Resources pursuant to ~~Articles 8, 9, 10, 11, and 12~~Articles 9, 10, and 11 of this Chapter."

SECTION 12E.4.(o) G.S. 130A-34.1(a) reads as rewritten:

"(a) The Local Health Department Accreditation Board is established within the North Carolina Institute for Public Health. The Board shall be composed of 17 members appointed by the Secretary of the Department of Health and Human Services as follows:

(1) Four shall be county commissioners recommended by the North Carolina Association of County Commissioners, and four shall be members of a local board of health as recommended by the Association of North Carolina Boards of Health.

(2) Three local health directors.

(3) ~~Three~~ Two staff members from the Division of Public Health, Department of Health and Human Services.

(4) ~~Repealed by Session Laws 2011-145, s. 13.3(zz), effective July 1, 2011.~~One staff member from the Division of Environmental Health, recommended by the Secretary of Environment and Natural Resources.

(5) Three at large."

SECTION 12E.4.(p) G.S. 130A-334(1) is recodified as G.S. 130A-334(1a).

SECTION 12E.4.(q) G.S. 130A-334 (1a) is recodified as G.S. 130A-334(1b) and reads as rewritten:

"~~(1a)~~(1b) "Department" means the Department of ~~Health and Human Services.~~Environmental and Natural Resources."

SECTION 12E.4.(r) G.S. 130A-334 is amended by adding a new subdivision to read:

"(1) "Commission" means the Environmental Management Commission."

SECTION 12E.4.(s) G.S. 130A-335(b) reads as rewritten:

"(b) ~~All wastewater~~Wastewater systems including all of the following shall be regulated by the Department under rules adopted by the ~~Commission except for the following wastewater systems that shall be regulated by the Department under rules adopted by the Environmental Management~~ Commission:

(1) Wastewater collection, treatment, and disposal systems designed to discharge effluent to the land surface or surface waters.

(2) Wastewater systems designed for groundwater remediation, groundwater injection, or landfill leachate collection and disposal.

(3) Wastewater systems designed for the complete recycle or reuse of industrial process wastewater.

(4) Gray water systems as defined in G.S. 143-350."

SECTION 12E.4.(t) G.S. 130A-335(h) reads as rewritten:

"(h) Except as provided in this subsection, a chemical or portable toilet may be placed at any location where the chemical or portable toilet can be operated and maintained under sanitary conditions. A chemical or portable toilet shall not be used as a replacement or substitute for a water closet or urinal where a water closet or urinal connected to a permanent wastewater treatment system is required by the North Carolina State Building Code, except that a chemical or portable toilet may be used to supplement a water closet or urinal during periods of peak use. A chemical or portable toilet shall not be used as an alternative to the repair of a water closet, urinal, or wastewater treatment system. It shall be unlawful to discharge sewage or other waste from a chemical or portable toilet used for human waste except into a wastewater system that has been approved by the Department under rules adopted by the Commission ~~or by the Environmental Management Commission~~ or at a site that is permitted by the Department under G.S. 130A-291.1."

SECTION 12E.4.(u) The Revisor of Statutes may conform names and titles changed by this section, and may correct statutory references as required by this section, throughout the General Statutes. In making the changes authorized by this section, the Revisor may also adjust subject and verb agreement and the placement of conjunctions.

Senate Only

PROGRAM EVALUATION STUDY OF CHIEF MEDICAL EXAMINER'S OFFICE

SECTION 12E.5. The Joint Legislative Program Evaluation Oversight Committee shall consider including in the 2014-2015 Work Plan for the Program Evaluation Division of the General Assembly a study on ways to improve North Carolina's medical examiner system. The study shall include (i) an evaluation of the Office of the Chief Medical Examiner within the Epidemiology Section of the Department of Health and Human Services, Division of Public Health, and that Office's policies and procedures with respect to death investigations and (ii) recommendations for best practices in death investigations to achieve greater efficiencies.

House Only

OPERATIONAL EFFICIENCIES FOR OFFICE OF THE CHIEF MEDICAL EXAMINER

SECTION 12E.6.(a) G.S. 130A-382 reads as rewritten:

"**§ 130A-382. County medical examiners; appointment; term of office; vacancies.**

~~One or more county medical examiners for each county shall be appointed by the Chief Medical Examiner~~The Chief Medical Examiner shall appoint one or more county medical examiners for each county for a three-year term. ~~County medical examiners shall be appointed from a list of physicians licensed to practice medicine in this State submitted by the medical society of the county in which the appointment is to be made. If no names are submitted by the society, the Chief Medical Examiner shall appoint one or more medical examiners from physicians in the county licensed to practice medicine in this State. In the event no licensed physician in a county accepts an appointment, the Chief Medical Examiner may appoint as acting county medical examiner one or more physicians licensed to practice medicine in this State from other counties, a licensed physician assistant,a nurse, a coroner, or an individual who has taken an approved course of training as required by the Chief Medical Examiner. The acting county medical examiner shall have all the duties and authority of the physician medical examiner except to perform autopsies.~~In appointing medical examiners for each county, the Chief Medical Examiner shall give preference to physicians licensed to practice medicine in this State but may also appoint licensed physician assistants, nurse practitioners, nurses, coroners, or emergency medical technician paramedics. A medical examiner may serve more than one county. The Chief Medical Examiner may take jurisdiction in any case or appoint another medical examiner to do so."

SECTION 12E.6.(b) By December 1, 2014, the Department of Health and Human Services, Division of Public Health, shall study and report to the Joint Legislative Oversight Committee on Health and Human Services on the adequacy of the current fee paid by the State and counties (i) pursuant to G.S. 130A-387 for investigations and reports and (ii) pursuant to G.S. 130A-389 for autopsies. The report due under this subsection shall include recommendations for any fee increase deemed necessary by the Department as well as an explanation and documentation to support the recommended fee increase.

SECTION 12E.6.(c) A portion of the funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, for the Office of the Chief Medical Examiner for the 2014-2015 fiscal year shall be used by the Department to establish a system of oversight to achieve operational efficiencies and improve quality assurance with respect to postmortem medicolegal examinations conducted under the authority of the Office of the Chief Medical Examiner pursuant to Part 1 of Article 16 of Chapter 130A of the General Statutes. In establishing the system of oversight required by this subsection, the Department shall develop and implement uniform protocols for conducting postmortem medicolegal examinations in accordance with established best practices for these examinations.

House Only

~~ADJUST~~ REPORTING DATE FOR DIABETES COORDINATION REPORT

SECTION 12E.7. G.S. 130A-221.1(b) reads as rewritten:

"(b) On or before ~~December~~ January 1 of each ~~even-numbered~~odd-numbered year, the entities referenced in subsection (a) of this section shall collectively submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. The report shall provide the following:

(1) An assessment of the financial impact that each type of diabetes has on each entity and collectively on the State. This assessment shall include: the number of individuals with diabetes served by the entity, the cost of diabetes prevention and control programs implemented by the entity, the financial toll or impact diabetes and related complications places on the program, and the financial toll or impact diabetes and related complications places on each program in comparison to other chronic diseases and conditions.

(2) A description and an assessment of the effectiveness of each entity's programs and activities implemented to prevent and control diabetes. For each program and activity, the assessment shall document the source and amount of funding provided to the entity, including funding provided by the State.

(3) A description of the level of coordination that exists among the entities referenced in subsection (a) of this section, as it relates to activities, programs, and messaging to manage, treat, and prevent all types of diabetes and the complications from diabetes.

(4) The development of and revisions to detailed action plans for preventing and controlling diabetes and related complications. The plans shall identify proposed action steps to reduce the impact of diabetes, pre-diabetes, and related diabetic complications; identify expected outcomes for each action step; and establish benchmarks for preventing and controlling diabetes.

(5) A detailed budget identifying needs, costs, and resources required to implement the plans identified in subdivision (4) of this subsection, including a list of actionable items for consideration by the Committee."

House Only

FOOD PROTECTION PROGRAM BUDGET REALIGNMENT

Follows $

SECTION 12E.8. Notwithstanding any other provision of law, the four hundred thousand dollars ($400,000) that is appropriated under this act for aid to counties for local food and lodging programs shall be retained by the State beginning with the 2014-2015 fiscal year, to pay for the costs to operate the State elements of the food and lodging program, which was transferred to the Department of Health and Human Services pursuant to Section 13.3(d) of S.L. 2011-145.

House Only

Follows $

TRANSFER OF SUMMER FOOD SERVICE PROGRAM TO DEPARTMENT OF PUBLIC INSTRUCTION

SECTION 12E.9. The North Carolina Summer Food Service Program is hereby transferred from the Division of Public Health, Department of Health and Human Services, to the Department of Public Instruction, by a Type I transfer, as defined in G.S. 143A-6.

Senate and House Differ

Senate Version

Follows $

TRAUMATIC BRAIN INJURY FUNDING

SECTION 12F.1. Of the funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2014-2015 fiscal year, the sum of two million three hundred seventy-three thousand eighty-six dollars ($2,373,086) shall be used exclusively to support traumatic brain injury (TBI) services as follows:

(1) The sum of three hundred fifty-nine thousand two hundred eighteen dollars ($359,218) shall be used to fund contracts with the Brain Injury Association of North Carolina and Carolinas Rehabilitation.

(2) The sum of seven hundred ninety-six thousand nine hundred thirty-four dollars ($796,934) shall be used to support residential programs across the State that are specifically designed to serve individuals with TBI.

(3) The sum of one million two hundred sixteen thousand nine hundred thirty-four dollars ($1,216,934) shall be used to support requests submitted by individual consumers for assistance with residential support services, home modifications, transportation, and other requests deemed necessary by the consumer's local management entity and primary care physician.

House Version

TRAUMATIC BRAIN INJURY FUNDING

Follows $

SECTION 12F.1. Of the funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2014-2015 fiscal year, the sum of two million three hundred seventy-three thousand eighty-six dollars ($2,373,086) shall be used exclusively to support traumatic brain injury (TBI) services as follows:

(1) The sum of three hundred fifty-nine thousand two hundred eighteen dollars ($359,218) shall be used to fund contracts with the Brain Injury Association of North Carolina, Carolinas Rehabilitation, or other appropriate service providers.

(2) The sum of seven hundred ninety-six thousand nine hundred thirty-four dollars ($796,934) shall be used to support residential programs across the State that are specifically designed to serve individuals with TBI.

(3) The sum of one million two hundred sixteen thousand nine hundred thirty-four dollars ($1,216,934) shall be used to support requests submitted by individual consumers for assistance with residential support services, home modifications, transportation, and other requests deemed necessary by the consumer's local management entity and primary care physician.

Senate Only

CLOSURE OF WRIGHT SCHOOL

SECTION 12F.2.(a) The Department of Health and Human Services shall not allow any new admissions or readmissions to the Wright School after July 1, 2014. The Department shall, in consultation with local management entities that are approved to operate as managed care organizations, develop a plan to transition all students enrolled at the Wright School to other appropriate educational and treatment settings.

SECTION 12F.2.(b) By September 30, 2014, the Department shall permanently cease operations at the Wright School.

SECTION 12F.2.(c) G.S. 122C-181(a)(5)b. is repealed effective October 1, 2014.

Senate and House Differ

Senate Version

REPORT ON STRATEGIES FOR IMPROVING MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

SECTION 12F.3.(a) The Department of Health and Human Services (Department) shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2014, that includes all of the following components:

(1) A strategy for improving communication and coordination among all divisions within the Department that administer funds or programs related to the delivery of behavioral health services, especially regarding the most appropriate and efficient uses of public and private inpatient behavioral health services. The Department shall include as part of its strategy a process to address shortages and deficiencies identified in the annual State Medical Facilities Plan.

(2) A plan developed in collaboration with local management entities that have been approved to operate as managed care organizations (LME/MCOs) to increase access to, and availability of, community-based outpatient crisis and emergency services for the stabilization and treatment of individuals experiencing mental health, developmental disability, or substance abuse crises in settings other than local hospital emergency departments and State-operated psychiatric hospitals.

(3) A plan to ensure that a comprehensive array of outpatient treatment and crisis prevention and intervention services are available and accessible to children, adolescents, and adults in every LME/MCO catchment area. The plan shall ensure that an adequate number of crisis stabilization units are available in each LME/MCO catchment area.

(4) Findings and recommendations for increasing the inventory of inpatient psychiatric and substance abuse services within the State. In developing its findings and recommendations, the Department shall examine the advantages and disadvantages of increasing this inventory of services through (i) additional State-operated facilities, (ii) community hospital beds, (iii) United States Department of Veterans Affairs beds, and (iv) community-based services that decrease the need for inpatient treatment.

(5) A plan for offering hospitals and other entities incentives to apply for licenses to begin offering new inpatient behavioral health services, or to begin operating existing licensed beds that are currently unstaffed, or both.

(6) Recommendations on the use of the existing Cherry Hospital buildings after patients and operations are relocated to the replacement facility. In developing its findings and recommendations, the Department shall conduct a study that includes development of an inventory and assessment of the condition of every building located on the existing Cherry Hospital campus. The study shall include an examination of the feasibility of using the existing Cherry Hospital facility to provide community-based and facility-based behavioral health services, including additional child and adolescent inpatient beds.

(7) A method by which the Division of Health Service Regulation can begin tracking and separately reporting no later than January 1, 2015, on the inventory of inpatient behavioral health beds for children ages six through 12 and for adolescents over age 12.

(8) A status update on the implementation of each component of the 2008 Mental Health Commission Workforce Development Plan.

SECTION 12F.3.(b) The Department shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by March 1, 2015, that includes all of the following components:

(1) A comprehensive strategy, developed in collaboration with stakeholders deemed relevant by the Department, to address the dearth of licensed child and adolescent inpatient psychiatric beds throughout the State. The strategy shall:

a. Ensure that an adequate inventory of child and adolescent beds are available in each LME/MCO catchment area.

b. Include the development and implementation of a child and adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed inpatient facility in the State.

(2) Recommendations for meaningful outcome measures to be implemented by State-operated alcohol and drug abuse treatment centers to assess the impact of inpatient treatment on an individual's substance use following discharge from a State-operated alcohol and drug abuse treatment center. The recommendations shall include a proposed time line for implementation of these outcome measures.

House Version

REPORT ON STRATEGIES FOR IMPROVING MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

SECTION 12F.3.(a) The Department of Health and Human Services (Department) shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2014, that includes all of the following components:

(1) A strategy for improving communication and coordination among all divisions within the Department that administer funds or programs related to the delivery of behavioral health services, especially regarding the most appropriate and efficient uses of public and private inpatient behavioral health services. The Department shall include as part of its strategy a process to address shortages and deficiencies identified in the annual State Medical Facilities Plan.

(2) A plan developed in collaboration with local management entities that have been approved to operate as managed care organizations (LME/MCOs) to increase access to, and availability of, community-based outpatient crisis and emergency services for the stabilization and treatment of individuals experiencing mental health, developmental disability, or substance abuse crises in settings other than local hospital emergency departments and State-operated psychiatric hospitals.

(3) A plan to ensure that a comprehensive array of outpatient treatment and crisis prevention and intervention services are available and accessible to children, adolescents, and adults in every LME/MCO catchment area. The plan shall ensure that an adequate number of crisis stabilization units are available in each LME/MCO catchment area. The plan shall include specific strategies for increasing the number of Facility-Based Crisis Programs for Children and Adolescents in high-need areas of the State and the availability of Professional Treatment Services in Facility-Based Crisis Programs for Children and Adolescents as defined in section 4.b.(8)(k) of the current Medicaid State Plan. The plan shall further describe in detail all actions necessary to implement those strategies, including a description of how the Department's funds will be utilized.

(4) Findings and recommendations for increasing the inventory of inpatient psychiatric and substance abuse services within the State. In developing its findings and recommendations, the Department shall examine the advantages and disadvantages of increasing this inventory of services through (i) additional State-operated facilities, (ii) community hospital beds, (iii) United States Veterans Administration beds, and (iv) community-based services that decrease the need for inpatient treatment.

(5) A plan for offering hospitals and other entities incentives to apply for licenses to begin offering new inpatient behavioral health services, or to begin operating existing licensed beds that are currently unstaffed, or both.

(6) Recommendations on the use of the existing Cherry Hospital buildings after patients and operations are relocated to the replacement facility. In developing its findings and recommendations, the Department shall conduct a study that includes development of an inventory and assessment of the condition of every building located on the existing Cherry Hospital campus. The study shall include an examination of the feasibility of using the existing Cherry Hospital facility to provide community-based and facility-based behavioral health services, including additional child and adolescent inpatient beds.

(7) A method by which the Division of Health Service Regulation can begin tracking and separately reporting no later than January 1, 2015, on the inventory of

* Hol Only

Technical Fix

inpatient behavioral health beds for children ages six through 12 and for adolescents over age 12.

(8) A status update on the implementation of each component of the 2008 Mental Health Commission Workforce Development Plan.

SECTION 12F.3.(b) The Department shall submit a report to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division by March 1, 2015, that includes all of the following components: House Only

(1) A comprehensive strategy, developed in collaboration with stakeholders deemed relevant by the Department, to address the dearth of licensed child and adolescent inpatient psychiatric beds in facilities throughout the State. The strategy shall do all of the following: Technical Fixes

a. Ensure that an adequate inventory of child and adolescent beds are available in each LME/MCO catchment area.

b. Include the development and implementation of a child and adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed and nonlicensed facility in the State.

c. Include recommendations as to any regulatory changes necessary to ensure safety and quality in Facility-Based Crisis Programs for Children and Adolescents. * House only

(2) Recommendations for meaningful outcome measures to be implemented by State-operated alcohol and drug abuse treatment centers to assess the impact of inpatient treatment on an individual's substance use following discharge from a State-operated alcohol and drug abuse treatment center. The recommendations shall include a proposed time line for implementation of these outcome measures.

House Only

REPORT AND PLAN REGARDING BUDGET SHORTFALLS WITHIN THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

SECTION 12F.4. By December 1, 2014, the Department of Health and Human Services shall provide a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the budget shortfalls within the Department as a result of liabilities associated with (i) the provision of community services for the treatment of mental illness, developmental disabilities, and substance abuse disorders and (ii) the State-operated health care facilities under the jurisdiction of the Department. The report shall include a detailed explanation of all of the following:

(1) A history of the annual budget shortfalls since 2008 and all the contributing factors.

(2) An explanation of actions taken by the Department and the Office of State Budget and Management to address these budget shortfalls.

(3) A plan for eliminating these budget shortfalls.

House Only

FUNDS APPROPRIATED TO IMPLEMENT RECOMMENDATIONS OF THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES REGARDING BEHAVIORAL HEALTH CRISIS SERVICES

SECTION 12F.5.(a) The following definitions apply in this section:

(1) Facility-Based Crisis Center. – A 24-hour residential facility licensed under 10A NCAC 27G .5000 to provide facility-based crisis service as described in 10A NCAC 27G .5001.

(2) Secretary. – The Secretary of the North Carolina Department of Health and Human Services.

(3) Behavioral Health Urgent Care Center. – An outpatient facility that provides walk-in crisis assessment, referral, and treatment by licensed behavioral health professionals with prescriptive authority to individuals with an urgent or emergent need for mental health, intellectual or developmental disabilities, or substance abuse services.

SECTION 12F.5.(b) From funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for community services for the 2014-2015 fiscal year, the Division shall use five million twenty-eight thousand six hundred seventy-seven dollars ($5,028,677) in recurring funds to accomplish the following:

Follows $

(1) To increase the number of co-located or operationally linked behavioral health urgent care centers and facility-based crisis centers.

(2) To increase the number of facility-based crisis centers designated by the Secretary as facilities for the custody and treatment of involuntary clients pursuant to G.S. 122C-252 and 10A NCAC 26C .0101. The Department shall give priority to areas of the State experiencing a shortage of these types of facilities.

(3) To provide reimbursement for services provided by facility-based crisis centers.

(4) To establish facility-based crisis centers for children and adolescents.

Senate Only

~~HEALTH~~ CARE COST REDUCTION AND TRANSPARENCY ACT REVISIONS

SECTION 12G.2. G.S. 131E-214.13 reads as rewritten:

"**§ 131E-214.13. Disclosure of prices for most frequently reported DRGs, CPTs, and HCPCSs.**

(a) The following definitions apply in this Article:

(1) Ambulatory surgical facility. – A facility licensed under Part 4 of Article 6 of this Chapter.

(2) Commission. – The North Carolina Medical Care Commission.

(3) Health insurer. – ~~As defined in G.S. 108A-55.4, provided that "health insurer" shall not include self-insured plans and group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974.~~Includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, [29 U.S.C. § 1167(1)]), service benefit plans, managed care organizations, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service as a condition of doing business in the State.

(4) Hospital. – A medical care facility licensed under Article 5 of this Chapter or under Article 2 of Chapter 122C of the General Statutes.

(5) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Beginning with the quarter ending June 30, 2014, and quarterly thereafter, each hospital shall provide to the Department of Health and Human Services, utilizing electronic health records software, the following information about the 100 most frequently reported admissions by DRG for inpatients as established by the ~~Commission:~~Department:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges.

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection.

(3) The amount of Medicaid reimbursement for each DRG, including claims and pro rata supplemental payments.

(4) The amount of Medicare reimbursement for each DRG.

(5) For each of the five largest health insurers providing payment to the hospital on behalf of insureds and teachers and State employees, the range and the average of the amount of payment made for each DRG. Prior to providing this information to the Department, each hospital shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

A hospital shall not be required to report the information required by this subsection for any of the 100 most frequently reported admissions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(c) The Commission shall adopt rules on or before March 1, 2014, to ensure that subsection (b) of this section is properly implemented and that hospitals report this information to the Department in a uniform manner. The rules shall include all of the following:

(1) The method by which the Department shall determine the 100 most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection (b) of this section.

(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the Department's Internet Web site.

(d) Beginning with the quarter ending September 30, 2014, and quarterly thereafter, each hospital and ambulatory surgical facility shall provide to the Department, utilizing electronic health records software, information on the total costs for the 20 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in hospital outpatient settings or in ambulatory surgical facilities, along with the related CPT and HCPCS codes. Hospitals and ambulatory surgical facilities shall report this information in the same manner as required by subdivisions (b)(1) through (5) of this section, provided that hospitals and ambulatory surgical facilities shall not be required to report the information required by this subsection where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(e) The Commission shall adopt rules on or before June 1, 2014, to ensure that subsection (d) of this section is properly implemented and that hospitals and ambulatory surgical facilities report this information to the Department in a uniform manner. The rules shall include the ~~list of~~ method by which the Department shall determine the 20 most common surgical procedures and the 20 most common imaging ~~procedures, by volume, performed in a hospital outpatient setting and those performed in an ambulatory surgical facility, along with the related CPT and HCPCS codes.~~procedures for which the hospitals must provide the data set out in subsection (d) of this section.

(f) Upon request of a patient for a particular DRG, imaging procedure, or surgery procedure reported in this section, a hospital or ambulatory surgical facility shall provide the information required by subsection (b) or subsection (d) of this section to the patient in writing, either electronically or by mail, within three business days after receiving the request.

(g) G.S. 150B-21.3 does not apply to rules adopted under this section. A rule adopted under this section becomes effective on the last day of the month following the month in which the rule is approved by the Commission."

Senate and House Differ

Senate Version

MORATORIUM ON HOME CARE AGENCY LICENSES FOR IN-HOME AIDE SERVICES

SECTION 12G.4.(a) Notwithstanding the provisions of the Home Care Agency Licensure Act set forth in Part 3 of Article 6 of Chapter 131E of the General Statutes or any rules adopted pursuant to that Part, the Department of Health and Human Services shall not issue any licenses for home care agencies as defined in G.S. 131E-136(2) that intend to offer in-home aide services. This prohibition does not apply to companion and sitter services and shall not restrict the Department from doing any of the following:

(1) Issuing a license to a certified home health agency as defined in G.S. 131E-176(12) that intends to offer in-home aide services.

(2) Issuing a license to an agency that needs a new license for an existing home care agency being acquired.

(3) Issuing a license for a new home care agency in any area of the State upon a determination by the Secretary of the Department of Health and Human Services that increased access to care is necessary in that area.

SECTION 12G.4.(b) This section shall not expire until the General Assembly enacts legislation to lift the moratorium established by this section.

* Senate only

{Makes moratorium permanent, until GA enacts legislation to lift it.}

House Version

MORATORIUM ON HOME CARE AGENCY LICENSES FOR IN-HOME AIDE SERVICES

SECTION 12G.4. For the period commencing July 1, 2014, and ending July 1, 2016, and notwithstanding the provisions of the Home Care Agency Licensure Act set forth in Part 3 of Article 6 of Chapter 131E of the General Statutes or any rules adopted pursuant to that Part, the Department of Health and Human Services shall not issue any licenses for home care agencies as defined in G.S. 131E-136(2) that intend to offer in-home aide services. This prohibition does not apply to companion and sitter services and shall not restrict the Department from doing any of the following:

(1) Issuing a license to a certified home health agency as defined in G.S. 131E-176(12) that intends to offer in-home aide services.

(2) Issuing a license to an agency that needs a new license for an existing home care agency being acquired.

(3) Issuing a license for a new home care agency in any area of the State upon a determination by the Secretary of the Department of Health and Human Services that increased access to care is necessary in that area.

{Extends moratorium by 2 years.}

Senate and House Differ

Senate Version

MORATORIUM ON SPECIAL CARE UNIT LICENSES

SECTION 12G.5.(a) Section 12G.1(a) of S.L. 2013-360 reads as rewritten:

"**SECTION 12G.1.(a)** ~~For the period beginning July 31, 2013, and ending July 1, 2016,~~ Notwithstanding the provisions of Article 1 of Chapter 131D of the General Statutes, Article 6 of Chapter 131E of the General Statutes, and any rules adopted pursuant to these Articles, the Department of Health and Human Services, Division of Health Service Regulation (Department), shall not issue any licenses for special care units as defined in G.S. 131D-4.6 and G.S. 131E-114. This prohibition shall not restrict the Department from doing any of the following:

(1) Issuing a license to a facility that is acquiring an existing special care unit.

(2) Issuing a license for a special care unit in any area of the State upon a determination by the Secretary of the Department of Health and Human Services that increased access to this type of care is necessary in that ~~area during the three-year moratorium imposed by this section.~~area.

(3) Processing all completed applications for special care unit licenses received by the Division of Health Service Regulation along with the applicable license fee prior to June 1, 2013.

(4) Issuing a license to a facility that was in possession of a certificate of need as of July 31, 2013, that included authorization to operate special care unit beds."

SECTION 12G.5.(b) Section 12G.1(a) of S.L. 2013-360, as amended by subsection (a) of this section, shall not expire until the General Assembly enacts legislation to lift the moratorium established by that Section.

* Senate only

{Makes moratorium permanent until GA enacts legislation to lift it.}

House Version

MORATORIUM ON SPECIAL CARE UNIT LICENSES

SECTION 12G.5. Section 12G.1(a) of S.L. 2013-360 reads as rewritten:

"**SECTION 12G.1.(a)** For the period beginning July 31, 2013, and ending ~~July 1, 2016,~~July 1, 2015, the Department of Health and Human Services, Division of Health Service Regulation (Department), shall not issue any licenses for special care units as defined in G.S. 131D-4.6 and G.S. 131E-114. This prohibition shall not restrict the Department from doing any of the following:

(1) Issuing a license to a facility that is acquiring an existing special care unit.

(2) Issuing a license for a special care unit in any area of the State upon a determination by the Secretary of the Department of Health and Human Services that increased access to this type of care is necessary in that area during the ~~three-year~~two-year moratorium imposed by this section.

(3) Processing all completed applications for special care unit licenses received by the Division of Health Service Regulation along with the applicable license fee prior to June 1, 2013.

(4) Issuing a license to a facility that was in possession of a certificate of need as of July 31, 2013, that included authorization to operate special care unit beds."

{Sunsets moratorium 1 year early, on 7/1/15 -- instead of 7/1/16.}

House Only

PROHIBITION ON YOUTH USING TANNING EQUIPMENT

SECTION 12G.6.(a) G.S. 104E-9.1(a) reads as rewritten:

"(a) Operators of tanning equipment and owners of tanning facilities subject to rules adopted pursuant to this Chapter shall comply with or ensure compliance with the following:

(1) The operator shall provide to each consumer a warning statement that defines the potential hazards and consequences of exposure to ultraviolet radiation. Before allowing the consumer's initial use of the tanning equipment, the operator shall obtain the signature of the consumer on the warning statement acknowledging receipt of the warning.

(2) The operator shall not allow a person ~~13 years and younger~~under 18 years of age to use tanning ~~equipment without a written prescription from the person's medical physician specifying the nature of the medical condition requiring the treatment, the number of visits, and the time of exposure for each visit.~~equipment.

(3) Neither an operator nor an owner shall claim or distribute promotional materials that claim that using tanning equipment is safe or free from risk or that using tanning equipment will result in medical or health benefits."

SECTION 12G.6.(b) This section becomes effective October 1, 2014.

Senate and House Differ

Senate Version

MEDICAID REORGANIZATION TO WORK TOWARDS REFORM

SECTION 12H.1.(a) It is the intent of the General Assembly to transfer the Medicaid and NC Health Choice programs to a new state entity that will define a new, more successful direction for the programs and that will be able to focus more clearly on the operation of the programs. Specifically, the Medicaid program shall move away from unmanaged fee-for-service towards a system that manages care. To that end, Medicaid shall include all dimensions of care for a recipient through full-risk, provider-led and non-provider-led, capitated health plans. Such full-risk capitated health plans shall include all aspects of care, without exceptions, so that the State will bear only the risk of enrollment numbers and enrollment mix.

The governance structure of the new State entity shall include a board. In the short-term, the new State entity shall do the following:

(1) Strategically design a program that meets the primary goal of providing budget predictability as well as the following goals:
   a. Controls the growth of program expenditures.
   b. Reduces programmatic spending, both on payments to providers of services or insurance and on administrative spending.
   c. Provides "whole person" care.
   d. Establishes provider accountability for budget and program outcomes, while integrating quality into the basic payment model.
   e. Maintains administrative accountability for budget and program outcomes.
   f. Ensures transparency of reporting, provider information, decision making, and administrative functions.
   g. Ensures recipient access to appropriate care and services.

(2) Carefully select individuals to serve in the key leadership positions within the new State entity.

(3) Develop a detailed timeline for a reform.

(4) Propose statutory changes or other legal authorization to allow the reform to be implemented.

(5) Prepare draft State Plan Amendments and waivers necessary to effectuate the reform.

(6) Design a robust information technology infrastructure, including a strategy to transfer existing data and resources at the Department of Health and Human Services to the new entity.

SECTION 12H.1.(b) The Department of Health and Human Services shall cease any activities related to implementing Medicaid reform based on its proposed accountable care organization (ACO) model.

SECTION 12H.1.(c) Funds appropriated elsewhere in this act to the Department of Health and Human Services, Division of Medical Assistance, for Medicaid reform shall be transferred to the Office of State Budget and Management, which shall then transfer the funds to the appropriate new entity that is contemplated in subsection (a) of this section. Such funds may be

used only for Medicaid reorganization and reform and, notwithstanding the State Budget Act, may not be used for any other purpose such as funding any shortfalls in the Medicaid program.

House Version

APPROPRIATION FOR MEDICAID REFORM TO BE USED SOLELY FOR MEDICAID REFORM

SECTION 12H.1. Funds appropriated elsewhere in this act to the Department of Health and Human Services, Division of Medical Assistance, for Medicaid reform may be used only for Medicaid reform and, notwithstanding the State Budget Act, may not be used for any other purpose, such as funding any shortfalls in the Medicaid program.

Follows $

Senate version:
① New Medicaid entity outside of DHHS
② Full-risk capitated health plans for Medicaid

Senate Only

ADJUSTMENTS TO MEDICAID ELIGIBILITY

SECTION 12H.3.(a) Effective January 1, 2015, the following adjustments are made to eligibility for the Medicaid Program:

(1) Categorical coverage for recipients of the optional state supplemental program State-County Special Assistance is eliminated.

(2) Coverage for the medically needy is eliminated, except those categories that the State is prohibited from eliminating by the maintenance of effort requirement of the Patient Protection and Affordable Care Act. Effective October 1, 2019, coverage for all medically needy categories is eliminated.

SECTION 12H.3.(b) It is the intent of the General Assembly to reduce optional coverage for certain aged, blind, and disabled persons effective July 1, 2015, while meeting the State's obligation under the Americans with Disabilities Act and the United States Supreme Court decision in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999). No later than March 1, 2015, the Department of Health and Human Services, Division of Medical Assistance, shall submit to the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services a draft waiver or other proposal that limits Medicaid coverage for the aged, blind, and disabled to the minimum required to meet mandatory requirements of the Medicaid program and the Americans with Disabilities Act. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

Senate Only

STUDY ADDITIONAL 1915(C) WAIVER

SECTION 12H.5. The Department of Health and Human Services, Division of Medical Assistance, shall design and draft a 1915(c) wavier that meets the following requirements:

(1) The waiver should create 1,000 new slots each year for 3 years, to serve a total of 3,000 additional adults with developmental disabilities from January 1, 2016, to June 30, 2019.

(2) The budget for each slot should be capped at twenty thousand dollars ($20,000) per plan year per beneficiary, and slots will target individuals on the registry of unmet needs.

(3) The slots should be managed as part of the LME/MCO managed care system.

The Department shall report the draft waiver, other findings, and any other options or recommendations to best serve the additional adults with developmental disabilities on the registry of unmet needs to the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services by March 1, 2015. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

Senate and House Differ

Senate Version

TRAUMATIC BRAIN INJURY WAIVER

SECTION 12H.6. The Department of Health and Human Services, Division of Medical Assistance, shall design and draft a waiver to add a new service package for Medicaid eligibles with traumatic brain injury (TBI). This draft waiver may be based on an update to the 2010 report on a waiver to serve individuals with traumatic brain injury. The Department shall report the draft waiver, other findings, and any other options to provide Medicaid services to those suffering from TBI to the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services by February 1, 2015. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

House Version

TRAUMATIC BRAIN INJURY WAIVER

SECTION 12H.6. The Department of Health and Human Services, Division of Medical Assistance, and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in conjunction with the North Carolina Traumatic Brain Injury Advisory Council, shall design and draft a 1915(c) waiver to add a new service package for Medicaid eligibles with traumatic brain injury (TBI). This draft waiver may be based on an update to the 2010 report on a waiver to serve individuals with traumatic brain injury. The Department shall report the draft waiver, other findings, and any additional options to provide Medicaid services to those suffering from TBI to the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services by February 1, 2015. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

{House version contains additional text underlined above.}

Senate Only

Follows $

FREEZE NURSING HOME CASE MIX INDEX

SECTION 12H.7. Section 12H.13(b) of S.L. 2013-360 reads as rewritten:

"**SECTION 12H.13.(b)** Effective July 1, 2013, any rate methodologies that contain an automatic inflationary or increase factor shall not increase above the rate in effect on June 30, 2013, unless the rate is otherwise increased by the General Assembly. Interim hospital outpatient services' percentage of cost used for payment shall be adjusted to compensate for expected inflation that hospitals would be eligible for, and cost settlement will only be up to the percentage in subsection (e) of this section. The following rates are excluded from this subsection: Federally Qualified Health Centers, Rural Health Centers, critical access hospitals, State-Operated services, Hospice, Part B and D Premiums, third-party and HMO premiums, drugs, MCO capitation payments, and nursing home direct care services case mix index increases. Notwithstanding the foregoing, the exclusion from this subsection for nursing home direct care services case mix index increases expires January 1, 2015, and the rate for nursing home direct care services case mix shall not increase above the rate in effect on December 31, 2014."

Senate and House Differ

Senate Version

Follows S

DRUG REIMBURSEMENT USING AVERAGE ACQUISITION COST

SECTION 12H.8.(a) The Department of Health and Human Services, Division of Medical Assistance, shall adopt an average acquisition cost methodology for brand and generic drug ingredient pricing to be effective beginning on January 1, 2015. The drug ingredient pricing methodology shall be consistent with new federal requirements or, if the new federal requirements have not yet been finalized by October 1, 2014, consistent with the draft federal requirements. In adopting a new drug ingredient pricing methodology, the Department shall also adjust the rates for dispensing drugs as follows:

(1) Raise dispensing fees so that the average acquisition cost ingredient pricing plus the dispensing fees, net of any drug rebates, generates nine hundred seventy-five thousand dollars ($975,000) in savings in General Fund appropriations.

(2) Maintain a distinction between the dispensing fees for preferred and brand drugs.

SECTION 12H.8.(b) The Department of Health and Human Services, Division of Medical Assistance, shall issue a request for proposals (RFP) for a contractor to perform a statewide drug dispensing fee study to begin on July 1, 2015. The Department shall, no later than May 1, 2015, submit a cost estimate of such a study (i) to the chairs of the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee for Health and Human Services and (ii) to the Fiscal Research Division.

Follows $

House Version

DRUG REIMBURSEMENT USING AVERAGE ACQUISITION COST

SECTION 12H.8.(a) If federal drug pricing changes to use average acquisition cost for ingredients, then the Department of Health and Human Services, Division of Medical Assistance, shall, notwithstanding Section 12H.13(f) of S.L. 2013-360, adjust the rate for dispensing drugs to offset the impact to providers of any such changes to using average acquisition cost. In adjusting the rates for dispensing drugs, the Department shall do the following:

(1) Raise dispensing fees to make the shift to using average acquisition cost budget neutral.

(2) Maintain a distinction between the dispensing fees for preferred and brand drugs.

Any actions taken under this subsection shall be reported (i) to the chairs of the House Appropriations Committee, the Senate Appropriations/Base Budget Committee, and the Joint Legislative Oversight Committee on Health and Human Services, (ii) to the Fiscal Research Division, and (iii) to the Office of State Budget and Management. Any State plan amendments required to implement this subsection shall not be subject to the 90 day prior submission requirement of G.S. 108A-54.1A(e), as amended by Section 12H.21 of this act.

SECTION 12H.8.(b) By August 1, 2015, the Department of Health and Human Services, Division of Medical Assistance, shall issue a request for proposals (RFP) for a contractor to perform a statewide drug dispensing fee study. The Department shall use the funds appropriated elsewhere in this budget for this study as the State share to draw down additional federal Medicaid funds for this study.

Conditionally effective Senate is effective 1/1/15

House Only

SUBSTITUTION OF GENERIC DRUGS FOR UNAVAILABLE PREFERRED DRUGS

SECTION 12H.8A. If the Department of Health and Human Services, Division of Medical Assistance, finds that there are net General Fund savings to the Medicaid program from doing so, then the Division may allow a pharmacist to substitute and dispense a generic drug in place of a preferred drug without prior authorization, subject to all of the following being true:

(1) The Division normally requires the dispensing of the preferred drug over the equivalent generic drug.

(2) The pharmacist has not been able to acquire the preferred drug from at least two separate wholesalers within the two weeks prior to dispensing the generic substitute.

(3) The pharmacist maintains records of the failed attempts to acquire the preferred drug. Such records shall be open to inspection and audit by the Division.

(4) The prescriber has not indicated that the preferred drug is "medically necessary."

For purposes of this section, "savings to the Medicaid program" shall not be limited to savings within the prescription drug service area, but shall also include savings in other areas of the program such as savings from not having to send the prescription back to the prescriber for prior authorization of the generic substitution or savings from instances where missed doses may lead to negative and costly patient outcomes.

Senate Only

Follows $

MENTAL HEALTH DRUG MANAGEMENT

SECTION 12H.9.(a) Effective January 1, 2015, Section 12H.13(g) of S.L. 2013-360, as amended by Section 4.4 of S.L. 2013-363, is repealed.

SECTION 12H.9.(b) Effective January 1, 2015, the Department of Health and Human Services, Division of Medical Assistance, shall impose prior authorization requirements, when such prior authorization requirements are cost-effective, or other restrictions on medications prescribed to Medicaid and Health Choice recipients for the treatment of mental illness that are sufficient to produce twelve million dollars ($12,000,000), net of rebates, in recurring annual savings to General Fund appropriations to the Medicaid program. Notwithstanding the foregoing, because of the effective date of this section, savings in fiscal year 2014-2015 shall be six million dollars ($6,000,000).

SECTION 12H.9.(c) No later than October 1, 2015, the Department of Health and Human Services, Division of Medical Assistance, shall report to the Joint Legislative Oversight Committee on Health and Human Services on the Department's fiscal year 2014-2015 savings from making the changes required by subsection (b) of this section.

Senate and House Differ

Senate Version

PERSONAL CARE SERVICES MANAGEMENT

SECTION 12H.10.(a) The Department of Health and Human Services, Division of Medical Assistance, shall implement the rate reduction specified in Section 2 of S.L. 2013-306 retroactively to October 1, 2013, by recouping all payments in excess of the rate approved in the State plan amendment required in Section 3 of the Session Law. The Department shall then additionally recoup the three percent (3%) reduction required by Section 12H.18(b) of S.L. 2013-360.

SECTION 12H.10.(b) Effective July 1, 2014, the Department of Health and Human Services, Division of Medical Assistance, shall further reduce the rate paid for personal care services (PCS) in order to remain within the fiscal year 2013-2014 certified budget for PCS, code 1310, North Carolina Accounting System code 536144, in the Division of Medical Assistance fund 14445. In calculating the reduced rate, the Department shall anticipate usage growth for fiscal year 2014-2015 and factor that rate into the calculation. Any State plan amendments required to implement this section shall not be subject to the 90 day prior submission requirement of G.S. 108A-54.1A(e).

* Senate only

SECTION 12H.10.(c) The Joint Legislative Oversight Committee on Health and Human Services shall engage a contractor to study issues related to reforming and redesigning personal care services (PCS) while meeting the State's obligations under the Americans with Disabilities Act and the United States Supreme Court's decision in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999). The study shall examine the following issues:

(1) What categories of Medicaid recipients are currently receiving PCS, and in what settings are they being served?

(2) What is the total number of Medicaid recipients receiving PCS in each category, and what is the anticipated growth in each category?

(3) What is the current cost of serving Medicaid recipients in each setting, and specifically, the sources of public funding utilized to serve those individuals?

(4) What alternative, more cost-effective assistance models could be implemented for each category of Medicaid recipient?

(5) Specifically, whether more cost-effective assistance could be offered through the new 1915(i) State plan home- and community-based services and 1915 waiver options for each category of Medicaid recipient.

(6) Recommendations regarding what outcomes the redesigned program should be designed to achieve.

(7) Other areas as deemed appropriate by the chairs of the Joint Legislative Oversight Committee on Health and Human Services.

No later than December 1, 2015, the contractor shall report the results and recommendations of the study to the Joint Legislative Oversight Committee on Health and Human Services. The Department of Health and Human Services shall give the contractor full access to all data necessary to complete the study and the report. The Department of Health and Human Services shall make payments to the contractor hired by the Joint Legislative Oversight Committee on Health and Human Services from the two hundred thousand dollars ($200,000) appropriated elsewhere in

this budget for this contract as well as from federal Medicaid matching funds available for this contract.

House Version

CONTRACTED STUDY OF PERSONAL CARE SERVICES OPTIONS

SECTION 12H.10. The Joint Legislative Oversight Committee on Health and Human Services shall engage a contractor to study issues related to reforming and redesigning personal care services (PCS) while meeting the State's obligations under the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999). The study shall examine the following issues:

(1) What categories of Medicaid recipients are currently receiving PCS, and in what settings are they being served?

(2) What is the total number of Medicaid recipients receiving PCS in each category, and what is the anticipated growth in each category?

(3) What is the current cost of serving Medicaid recipients in each setting, and specifically, the sources of public funding utilized to serve those individuals?

(4) What alternative, more cost-effective assistance models could be implemented for each category of Medicaid recipient?

(5) Specifically, whether more cost-effective assistance could be offered through the new 1915(i) State plan home- and community-based services and 1915 waiver options for each category of Medicaid recipient.

(6) Recommendations regarding what outcomes the redesigned program should be designed to achieve.

(7) The impact of reforming and redesigning personal care services on appeals and litigation. * House Only

(8) Other areas as deemed appropriate by the chairs of the Joint Legislative Oversight Committee on Health and Human Services.

The study shall also address the quality of resident care within adult care homes and the adequacy of State oversight of adult care homes, including inspections, procedures, and processes. * House Only

No later than December 1, 2015, the contractor shall report the results and recommendations of the study to the Joint Legislative Oversight Committee on Health and Human Services. The Department of Health and Human Services shall give the contractor full access to all data necessary to complete the study and the report. The Department of Health and Human Services shall make payments to the contractor hired by the Joint Legislative Oversight Committee on Health and Human Services from funds appropriated elsewhere in this budget for this contract as well as from federal Medicaid matching funds available for this contract.

Senate and House Differ

Senate Version

CREATE STATEWIDE HOSPITAL BASE RATE

SECTION 12H.12.(a) Section 12H.20(b) of S.L. 2013-360 is repealed.

SECTION 12H.12.(b) Effective January 1, 2015, the individualized base rates for hospital inpatient services under the Medicaid and NC Health Choice programs are hereby replaced with a single statewide base rate for hospital inpatient services equal to the sum of two thousand seven hundred eighty-eight dollars ($2,788) or the statewide median rate on June 30, 2014, whichever is less. This subsection does not apply to the UNC Health Care System or Vidant Medical Center, which was previously known as Pitt County Memorial Hospital, and their base rates shall not be included in the calculation of the statewide median rate.

{House version studies regional base rates.}

House Version

STUDY REGIONAL BASE RATES

SECTION 12H.12. Section 12H.20(b) of S.L. 2013-360 reads as rewritten:

"**SECTION 12H.20.(b)** The Department of Health and Human Services, Division of Medical Assistance, shall ~~replace~~ study replacing the existing base rates for individual hospitals with new regional base rates for all hospitals within a given region. The Department shall consult with hospitals to define the regions and to identify appropriate regional differences in order to ~~establish~~ identify potential regional base rates. The ~~new~~ potential regional base rates shall do the following:

(1) Maintain the same statewide total for the base rates for all hospitals as before the base rate revision, after first adjusting the statewide total based on the changes to rates made by subsection (a) of this section.

(2) Ensure the sustainability of small rural hospitals, ensuring access to care.

The Division shall report its findings to the Joint Legislative Oversight Committee on Health and Human Services no later than December 1, 2014."

{ Senate version creates statewide base rate. }

Senate and House Differ

Senate Version

SUPPLEMENTAL PAYMENTS TO ELIGIBLE MEDICAL PROFESSIONAL PROVIDERS

SECTION 12H.13.(a) Effective July 1, 2014, supplemental payments that increase reimbursement to the average commercial rate for certain eligible medical providers described in the Medicaid State Plan, Attachment 4.19-B, Section 5, Pages 2 and 3, shall be modified to limit the number of eligible medical professional providers as follows:

(1) 375 with the East Carolina University (ECU) Brody School of Medicine,
(2) 1,176 with the University of North Carolina at Chapel Hill (UNC) Faculty Physicians,
(3) 14 with the UNC Hospitals Pediatric Clinic,
(4) 75 with UNC Physicians Network,
(5) 18 with Chatham Hospital.

The Department of Health and Human Services shall not make any other modifications to the portion of the Medicaid State Plan referenced in this section, except as provided herein.

SECTION 12H.13.(b) Beginning on December 31, 2014, and annually thereafter, UNC and ECU shall submit an annual report based on their preceding fiscal year to the Joint Legislative Oversight Committee on Health and Human Services containing all of the following information for each individual provider for whom this supplemental payment is received:

(1) For each service provided by the provider and for which the supplemental payment is received, the location where the service was provided, including county, municipality, and zip code.
(2) The percentage of the provider's total time spent serving Medicaid recipients annually that is for services provided at locations other than the ECU Brody School of Medicine, the Firetower Medical Office, or the UNC School of Medicine.
(3) The amount of Medicaid reimbursement for each service for which a supplemental payment was made for services provided by the provider.
(4) The percentage of the provider's time spent in clinical practice, the percentage of time spent teaching, and the percentage of time engaging in research on an annual basis.

SECTION 12H.13.(c) The entities receiving the supplemental payments addressed in subsection (a) of this section shall transfer an amount to the Department of Health and Human Services, Division of Medical Assistance, sufficient to ensure that after reducing the transfer by twenty-eight and eighty-five hundredths percent (28.85%) there are funds for the State share necessary to make the supplemental payments. That twenty-eight and eighty-five hundredths percent (28.85%) shall be retained by the State for the Medicaid program.

SECTION 12H.13.(d) Any state plan amendments required to implement this section shall not be subject to the 90-day prior submission requirement of G.S. 108A-54.1A(e).

House Version

SUPPLEMENTAL PAYMENTS TO ELIGIBLE MEDICAL PROFESSIONAL PROVIDERS

SECTION 12H.13.(a) Effective July 1, 2014, supplemental payments that increase reimbursement to the average commercial rate for certain eligible medical providers described in the Medicaid State Plan, Attachment 4.19-B, Section 5, Pages 2 and 3, shall be modified as follows:

(1) The number of eligible medical professional providers shall be limited as follows:

a. 418 with the East Carolina University (ECU) Brody School of Medicine.

b. 1,176 with the University of North Carolina at Chapel Hill (UNC) Faculty Physicians.

c. 14 with the UNC Hospitals Pediatric Clinic.

d. 75 with UNC Physicians Network.

e. 18 with Chatham Hospital.

(2) Supplement payments shall not be made for services provided in Wake County. 3 House addition

The Department of Health and Human Services shall not make any other modifications to the portion of the Medicaid State Plan referenced in this section, except as provided herein.

SECTION 12H.13.(b) Beginning on December 31, 2014, and annually thereafter, UNC and ECU shall submit an annual report based on their preceding fiscal year to the Joint Legislative Oversight Committee on Health and Human Services containing all of the following information for each individual provider for whom this supplemental payment is received:

(1) For each service provided by the provider and for which the supplemental payment is received, the location where the service was provided, including county, municipality, and zip code.

(2) The percentage of the provider's total time spent serving Medicaid recipients annually that is for services provided at locations other than the ECU Brody School of Medicine, the Firetower Medical Office, or the UNC School of Medicine.

(3) The amount of Medicaid reimbursement for each service for which a supplemental payment was made for services provided by the provider.

(4) On an annual basis, the percentage of the provider's time spent engaging in the following:

a. Clinical patient care.

b. Teaching.

c. Research.

d. Other activities.

SECTION 12H.13.(c) The entities receiving the supplemental payments addressed in subsection (a) of this section shall transfer an amount to the Department of Health and Human Services, Division of Medical Assistance, sufficient to ensure that after reducing the transfer by twenty-five and nine-tenths percent (25.9%) there are funds for the State share necessary to make the supplemental payments. That twenty-five and nine-tenths percent (25.9%) shall be retained by the State for the Medicaid program.

SECTION 12H.13.(d) Any State plan amendments required to implement this section shall not be subject to the 90-day prior submission requirement of G.S. 108A-54.1A(e).

Senate and House Differ

Senate Version

REPEAL SHARED SAVINGS PROGRAM; MAINTAIN CERTAIN RATE REDUCTIONS

SECTION 12H.14.(a) All subsections of Section 12H.18 of S.L. 2013-360, except for subsection (b), are repealed.

SECTION 12H.14.(b) Section 12H.18(b) of S.L. 2013-360 reads as rewritten:

"**SECTION 12H.18.(b)** During the 2013-2015 fiscal biennium, the Department of Health and Human Services shall ~~withhold~~reduce by three percent (3%) ~~of~~the payments for the following services rendered to Medicaid and NC Health Choice recipients on or after January 1, 2014:

...

~~Funds from payments withheld under this section that are budgeted to be shared with providers shall not revert to the General Fund.~~"

SECTION 12H.14.(c) Effective January 1, 2015, Section 12H.18(b) of S.L. 2013-360, as amended by subsection (b) of this section, reads as rewritten:

"**SECTION 12H.18.(b)** During the 2013-2015 fiscal biennium, the Department of Health and Human Services shall reduce by three percent (3%) the payments for the following services rendered to Medicaid and NC Health Choice recipients on or after January 1, 2014:

(1) Inpatient hospital.
(2) Physician, excluding primary care until January 1, 2015.
(3) Dental.
~~(4) Optical services and supplies.~~
~~(5) Podiatry.~~
~~(6) Chiropractors.~~
~~(7) Hearing aids.~~
(8) Personal care services.
(9) Nursing homes.
(10) Adult care homes.
(11) Dispensing drugs."

{House deleted only item (9) in list.}

House Version

REPEAL SHARED SAVINGS PROGRAM; MAINTAIN CERTAIN RATE REDUCTIONS

SECTION 12H.14.(a) All subsections of Section 12H.18 of S.L. 2013-360, except for subsection (b), are repealed.

SECTION 12H.14.(b) Section 12H.18(b) of S.L. 2013-360 reads as rewritten:

"**SECTION 12H.18.(b)** During the 2013-2015 fiscal biennium, the Department of Health and Human Services shall ~~withhold~~ reduce by three percent (3%) ~~of~~ the payments for the following services rendered to Medicaid and NC Health Choice recipients on or after January 1, 2014:

...

~~Funds from payments withheld under this section that are budgeted to be shared with providers shall not revert to the General Fund.~~"

SECTION 12H.14.(c) Effective January 1, 2015, Section 12H.18(b) of S.L. 2013-360, as amended by subsection (b) of this section, reads as rewritten:

"**SECTION 12H.18.(b)** During the 2013-2015 fiscal biennium, the Department of Health and Human Services shall reduce by three percent (3%) the payments for the following services rendered to Medicaid and NC Health Choice recipients on or after January 1, 2014:

(1) Inpatient hospital.
(2) Physician, excluding primary care until January 1, 2015.
(3) Dental.
(4) Optical services and supplies.
(5) Podiatry.
(6) Chiropractors.
(7) Hearing aids.
(8) Personal care services.
~~(9) Nursing homes.~~
(10) Adult care homes.
(11) Dispensing drugs."

{Senate deleted only items (4) - (7) in list.}

Senate Only

PUBLISH MEDICAID PAYMENTS TO PROVIDERS

SECTION 12H.15.(a) For payments made in fiscal year 2013-2014 and for subsequent fiscal years, the Department of Health and Human Services, Division of Medical Assistance, shall publish on its Web site comprehensive information on Medicaid payments made to providers. The information shall be updated annually within three months of the close of a State fiscal year to include payments for that fiscal year. The information published shall include all of the following for each individual providing Medicaid services:

(1) Name of the individual providing the service.
(2) Location of service provider's principal place of business.
(3) Location of provided services, listed with both municipality and county. If an individual provides services in multiple locations, then those shall be specified and the items in subdivisions (6) through (10) of this subsection shall be provided for each location.
(4) Practice name, hospital name, or other business name with which the individual providing service is affiliated.
(5) Type of service provider and practice area.
(6) Number of Medicaid patients seen.
(7) Number of visits with Medicaid patients.
(8) Number of procedures performed or items furnished for Medicaid patients.
(9) Amount of Medicaid service payments received.
(10) Amount of Medicaid supplemental payments received.
(11) Amount of Medicaid settlement payments received.
(12) Amount of Medicaid recoupments.

The information shall be published in a character-separated values (CSV) plain text format or other file format that may easily be imported into software used for spreadsheets, databases, and data analytics. The Department shall ensure that no protected patient information be published.

SECTION 12H.15.(b) The Department of Health and Human Services, Division of Medical Assistance, shall begin discussions with the UNC School of Public Health or any other appropriate party of an educational or nonprofit nature to perform analytics on the information or to generate an interactive Web site to access the information contained within the data required to be reported under subsection (a) of this section. Such a Web site should be designed to exceed the functionality of South Carolina's HealthViz Medicaid statistics Web site.

Senate Only

STUDY PHYSICIAN ASSESSMENT

SECTION 12H.16. The Department of Health and Human Services, in consultation with the North Carolina Medical Society and any other appropriate groups, shall study the imposition of an assessment on physicians as part of the federally authorized Medicaid assessment program. The study shall consider the opportunities to increase funding to the Medicaid program and to providers by collecting additional State funds to leverage additional federal funding. The Department shall report its findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2014.

Senate Only

INCREASE HOSPITAL ASSESSMENT RETENTION BY STATE

SECTION 12H.17.(a) G.S. 108A-121(8) reads as rewritten:

"(8) State's annual Medicaid payment. – For an assessment collected under this Article, an amount equal to ~~twenty-five and nine-tenths percent (25.9%)~~ twenty-eight and eighty-five one hundredths percent (28.85%) of the total amount collected under the assessment."

SECTION 12H.17.(b) G.S. 108A-128 reads as rewritten:

"**§ 108A-128. Payment for providers formerly subject to this Article.**

If a hospital provider (i) is exempt from both the equity and UPL assessments under this Article, (ii) makes an intergovernmental transfer (IGT) to the Department of Health and Human Services to be used to draw down matching federal funds, and (iii) has acquired, merged, leased, or managed another provider on or after March 25, 2011, then the hospital provider shall transfer to the State an additional amount, which shall be retained by the State. The additional amount shall be ~~twenty-five and nine-tenths percent (25.9%)~~ a percentage of the amount of funds that (i) would be transferred to the State through such an IGT and (ii) are to be used to match additional federal funds that the hospital provider is able to receive because of the acquired, merged, leased, or managed provider. That percentage shall be the same percentage provided in the definition of "State's annual Medicaid payment" under G.S. 108-121."

Senate and House Differ

Senate Version

ASSESSMENT FOR LME/MCOS

SECTION 12H.18. The Secretary of Health and Human Services shall implement a Medicaid assessment program for local management entities/managed care organizations (LME/MCOs) at a rate of three and one-half percent (3.5%). The Department of Health and Human Services shall retain for the Medicaid program sixty-five percent (65%) of the amount collected from the assessment program. Collections shall be based on payments to the LME/MCOs for services performed on or after July 1, 2014. Any assessment funds not retained by the Department shall be used to draw federal Medicaid matching funds for implementing increased rates or new reimbursement plans for the LME/MCOs.

Receipts from this assessment program are hereby appropriated for the 2014-2015 fiscal year, as well as for any future fiscal years, for the purposes set out in this section.

{House version allows assessment on 1915(c) waiver services, if federal law allows such assessments.}

House Version

1915(C) INNOVATIONS WAIVER SERVICES ASSESSMENT

SECTION 12H.18.(a) If (i) federal law or regulation is amended to allow the imposition of assessments on 1915(c) North Carolina Innovations Waiver (formerly Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD)) services or such assessments are otherwise allowed by the Centers for Medicare & Medicaid Services (CMS) through waivers and (ii) the providers of such services are willing to participate in an assessment program, then the Department of Health and Human Services, Division of Medical Assistance, may implement a Medicaid assessment program for such services up to the maximum percentage allowed by federal regulation. The Department may retain up to sixty-five percent (65%) of the amount from such an assessment program to support Medicaid expenditures. The Department shall amend contracts with local management entities that have been approved to operate as managed care organizations (LME/MCOs) to ensure that any assessment funds not retained by the Department are used to increase LME/MCO capitation rates and that the additional amounts are passed along to the providers of Innovations Waiver service providers through increased reimbursement rates.

SECTION 12H.18.(b) The authorization provided to the Department under subsection (a) of this section to impose a new assessment program on Innovations Waiver services shall continue to exist until July 1, 2017. If an assessment program has not been established by July 1, 2017, then this section expires.

{Senate version imposes assessment on LME/MCOs.}

Senate and House Differ

Senate Version

REPEAL PLANNED CCNC PAYMENT OF PMPMS

SECTION 12H.19. It is the intent of the General Assembly that the structure of per member per month (PMPM) payments or other payments to providers participating in Community Care of North Carolina (CCNC) programs be considered as a part of any Medicaid reform plan for the State. Therefore, Section 12H.22 of S.L. 2013-360 is repealed.

{House version directs CCNC payment of PMPMs.}

House Version

IMPLEMENT CCNC PAYMENT OF PMPMS

SECTION 12H.19. The Department of Health and Human Services, Division of Medical Assistance, shall implement the payment of per member per month (PMPM) payments to providers participating in Community Care of North Carolina (CCNC) programs by CCNC, as previously directed by Section 12H.22 of S.L. 2013-360.

{Senate version repeals CCNC payment of PMPMs.}

Senate and House Differ

Senate Version

CCNC CONTRACT ADJUSTMENTS

SECTION 12H.20.(a) It is the intent of the General Assembly to grant agency to the new Medicaid entity, which is contemplated in Section 12H.1 of this act, to act on behalf of the Department of Health and Human Services, Division of Medical Assistance, with respect to the authority to terminate without cause contract #28023 on 30 days written notice to North Carolina Community Care Networks, Inc., (CCNC).

SECTION 12H.20.(b) The Department of Health and Human Services shall not exercise the option to renew contract #28023 with CCNC, which contract expires on December 31, 2015.

SECTION 12H.20.(c) The Department of Health and Human Services shall not enter into any new contract with CCNC that would have a termination date after December 31, 2015.

{House version would require dual eligibles to enroll in primary care case management through entities such as CCNC and LME/MCOs.}

House Version

PRIMARY CARE CASE MANAGEMENT FOR DUAL ELIGIBLES

SECTION 12H.20.(a) The Department of Health and Human Services, Division of Medical Assistance, shall draft one or more waivers that will expand primary care case management and that are designed to accomplish the following:

(1) Medicare and Medicaid dual eligibles shall be required to enroll in primary care case management to the maximum extent allowed by the Centers for Medicare and Medicaid Services (CMS).

(2) Primary care case management shall be provided for enrolled dual eligibles.

(3) Primary care case management for dual eligibles with a primary diagnosis of mental illness may be administered by the LME/MCOs.

The Department may submit drafts of the waivers to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waivers for CMS approval until authorized by the General Assembly.

SECTION 12H.20.(b) No later than March 1, 2015, the Department shall submit to the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services a copy of the draft waivers and a report, which shall include the following:

(1) The anticipated increase in number of dual eligibles that will enroll in primary care case management.

(2) The costs associated with serving the increased number of enrolled dual eligibles.

(3) The anticipated savings to the Medicaid program.

(4) A detailed fiscal analysis supporting any calculation of anticipated savings.

{ Senate version eliminates contracting with CCNC. }

Senate and House Differ

Senate Version

COMPREHENSIVE PROGRAM INTEGRITY CONTRACT

SECTION 12H.22.(a) Effective March 1, 2015, the new Medicaid entity, which is contemplated in Section 12H.1 of this act, shall issue a request for proposals for one contract to become effective on September 1, 2015, for the following program integrity functions:

(1) Postpayment reviews
(2) Data analytics
(3) Medical necessity reviews
(4) Investigation
(5) Recovery Audit Contracts
(6) Prepayment review

SECTION 12H.22.(b) The Department of Health and Human Services shall not enter into any contract involving the program integrity functions listed in subsection (a) of this section that would have a termination date after September 1, 2015.

SECTION 12H.22.(c) This section shall not apply to program integrity functions performed by LME/MCOs.

SECTION 12H.22.(d) The program integrity contract described in this section shall not be subject to review by the State Chief Information Officer pursuant to Section 7.7(a) of S.L. 2013-360.

* Senate Only

House Version

COMPREHENSIVE PROGRAM INTEGRITY CONTRACT

SECTION 12H.22.(a) No later than March 1, 2015, the Department of Health and Human Services, Division of Medical Assistance, shall issue a request for proposals for one contract to become effective on September 1, 2015, for the following program integrity functions:

(1) Postpayment reviews.
(2) Data analytics.
(3) Medical necessity reviews.
(4) Investigation.
(5) Recovery Audit Contracts.
(6) Prepayment review.

SECTION 12H.22.(b) The Department of Health and Human Services shall not enter into any contract, other than the comprehensive contract allowed under subsection (a) of this section, involving the program integrity functions listed in subsection (a) of this section that would have a termination date after September 1, 2015.

Technical Fix

SECTION 12H.22.(c) This section shall not apply to program integrity functions performed by LME/MCOs.

Senate Only

RETURN BURDEN OF PROOF TO PROVIDERS IN MEDICAID APPEALS

SECTION 12H.23.(a) G.S. 108C-12(d) reads as rewritten:

"(d) Burden of Proof. – The ~~Department~~ petitioner shall have the burden of proof in appeals of Medicaid providers or applicants concerning an adverse determination."

SECTION 12H.23.(b) This section is effective when it becomes law, and applies to contested cases filed at the Office of Administrative Hearings on or after that date.

Senate Only

WITHHOLDING OVERPAYMENTS TO MEET FEDERAL PAYBACK REQUIREMENTS

SECTION 12H.24. G.S. 108C-5 reads as rewritten:

"**§ 108C-5. Payment suspension and audits utilizing extrapolation.**

(a) The Department may suspend payments to a provider in accordance with the requirements and procedures set forth in 42 C.F.R. § 455.23.

(b) In addition to the procedures for suspending payment set forth at 42 C.F.R. § 455.23, the Department may also suspend payment to any provider that (i) owes a final overpayment, assessment, or fine to the Department and has not entered into an approved payment plan with the Department or (ii) has had its participation in the Medicaid or Health Choice programs suspended or terminated by the Department. For purposes of this section, a suspension or termination of participation does not become final until all administrative appeal rights have been exhausted and shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings or in Superior Court provided that the Superior Court has entered a stay pursuant to the provisions of G.S. 150B-48.

(b1) The Department shall withhold payment to any North Carolina Medicaid provider or Health Choice provider for whom the Division of Medical Assistance, or its vendor, has identified an overpayment in a written notice to the provider. Withholding shall begin on the 75th day after the day the notice of overpayment is mailed and shall continue during the pendency of any appeal until the overpayment becomes a final overpayment. For purposes of this subsection, withholding during any month shall not exceed the amount of any interest required by law plus eleven and one-tenth percent (11.1%) of the sum of the total overpayment amount identified in the notice of overpayment and any penalty required by law. If the Department subsequently reduces the identified overpayment in writing, withholding during any subsequent month shall not exceed the amount of any interest required by law plus eleven and one-tenth percent (11.1%) of the sum of the total reduced identified overpayment and any penalty required by law. Total withholdings shall not exceed the total amount of the overpayment plus any penalty and interest charges required by law. If the total amount withheld exceeds the final overpayment plus interest and penalty required by law, the Department shall pay the provider the amount withheld in excess of the final overpayment plus penalty and interest. Upon request by the provider and for good cause shown, the Department is authorized to approve a payment plan for a provider to pay an overpayment, pursuant to subsection (g) of this section. Absent a showing of good cause for repayment to be made over a period of more than one year, the Department shall take all necessary and appropriate action to recover overpayments within 365 days of the date the notice of overpayment was mailed to the provider.

(c) For providers who owe a final overpayment, assessment, or fine to the Department, the payment suspension shall begin the thirty-first day after the overpayment, assessment, or fine becomes final. The payment suspension shall not exceed the amount owed to the Department, including any applicable penalty and interest charges.

(d) Providers whose participation in the Medicaid or Health Choice programs has been suspended or terminated shall have all payments suspended beginning on the thirty-first day after the suspension or termination becomes final.

(e) The Department shall consult with the N.C. Departments of Treasury and Revenue and other State departments and agencies to determine if a provider owes debts or fines to the State. The Department may collect any of these debts owed to the State subsequent to consideration by the Department of the financial impact upon the provider and the impact upon access to the services provided by the provider.

(f) When issuing payment suspensions and withholdings in accordance with this Chapter, the Department may suspend or withhold payment to all providers which share the same IRS Employee Identification Number or corporate parent as the provider or provider site location which owes the final overpayment, overpayment, assessment, or fine. The Department shall give 30 days advance written notice to all providers which share the same IRS Employee Identification Number or corporate parent as the provider or provider site location of the intention of the Department to implement a payment ~~suspension.~~suspension or withholding.

(g) The Department is authorized to approve a payment plan for a provider to pay a final overpayment, overpayment, assessment, or fine including interest and any penalty. The payment plan can include a term of up to 24 months. The Department shall establish in rule the conditions of such provider payment plans. Nothing in this subsection shall prevent the provider and the Department from mutually agreeing to modifications of a payment plan.

(h) All payments suspended or withheld in accordance with this Chapter shall be applied toward any final overpayment, assessment, or fine owed to the Department.

...."

Senate Only

APPEALS OF INTERLOCUTORY ORDERS OF THE OFFICE OF ADMINISTRATIVE HEARINGS

SECTION 12H.25.(a) G.S. 1A-1 is amended by adding a new Article to read as follows:

"Article 9.

"Extraordinary Writs.

"**Rule 90. Certiorari.**

(a) Scope of the Writ; Review of the Judgments, Decisions, and Orders of the Office of Administrative Hearings. – The writ of certiorari may be issued in appropriate circumstances by the Superior Court to permit review of the judgments, decisions, and orders of the Office of Administrative Hearings when no right of appeal from an interlocutory order exists.

(b) Petition for Writ; to Which Superior Court Addressed. – Application for the writ of certiorari shall be made by filing a petition therefor with the clerk of the superior court division to which appeal of right might lie from a final decision of the Office of Administrative Hearings in the contested case for which issuance of the writ is sought.

(c) Same; Filing and Service; Content. – The petition shall be filed without unreasonable delay and shall be accompanied by proof of service upon all other parties. The petition shall contain a statement of the facts necessary to an understanding of the issues presented by the application, a statement of the reasons why the writ should issue, and certified copies of the judgment, decision, order, or opinion or parts of the record which may be essential to an understanding of the matters set forth in the petition. The petition shall be verified by counsel or the petitioner. Upon receipt of the prescribed docket fee, the clerk will docket the petition.

(d) Response; Determination by Court. – Within 10 days after service of the petition any party may file a response thereto with supporting affidavits or certified portions of the record not filed with the petition. Filing shall be accompanied by proof of service upon all other parties. The court for good cause shown may shorten the time for filing a response. Determination will be made on the basis of the petition, the response, and any supporting papers. No briefs or oral argument will be received or allowed unless ordered by the court upon its own initiative.

"**Rule 91. Mandamus and Prohibition.**

(a) Petition for Writ; to Which Superior Court Addressed. – Applications for the writs of mandamus or prohibition directed to an administrative law judge shall be made by filing a petition therefor with the clerk of the superior court division to which appeal of right might lie from a final decision entered in the contested case for which issuance of the writ is sought.

(b) Same; Filing and Service; Content. – The petition shall be filed without unreasonable delay after the action by the Office of Administrative Hearings sought to be prohibited or compelled has been undertaken, or has occurred, or has been refused, and shall be accompanied by proof of service on the respondent administrative law judge or administrative law judges and on all other parties to the action. The petition shall contain a statement of the facts necessary to an understanding of the issues presented by the application, a statement of the issues presented and of the relief sought, a statement of the reasons why the writ should issue, and certified copies of any order or opinion or parts of the record that may be essential to an understanding of the matters set forth in the petition. The petition shall be verified by counsel or the petitioner. Upon receipt of the prescribed docket fee, the clerk shall docket the petition.

(c) Response; Determination by Court. – Within 10 days after service of the petition the respondent or any party may file a response thereto with supporting affidavits or certified portions of the record not filed with the petition. Filing shall be accompanied by proof of service upon all other parties. The court for good cause shown may shorten the time for filing a response.

Determination will be made on the basis of the petition, the response, and any supporting papers. No briefs or oral argument will be received or allowed unless ordered by the court upon its own initiative.

"**Rule 92. Supersedeas.**

(a) Pending Review of Office of Administrative Hearings Judgments, Decisions, and Orders. – Application may be made to the appropriate superior court for a writ of supersedeas to stay the execution or enforcement of any judgment, decision, order, or other determination of the Office of Administrative Hearings which is not automatically stayed by the taking of appeal when an appeal has been taken or a petition for mandamus, prohibition, or certiorari has been filed to obtain review of the judgment, decision, order, or other determination and (i) a stay order or entry has been sought by the applicant by deposit of security or by motion at the Office of Administrative Hearings and such order or entry has been denied or vacated by the trial tribunal or (ii) extraordinary circumstances make it impracticable to obtain a stay by deposit of security or by application to the Office of Administrative Hearings for a stay order.

(b) Petition; Filing and Service; Content. – The petition shall be filed with the clerk of the superior court division to which appeal of right might lie from a final decision of the Office of Administrative Hearings in the contested case for which issuance of the writ is sought. The petitions shall be accompanied by proof of service upon all other parties. The petition shall be verified by counsel or the petitioner. Upon receipt of the required docket fee, the clerk will docket the petition. For stays of the judgments of the Office of Administrative Hearings, the petition shall contain a statement that a stay has been sought in the Office of Administrative Hearings and denied or vacated or shall contain facts showing that it was impracticable there to seek a stay. For stays of any judgment, the petition shall contain (i) a statement of any facts necessary to an understanding of the basis upon which the writ is sought and (ii) a statement of reasons why the writ should issue in justice to the applicant. The petition may be accompanied by affidavits and by any certified portions of the record pertinent to its consideration. It may be included in a petition to the superior court for certiorari, mandamus, or prohibition.

(c) Response; Determination by Court. – Within 10 days after service of the petition, any party may file a response thereto with supporting affidavits or certified portions of the record not filed with the petition. Filing shall be accompanied by proof of service upon all other parties. The court for good cause shown may shorten the time for filing a response. Determination will be made on the basis of the petition, the response, and any supporting papers. No briefs or oral argument will be received or allowed unless ordered by the court upon its own initiative.

(d) Temporary Stay. – Upon the filing of a petition for supersedeas, the applicant may apply, either within the petition or by separate paper, for an order temporarily staying enforcement or execution of the judgment, decision, order, or other determination pending decision by the court upon the petition for supersedeas. If application is made by separate paper, it shall be filed and served in the manner provided for the petition for supersedeas in Rule 92(b). The court for good cause shown in such a petition for temporary stay may issue such an order ex parte."

SECTION 12H.25.(b) Article 4 of Chapter 150B of the General Statutes is amended by adding a new section to read:

"**§ 150B-53. Writs.**

Any party to a contested case may petition for writs of certiorari, mandamus, prohibition, or supersedeas in the manner prescribed in Rules 90, 91, and 92 of the North Carolina Rules of Civil Procedure."

SECTION 12H.25.(c) This section is effective when it becomes law, and applies to judgments, decisions, and orders of the Office of Administrative Hearings entered on or after that date.

Senate and House Differ

Senate Version

MODIFICATIONS TO RECIPIENT APPEALS

SECTION 12H.27.(a) G.S. 108A-70.9A(d) reads as rewritten:

"(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~~ may request a hearing only within ~~30 days of~~ the time period beginning upon the mailing of the notice required by subsection (c) of this section and ending on the effective date of the adverse determination, which shall be the period for appeal. In order to request a hearing, a recipient must ~~by sending~~ file an appeal request form ~~to~~ with OAH and the ~~Department.~~ Department within the period for appeal. If the recipient does not request a hearing during the period for appeal, the recipient shall be deemed to have waived any right of appeal, and OAH shall deny any hearing request filed outside the period for appeal. Upon demonstration during any contested case that the hearing request was filed outside the period for appeal, OAH shall dismiss the contested case. 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."

SECTION 12H.27.(b) G.S. 108A-70.9B reads as rewritten:

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

...

(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. 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.~~ If the recipient accepts an offer of mediation and then fails to meaningfully participate without good cause, OAH shall dismiss the contested case.

(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. The party with the burden of proof on any issue~~ on all issues submitted

to OAH for a Medicaid contested case hearing and has the burden of going ~~forward,~~ forward. ~~and the~~ The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

* Senate only

...."

SECTION 12H.27.(c) G.S. 108D-15(i) reads as rewritten:

"(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee 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 LME/MCO within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of a managed care action until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (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.~~ If the enrollee accepts an offer of mediation and then fails to meaningfully participate without good cause, OAH shall dismiss the contested case."

SECTION 12H.27.(d) This section is effective October 1, 2014, and applies to appeals of notices of adverse determination mailed on or after that date and appeals of notices of resolution mailed on or after that date.

House version ≈ "attend mediation"

House Version

PARTICIPATION IN MEDIATION IN RECIPIENT APPEALS

SECTION 12H.27.(a) G.S. 108A-70.9B reads as rewritten:

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

...

(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. 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.~~ If the recipient accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

...."

SECTION 12H.27.(b) G.S. 108D-15(i) reads as rewritten:

"(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee 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 LME/MCO within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of a managed care action until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (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.~~ If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case."

SECTION 12H.27.(c) This section is effective October 1, 2014, and applies to appeals of notices of adverse determination mailed on or after that date and appeals of notices of resolution mailed on or after that date.

Senate version ≈ "meaningfully participate"

Senate Only

REPORT ON FUNDING OF STATE MEDICAL SCHOOLS

SECTION 12H.28. The University of North Carolina System, working with the appropriate constituent institutions and health systems, shall report to the Joint Legislative Oversight Committee on Health and Human Services on how the medical schools are funded. The report shall include a detailed explanation of the sources of all income within both a current and historical context, noting any changes in funding sources and amounts over time. The report required by this section is due by October 1, 2014.

{House included, with slight modifications, at Section 11.20/Education.}

Senate and House Differ

Senate Version

Technical Fix

EXTEND EXISTING IMAGING UTILIZATION MANAGEMENT SERVICES CONTRACT; CONTAIN COSTS OF FUTURE CONTRACTS

SECTION 12H.30.(a) The Department of Health and Human Services, Division of Medical Assistance, shall renegotiate the existing contract for imaging utilization management services in order to achieve five million five hundred thousand dollars ($5,500,000) in annual savings of net General Fund appropriations.

SECTION 12H.30.(b) The Department of Health and Human Services, Division of Medical Assistance, shall issue a request for proposals (RFP) for a contract for imaging utilization management services to ascertain whether the State can achieve better savings with an alternative vendor and, if so, enter into a contract with the alternative vendor. Such an RFP shall incorporate the same requirements as those specified in Section 10.68B of S.L. 2009-451, which was enacted by Section 6 of S.L. 2009-575.

SECTION 12H.30.(c) No later than March 1, 2015, the Department of Health and Human Services, Division of Medical Assistance, shall report on the results of this section to (i) the House Appropriations Subcommittee on Health and Human Services, (ii) the Senate Appropriations Committee on Health and Human Services, and (iii) the Fiscal Research Division.

{ Identical to House Version, which has a typo in title }

House Version

EXTEND EXISTING IMAGE UTILIZATION MANAGEMENT SERVICES CONTRACT; CONTAIN COSTS OF FUTURE CONTRACTS

SECTION 12H.30.(a) The Department of Health and Human Services, Division of Medical Assistance, shall renegotiate the existing contract for imaging utilization management services in order to achieve five million five hundred thousand dollars ($5,500,000) in annual savings of net General Fund appropriations.

SECTION 12H.30.(b) The Department of Health and Human Services, Division of Medical Assistance, shall issue a request for proposals (RFP) for a contract for imaging utilization management services to ascertain whether the State can achieve better savings with an alternative vendor and, if so, enter into a contract with the alternative vendor. Such an RFP shall incorporate the same requirements as those specified in Section 10.68B of S.L. 2009-451, which was enacted by Section 6 of S.L. 2009-575.

SECTION 12H.30.(c) No later than March 1, 2015, the Department of Health and Human Services, Division of Medical Assistance, shall report on the results of this section to (i) the House Appropriations Subcommittee on Health and Human Services, (ii) the Senate Appropriations Committee on Health and Human Services, and (iii) the Fiscal Research Division.

House Only

NONEMERGENCY MEDICAL TRANSPORTATION CONTRACT

SECTION 12H.31. The Department of Health and Human Services, Division of Medical Assistance, shall develop and issue a request for proposal for a contract beginning January 1, 2015, for the statewide management of Medicaid nonemergency medical transportation services.

House Only

AMBULANCE TRANSPORTS TO CRISIS CENTERS

SECTION 12H.32. The Department of Health and Human Services, Division of Medical Assistance, shall study the practice of reimbursing for ambulance transports that divert individuals in mental health crisis from hospital emergency departments to alternative appropriate locations for care. The Department shall study existing pilot programs in North Carolina, as well as other states, and shall specifically study expansion of the Wake County Emergency Medical Services (EMS) Advanced Practice Paramedics pilot program. The study shall do the following:

(1) Propose necessary Medicaid and mental health policy changes.

(2) Identify funding needs.

(3) Identify available funding sources.

(4) Identify any other actions that would be necessary to facilitate implementation.

The Department shall report its findings and recommendations to the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services by March 1, 2015.

House Only

PARAGARD REIMBURSEMENT

SECTION 12H.33.(a) Beginning July 1, 2014, the Department of Health and Human Services, Division of Medical Assistance, shall reimburse for Paragard using the same reimbursement methodology as is used for Implanon and Mirena.

SECTION 12H.33.(b) Any State plan amendment required to implement this section shall not be subject to the 90-day prior submission requirement of G.S. 108A-54.1A(e).

House Only

STUDY BOTOX REIMBURSEMENT

SECTION 12H.33A. Prior to the convening of the 2015 General Assembly, the Joint Legislative Oversight Committee on Health and Human Services shall study the issue of implementing uniform Medicaid reimbursement rates for Botox for physicians and pharmacists.

House Only

REPORT ON PACE PROGRAM

SECTION 12H.34.(a) By September 1, 2014, the Department of Health and Human Services, Division of Medical Assistance, shall report to the Joint Legislative Oversight Committee on Health and Human Services with the following information on the Program of All-Inclusive Care for the Elderly (PACE):

(1) The number of individuals being served in each of the PACE service areas.

(2) A description of the program enrollment criteria and enrollment process.

(3) Detailed figures showing how funding for the program has been spent during the past two fiscal years.

(4) The per member per month cost of serving individuals through the PACE program compared to the cost of serving individuals in a nursing home.

(5) An estimate of how many PACE participants would enter a nursing home if they were not enrolled with the PACE program.

SECTION 12H.34.(b) By December 1, 2014, the Department of Health and Human Services, Division of Medical Assistance, shall submit an additional report to the Joint Legislative Oversight Committee on Health and Human Services with the following information on the Program of All-Inclusive Care for the Elderly (PACE):

(1) An update on all of the information required by subsection (a) of this section.

(2) A comparison of North Carolina's PACE program to PACE programs in other states.

(3) Recommendations for how to make the program sustainable.

House Only

ALLOW FOR THE MOVEMENT OF CERTAIN MEDICAID RECIPIENTS

SECTION 12H.35. Individuals served pursuant to the State's Section 1915(b)/(c) managed care waiver are exempt from Medicaid home origin requirements for the purposes of services provided under the Section 1915(b)/(c) managed care waiver. Medicaid provided for individuals served pursuant to the State's Section 1915(b)/(c) managed care waiver shall be based on the individual's Medicaid current county of residence. Notwithstanding the forgoing, however, Section 1915(c) innovations waiver slots shall be portable and recognized uniformly throughout all counties of North Carolina; an individual who receives an innovations waiver in one county shall not be required to reapply in another county if that individual moves or seeks services in another county.

House Only

APPOINTMENT AND CONFIRMATION OF MEDICAID DIRECTOR

SECTION 12H.36.(a) Effective July 1, 2014, and applying to Directors of the Division of Medical Services appointed on or after that date, G.S. 108A-54 is amended by adding a new subsection to read:

"**§ 108A-54. Authorization of Medical Assistance Program; administration.**

...

(e) The Medicaid Program shall be managed by the Director of the Division of Medical Assistance (Medicaid Director), who shall be recommended by the Secretary of Health and Human Services and appointed by the Governor, subject to confirmation by the General Assembly by joint resolution. The term of office for the Medicaid Director shall be five years beginning upon the date of qualification for office. In case of a vacancy in the office of Medicaid Director for any reason prior to the expiration of his or her term of office, the name of his or her successor for a new five year term shall be submitted by the Governor to the General Assembly not later than 60 days after the vacancy arises. If a vacancy arises in the office when the General Assembly is not in session, the Medicaid Director shall be appointed by the Governor to serve on an interim basis pending confirmation by the General Assembly.

Upon failure of the Governor to submit a name at least 90 days before the expiration of a term or within 60 days of occurrence of a vacancy, the President Pro Tempore of the Senate and the Speaker of the House of Representatives jointly shall submit a name of an appointee to the General Assembly. The appointment shall then be made by enactment of a bill. The bill shall state the name of the person being appointed, the office to which the appointment is being made, the effective date of the appointment, the date of expiration of the term, the city and state of residence of the appointee, and that the appointment is made upon the joint recommendation of the Speaker of the House of Representatives and the President Pro Tempore of the Senate. Nothing precludes any member of the General Assembly from proposing an amendment to any bill making such an appointment.

The Medicaid Director may be removed by either the Secretary of Health and Human Services or the Governor for any of the grounds set forth in G.S. 143B-13(b), (c), or (d)."

SECTION 12H.36.(b) The Director of the Division of Medical Assistance (Medicaid Director) serving as of July 1, 2014, shall continue to serve until a successor is appointed under 108A-54(e).

House Only

ALIGN ANNUAL MEDICAID BASIC BILLING UNIT LIMITS TO FISCAL YEAR

SECTION 12H.37.(a) Beginning July 1, 2015, the Department of Health and Human Services, Division of Medical Assistance, shall require that annual Medicaid billing unit limits for services managed by the LME/MCOs be based upon the fiscal year, provided that this standardization can be accomplished with no net fiscal impact on General Fund appropriations.

SECTION 12H.37.(b) Any State Plan Amendment required to implement this section shall not be subject to the 90-day prior submission requirement of G.S. 108A-54.1A(e).

Senate and House Differ

Senate Version

CONTROL OF DATA DISCLOSED TO THE NORTH CAROLINA HEALTH INFORMATION EXCHANGE BY REQUIRED PARTICIPANTS

SECTION 12I.1.(a) G.S. 90-413.3A(b) reads as rewritten:

"(b) Any hospital, as defined in ~~G.S. 131E-76(c),~~ G.S. 131E-76(3) that has an electronic health record system shall connect to the ~~NC HIE~~ HIE Network and submit individual patient demographic and clinical data on services paid for with Medicaid funds, based upon the findings set forth in subsection (a) of this section and notwithstanding the voluntary nature of the NC HIE under G.S. 90-413.2. The NC HIE shall give the Department of Health and Human Services and professional staff of the Fiscal Research, Bill Drafting, Research, and Program Evaluation Divisions of the General Assembly real-time access to data and information ~~contained in the NC HIE.~~disclosed through the HIE Network."

SECTION 12I.1.(b) G.S. 90-413.3A is amended by adding a new subsection to read:

"(c) Any data disclosed through the HIE Network pursuant to subsection (b) of this section shall be and will remain the sole property of the State. Any data or product derived from the data disclosed to the HIE Network pursuant to subsection (b) of this section, including a consolidation or analysis of the data, shall be and will remain the sole property of the State. The NC HIE shall not allow proprietary information it receives pursuant to this section to be used by any person or entity for commercial purposes."

SECTION 12I.1.(c) In order to ensure the successful, uninterrupted operation of the statewide health information exchange network (HIE Network), the Department of Health and Human Services (Department) shall develop a transition plan for transferring the responsibilities imposed on the NC HIE under Article 29A of the General Statutes to another entity in the event the NC HIE is unable or unwilling to continue overseeing and administering the HIE Network. The Department shall develop the plan in consultation with the Office of Information Technology Services and the NC HIE, and submit the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than February 1, 2015.

House Version

CONTROL OF DATA DISCLOSED TO THE NORTH CAROLINA HEALTH INFORMATION EXCHANGE BY REQUIRED PARTICIPANTS

SECTION 12I.1.(a) G.S. 90-413.3A(b) reads as rewritten:

"(b) Any hospital, as defined in ~~G.S. 131E-76(c),~~ G.S. 131E-76(3) that has an electronic health record system shall connect to the ~~NC HIE~~ HIE Network and submit individual patient demographic and clinical data on services paid for with Medicaid funds, based upon the findings set forth in subsection (a) of this section and notwithstanding the voluntary nature of the NC HIE under G.S. 90-413.2. The NC HIE shall give the Department of Health and Human Services real-time access to data and information ~~contained in the NC HIE.~~disclosed through the HIE Network. At the request of the Director of the Fiscal Research, Bill Drafting, Research, or Program Evaluation Divisions of the General Assembly, the NC HIE shall provide the professional staff of these Divisions with data and information responsive to the Director's request. Prior to providing the General Assembly's staff with any data or information disclosed through the HIE Network pursuant to this subsection, the NC HIE shall redact any personal identifying information in a manner consistent with the standards specified for de-identification of health information under the HIPAA Privacy Rule, 45 C.F.R. 164.15, as amended."

SECTION 12I.1.(b) G.S. 90-413.3A is amended by adding a new subsection to read:

"(c) Any data disclosed through the HIE Network pursuant to subsection (b) of this section shall be and will remain the sole property of the State. Any data or product derived from the data disclosed to the HIE Network pursuant to subsection (b) of this section, including a consolidation or analysis of the data, shall be and will remain the sole property of the State. The NC HIE shall not allow proprietary information it receives pursuant to this section to be used by any person or entity for commercial purposes."

SECTION 12I.1.(c) In order to ensure the successful, uninterrupted operation of the statewide health information exchange network (HIE Network), the Department of Health and Human Services (Department) shall develop a transition plan for transferring the responsibilities imposed on the NC HIE under Article 29A of the General Statutes to another entity in the event the NC HIE is unable or unwilling to continue overseeing and administering the HIE Network. The Department shall develop the plan in consultation with the Office of Information Technology Services and the NC HIE and submit the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than February 1, 2015.

Senate Only

ESTABLISHMENT OF JOINT LEGISLATIVE STUDY COMMISSION ON TRAUMATIC BRAIN INJURY

SECTION 12I.2.(a) There is created the Joint Legislative Study Commission on the Service Needs of Individuals with Traumatic Brain Injury (TBI). The purpose of the Commission is to study and make recommendations about the service needs of individuals with TBI.

SECTION 12I.2.(b) The Commission shall consist of 15 members as follows:

(1) Five members appointed by the Speaker of the House of Representatives with the following qualifications:
   a. Two members of the House of Representatives.
   b. One licensed physician with experience assessing and treating adults who have suffered TBI.
   c. One neuropsychologist with experience assessing and treating individuals with TBI.
   d. One adult survivor of TBI.

(2) Five members appointed by the President Pro Tempore of the Senate with the following qualifications:
   a. Two members of the Senate.
   b. One operator of a rehabilitation facility for adults with TBI.
   c. One representative of the Veterans Administration with knowledge and experience in the range of TBI services available to members of the military and veterans.
   d. One parent of a child survivor of TBI.

(3) The Secretary of the Department of Health and Human Services, or the Secretary's designee.

(4) The Director of the Division of Medical Assistance, or the Director's designee.

(5) The Executive Director of the North Carolina Brain Injury Council, or the Executive Director's designee.

(6) The Executive Director of Community Care of North Carolina, or the Executive Director's designee.

(7) One Chief Executive Officer (CEO) of a local management entity that has been approved to operate the 1915(b)/(c) Medicaid Waiver, who is currently managing services for children and adults with TBI, or the CEO's designee, appointed jointly by the cochairs of the Commission.

SECTION 12I.2.(c) The Commission shall have two cochairs, one designated by the Speaker of the House of Representatives and one designated by the President Pro Tempore of the Senate from among their respective appointees. The Commission shall meet upon the call of the cochairs. Any vacancy on the Commission shall be filled by the original appointing authority. A quorum shall consist of a majority of the total membership of the Commission.

SECTION 12I.2.(d) The Commission shall study all of the following issues:

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

(2) Existing TBI-specific service definitions for children and adults who receive services through federally funded programs, including Medicaid, federal block grants, and the Veterans Administration; through State-funded programs, including the Traumatic Brain Injury Trust Fund; through county-funded

programs; and through other funding sources, as well as the need for additional or revised service definitions to meet the specific needs of those with TBI.

(3) Current reimbursement rates tied to settings that treat adults with TBI, and the adequacy of these reimbursement rates.

(4) Current accessibility to TBI services, service information, educational materials, and family resources; and any deficiencies that need to be addressed.

(5) Current status of TBI-specific screening, assessment, triage, and service referrals for children, adults, and veterans; and any deficiencies that need to be addressed.

(6) This State's current organizational model for providing comprehensive needs assessment, information management, policy development, service delivery, monitoring, and quality assurance for children and adults with TBI as compared to TBI organizational structures in other states; and specific organizational models to manage services for persons with TBI that are well coordinated for all citizens, including veterans.

(7) Any other matters related to TBI services for children, adults, veterans, and their families.

SECTION 12I.2.(e) Members of the Commission shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Commission, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Commission may meet in the Legislative Building or the Legislative Office Building.

With approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Commission in its work. Upon the direction of the Legislative Services Commission, the Director of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Commission. The expenses for clerical employees shall be borne by the Commission. The Commission may contract for consultants or hire employees in accordance with G.S. 120-32.02.

SECTION 12I.2.(f) The Commission shall submit a final report of its findings and recommendations, including any proposed legislation, to the 2016 Regular Session of the 2015 General Assembly no later than May 1, 2016. The Commission shall terminate upon the filing of its final report.

Senate Only

PED STUDY CONCERNING ALCOHOL AND SUBSTANCE ABUSE EDUCATION AND PREVENTION INITIATIVE TO BE FUNDED BY LOCAL ALCOHOLIC BEVERAGE CONTROL BOARDS.

SECTION 12I.3.(a) The Joint Legislative Program Evaluation Oversight Committee shall consider including in the 2014-2015 Work Plan for the Program Evaluation Division of the General Assembly a study of the benefits and disadvantages to the State of requiring local Alcoholic Beverage Control boards to (i) cease payments effective July 1, 2015, to the Department of Health and Human Services under G.S. 18B-805(b)(3) for alcoholism or substance abuse research, treatment, or education and (ii) redirect these payments to the North Carolina Alcoholic Beverage Control Commission, effective July 1, 2015, for an alcohol and substance abuse education and prevention initiative.

SECTION 12I.3.(b) If the Joint Legislative Program Evaluation Oversight Committee adds the study described in subsection (a) to its 2014-2015 Work Plan, the Program Evaluation Division shall submit its findings and recommendations to the Joint Legislative Program Evaluation Oversight Committee and the Fiscal Research Division no later than February 1, 2015.

House Only

REINSTATEMENT OF HOSPITAL SETOFF DEBT COLLECTION

SECTION 12I.4.(a) G.S. 105A-2(9) reads as rewritten:

"(9) State agency. – Any of the following:

a. A unit of the executive, legislative, or judicial branch of State ~~government, except for the following:~~

~~1. Any school of medicine, clinical program, facility, or practice affiliated with one of the constituent institutions of The University of North Carolina that provides medical care to the general public.~~

~~2. The University of North Carolina Health Care System and other persons or entities affiliated with or under the control of The University of North Carolina Health Care System.~~government.

b. A local agency, to the extent it administers a program supervised by the Department of Health and Human Services or it operates a Child Support Enforcement Program, enabled by Chapter 110, Article 9, and Title IV, Part D of the Social Security Act.

c. A community college."

SECTION 12I.4.(b) This section is effective when it becomes law and applies to tax refunds determined by the Department of Revenue on or after that date.

Follows $

Senate and House Differ

Senate Version

REVISE DHHS BLOCK GRANTS

SECTION 12J.1. Section 12J.1 of S.L. 2013-360 reads as rewritten:

"DHHS BLOCK GRANTS

"SECTION 12J.1.(a) Except as otherwise provided, appropriations from federal block grant funds are made for each year of the fiscal biennium ending June 30, 2015, according to the following schedule:

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) FUNDS		**FY2013-2014**	**FY2014-2015**
Local Program Expenditures			
Division of Social Services			
01.	Work First Family Assistance	$ 60,285,413	$ 60,285,413
02.	Work First County Block Grants	82,485,495	82,485,495
03.	Work First Electing Counties	2,352,521	2,352,521
04.	Adoption Services – Special Children Adoption Fund	2,026,877	2,026,877
05.	Child Protective Services – Child Welfare Workers for Local DSS	9,412,391	9,412,391
06.	Child Welfare Collaborative	632,416	632,416
06A.	Foster Care Services		1,385,152
Division of Child Development and Early Education			
07.	Subsidized Child Care Program	57,172,097~~55,409,695~~	54,054,806
08.	Swap Child Care Subsidy	6,352,644	6,352,644
08A.	Pre-K Swap Out		7,195,807
Division of Public Health			
09.	Teen Pregnancy Initiatives	2,500,000	2,500,000

DHHS Administration			
10.	Division of Social Services	2,482,260	2,482,260
11.	Office of the Secretary	34,042	34,042
Transfers to Other Block Grants			
	Division of Child Development and Early Education		
12.	Transfer to the Child Care and Development Fund	71,773,001	71,773,001
13.	Transfer to Social Services Block Grant for Child Protective Services – Child Welfare Training in Counties	1,300,000	1,300,000
14.	Transfer to Social Services Block Grant for Child Protective Services	5,040,000	5,040,000
15.	Transfer to Social Services Block Grant for County Departments of Social Services for Children's Services	4,148,001	4,148,001
TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) FUNDS		**$307,997,158**	~~$306,234,756~~$313,460,826
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS			
Local Program Expenditures			
	Division of Social Services		
01.	Work First County Block Grants	$ 5,580,925	$ 5,580,925
02.	Work First Electing Counties	25,692	25,692
	Division of Child Development and Early Education		
03.	Subsidized Child Care	6,549,469	~~6,549,469~~11,679,394
TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS		**$12,156,086**	~~$ 12,156,086~~$ 17,286,011
SOCIAL SERVICES BLOCK GRANT			
Local Program Expenditures			
	Divisions of Social Services and Aging and Adult Services		

01.	County Departments of Social Services (Transfer from TANF $4,148,001)	$ 29,422,137	~~$ 29,422,137~~$ 27,427,015
02.	Child Protective Services (Transfer from TANF)	5,040,000	5,040,000
03.	State In-Home Services Fund	1,943,950	1,943,950
04.	Adult Protective Services	1,245,363	1,245,363
05.	State Adult Day Care Fund	1,994,084	1,994,084
06.	Child Protective Services/CPS Investigative Services – Child Medical Evaluation Program	563,868	563,868
07.	Special Children Adoption Incentive Fund	462,600	462,600
08.	Child Protective Services – Child Welfare Training for Counties (Transfer from TANF)	1,300,000	1,300,000
09.	Home and Community Care Block Grant (HCCBG)	1,696,888	1,696,888
10.	Child Advocacy Centers	375,000	375,000
11.	Guardianship	3,978,360	3,978,360
12.	UNC Cares Contract	229,376	~~229,376~~57,344
~~13.~~	~~Foster Care Services~~	~~1,385,152~~	~~1,385,152~~
	Division of Central Management and Support		
14.	DHHS Competitive Block Grants for Nonprofits	3,852,500	3,852,500
	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services		
15.	Mental Health Services – Adult and Child/Developmental Disabilities Program/ Substance Abuse Services – Adult	4,030,730	4,030,730
DHHS Program Expenditures			
	Division of Services for the Blind		
16.	Independent Living Program	3,361,323	3,361,323

Division of Health Service Regulation			
17.	Adult Care Licensure Program	381,087	381,087
18.	Mental Health Licensure and Certification Program	190,284	190,284
DHHS Administration			
19.	Division of Aging and Adult Services	577,745	577,745
20.	Division of Social Services	559,109	559,109
21.	Office of the Secretary/Controller's Office	127,731	127,731
22.	Division of Child Development	13,878	13,878
23.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	27,446	27,446
24.	Division of Health Service Regulation	118,946	118,946
TOTAL SOCIAL SERVICES BLOCK GRANT		**$ 62,877,557**	~~**$ 62,877,557**~~**$ 59,325,251**
LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT			
Local Program Expenditures			
Division of Social Services			
01.	Low-Income Energy Assistance Program (LIEAP)	$ 50,876,440	$ 50,876,440
02.	Crisis Intervention Program (CIP)	33,866,195	33,866,195
Local Administration			
Division of Social Services			
03.	County DSS Administration	6,757,731	6,757,731
DHHS Administration			
04.	Office of the Secretary/DIRM	412,488	412,488
05.	Office of the Secretary/Controller's Office	18,378	18,378
Transfers to Other State Agencies			
Department of Environment and Natural Resources (DENR)			

06.	Weatherization Program	14,947,789	~~14,947,789~~12,473,090	
07.	Heating Air Repair and Replacement Program (HARRP)	7,193,873	~~7,193,873~~6,636,633	
08.	Local Residential Energy Efficiency Service Providers – Weatherization	37,257	~~37,257~~692,950	
09.	Local Residential Energy Efficiency Service Providers – HARRP	338,352	~~338,352~~312,227	
10.	DENR Administration – Weatherization	37,257	~~37,257~~692,950	
11.	DENR Administration – HARRP	338,352	~~338,352~~312,226	
	Department of Administration			
12.	N.C. Commission on Indian Affairs	87,736	87,736	
TOTAL LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT		**$ 114,911,848**	**~~$ 114,911,848~~$113,139,044**	
CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT				
Local Program Expenditures				
	Division of Child Development and Early Education			
01.	Child Care Services (Smart Start $7,000,000)	$ 156,566,345	~~$ 158,328,747~~$168,536,136	
02.	Electronic Tracking System	3,000,000	3,000,000	
03.	Transfer from TANF Block Grant for Child Care Subsidies	71,773,001	71,773,001	
04.	Quality and Availability Initiatives (TEACH Program $3,800,000)	24,262,402	~~22,500,000~~24,168,551	
DHHS Administration				
	Division of Child Development and Early Education			
05.	DCDEE Administrative Expenses	6,000,000	~~6,000,000~~7,677,977	
	Division of Social Services			
06.	Local Subsidized Child Care Services Support	13,274,413	13,274,413	

Division of Central Administration			
07.	DHHS Central Administration – DIRM Technical Services	775,000	775,000
08.	Central Regional Maintenance		202,000
TOTAL CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT		**$ 275,651,161**	~~$ 275,651,161~~**$289,407,078**
MENTAL HEALTH SERVICES BLOCK GRANT			
Local Program Expenditures			
01.	Mental Health Services – Adult	$ 10,717,607	~~$ 10,717,607~~
02.	Mental Health Services – Child	5,121,991	~~5,121,991~~3,619,833
03.	Administration	200,000	200,000
04.	Mental Health Services – Adult/Child		12,398,643
05.	Crisis Solutions Initiative – Critical Time Intervention		750,000
TOTAL MENTAL HEALTH SERVICES BLOCK GRANT		**$ 16,039,598**	~~$ 16,039,598~~**$ 16,968,476**
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~~	~~$ 14,960,371~~	~~$ 14,960,371~~
~~02.~~	~~Substance Abuse Treatment Alternative for Women~~	~~6,050,300~~	~~6,050,300~~
03.	Substance Abuse – HIV and IV Drug	3,919,723	3,919,723
~~04.~~	~~Substance Abuse Prevention – Child~~	~~7,186,857~~	~~7,186,857~~
04A.	Substance Abuse Prevention		8,669,284
~~05.~~	~~Substance Abuse Services – Child~~	~~4,190,500~~	~~4,190,500~~
05A.	Substance Abuse Services – Treatment for Children/Adults		31,125,883
05B.	Veteran's Crisis – DOA Veterans Affairs		

		Call-in Crisis Center		250,000
	06.	Administration	454,000	454,000
		Division of Public Health		
	~~07.~~	~~Risk Reduction Projects~~	~~575,654~~	~~575,654~~
	~~08.~~	~~Aid to Counties~~	~~190,295~~	~~190,295~~
	08A.	HIV Testing for Individuals in Substance Abuse Treatment		765,949
	TOTAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT		**$ 37,527,700**	**~~$ 37,527,700~~$ 45,184,839**
	MATERNAL AND CHILD HEALTH BLOCK GRANT			
	Local Program Expenditures			
		Division of Public Health		
	01.	Children's Health Services (Safe Sleep Campaign $45,000)	$ 8,042,531	~~$ 8,042,531~~$ 7,574,703
	02.	Women's Health (March of Dimes $350,000; Teen Pregnancy Prevention Initiatives $650,000; Perinatal Quality Collaborative $350,000; 17P Project $52,000; Carolina Pregnancy Care Fellowship ~~$250,000;~~$300,000; Nurse-Family Partnership $509,018)	8,532,935	~~8,532,935~~8,095,148
	03.	Oral Health	44,901	44,901
	DHHS Program Expenditures			
		Division of Public Health		
	04.	Children's Health Services	1,301,504	~~1,301,504~~1,300,578
	05.	Women's Health – Maternal Health	105,419	~~105,419~~105,361
	06.	State Center for Health Statistics	164,487	~~164,487~~156,230
	07.	Health Promotion – Injury and Violence Prevention	89,374	~~89,374~~84,919
	DHHS Administration			
		Division of Public Health		

08.	Division of Public Health Administration	573,108	~~573,108~~552,571
TOTAL MATERNAL AND CHILD HEALTH BLOCK GRANT		**$ 18,854,259**	**~~$ 18,854,259~~$ 17,914,411**
PREVENTIVE HEALTH SERVICES BLOCK GRANT			
Local Program Expenditures			
01.	Physical Activity and Prevention	$ 1,186,142	~~$ 1,186,142~~$ 2,079,945
02.	Injury and Violence Prevention (Services to Rape Victims – Set-Aside)	169,730	~~169,730~~173,476
DHHS Program Expenditures			
Division of Public Health			
03.	HIV/STD Prevention and Community Planning	145,819	145,819
04.	Oral Health Preventive Services	46,302	46,302
05.	Laboratory Services – Testing, Training, and Consultation	10,980	~~10,980~~21,012
06.	Injury and Violence Prevention (Services to Rape Victims – Set-Aside)	199,634	199,634
07.	Heart Disease and Stroke Prevention	162,249	~~162,249~~187,693
08.	Performance Improvement and Accountability	213,971	~~213,971~~855,075
09.	Physical Activity and Nutrition	38,000	~~38,000~~68,073
10.	State Center for Health Statistics	61,406	~~61,406~~144,749
TOTAL PREVENTIVE HEALTH SERVICES BLOCK GRANT		**$ 2,234,233**	**~~$ 2,234,233~~$ 3,921,778**
COMMUNITY SERVICES BLOCK GRANT			
Local Program Expenditures			
Office of Economic Opportunity			
01.	Community Action Agencies	$ 22,402,724	~~$ 22,402,724~~$ 24,168,417
02.	Limited Purpose Agencies	1,244,596	~~1,244,596~~1,342,690

DHHS Administration

03.	Office of Economic Opportunity	1,244,596	~~1,244,596~~1,342,690
TOTAL COMMUNITY SERVICES BLOCK GRANT		**$ 24,891,916**	**~~$ 24,891,916~~$ 26,853,797**

"GENERAL PROVISIONS

"SECTION 12J.1.(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 12J.1.(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 develop a plan to adjust the block grants based on reduced federal funding.

Notwithstanding the provisions of this subsection, for fiscal years 2013-2014 and 2014-2015, increases in the federal fund availability for the Temporary Assistance to Needy Families (TANF) Block Grant shall be used only for the North Carolina Child Care Subsidy program to pay for child care in four- or five-star rated facilities for four-year-old ~~children.~~children and shall not be used to supplant State funds.

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 Oversight Committee on Health and Human Services, the Joint Legislative Commission on Governmental Operations, and the Fiscal Research Division.

"SECTION 12J.1.(d) Except as otherwise provided, appropriations from federal Block Grant funds are made for each year of the fiscal biennium ending June 30, 2015, according to the schedule enacted for State fiscal years 2013-2014 and 2014-2015 or until a new schedule is enacted by the General Assembly.

"SECTION 12J.1.(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 Joint Legislative Oversight 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.

"SECTION 12J.1.(e1) Except as otherwise provided, the Department of Health and Human Services shall have flexibility to transfer funding between the Temporary Assistance to Needy Families (TANF) Block Grant and the TANF Emergency Contingency Funds Block Grant so long as the total allocation for the line items within those block grants remains the same.

"TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) FUNDS

"SECTION 12J.1.(f) The sum of eighty-two million four hundred eighty-five thousand four hundred ninety-five dollars ($82,485,495) appropriated in this section in TANF funds to the Department of Health and Human Services, Division of Social Services, for each year of the 2013-2015 fiscal biennium shall be used for Work First County Block Grants. The Division shall certify these funds in the appropriate State-level services based on prior year actual expenditures. The Division has the authority to realign the authorized budget for these funds among the State-level services based on current year actual expenditures.

"SECTION 12J.1.(g) The sum of two million four hundred eighty-two thousand two hundred sixty dollars ($2,482,260) appropriated in this section in TANF funds to the Department of Health and Human Services, Division of Social Services, for each year of the 2013-2015 fiscal biennium shall be used to support administration of TANF-funded programs.

"SECTION 12J.1.(h) The sum of nine million four hundred twelve thousand three hundred ninety-one dollars ($9,412,391) appropriated in this section to the Department of Health and Human Services, Division of Social Services, in TANF funds for each year of the 2013-2015 fiscal biennium 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 post-adoption services for eligible families.

Counties shall maintain their level of expenditures in local funds for Child Protective Services workers. Of the Block Grant funds appropriated for Child Protective Services workers, the total expenditures from State and local funds for fiscal years 2013-2014 and 2014-2015 shall not be less than the total expended from State and local funds for the 2012-2013 fiscal year.

"SECTION 12J.1.(i) The sum of two million twenty-six thousand eight hundred seventy-seven dollars ($2,026,877) appropriated in this section in TANF funds to the Department of Health and Human Services, Special Children Adoption Fund, for each year of the 2013-2015 fiscal biennium shall be used in accordance with G.S. 108A-50.2. 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 12J.1.(j) The sum of six hundred thirty-two thousand four hundred sixteen dollars ($632,416) appropriated in this section to the Department of Health and Human Services in TANF funds for each year of the 2013-2015 fiscal biennium shall be used to continue support for the Child Welfare Collaborative.

"SOCIAL SERVICES BLOCK GRANT

"**SECTION 12J.1.(k)** The sum of twenty-nine million four hundred twenty-two thousand one hundred thirty-seven dollars ($29,422,137) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, for ~~each year of the 2013-2015 fiscal biennium~~the 2013-2014 fiscal year and the sum of twenty-seven million four hundred twenty-seven thousand fifteen dollars ($27,427,015) appropriated in this section in the Social Services Block Grant for the 2014-2015 fiscal year shall be used for county block grants. The Division shall certify these funds in the appropriate State-level services based on prior year actual expenditures. The Division has the authority to realign the authorized budget for these funds among the State-level services based on current year actual expenditures.

"**SECTION 12J.1.(l)** 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 each year of the 2013-2015 fiscal biennium 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 12J.1.(m)** 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 12J.1.(n)** Social Services Block Grant funds appropriated for the Special Childrens Adoption Incentive Fund will require a fifty percent (50%) local match.

"**SECTION 12J.1.(o)** The sum of five million forty thousand dollars ($5,040,000) appropriated in this section in the Social Services Block Grant for each year of the 2013-2015 fiscal biennium 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 Social Services Block Grant 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 12J.1.(p)** The sum of three million eight hundred fifty-two thousand five hundred dollars ($3,852,500) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Central Management and Support, shall be used for DHHS competitive block grants pursuant to Section 12A.2 of this act for each year of the 2013-2015 fiscal biennium. These funds are exempt from the provisions of 10A NCAC 71R .0201(3).

"**SECTION 12J.1.(q)** The sum of three hundred seventy-five thousand dollars ($375,000) appropriated in this section in the Social Services Block Grant for each year of the 2013-2015 fiscal biennium to the Department of Health and Human Services, Division of Social Services, shall be used to continue support for the Child Advocacy Centers and are exempt from the provisions of 10A NCAC 71R .0201(3).

"**SECTION 12J.1.(r)** The sum of three million nine hundred seventy-eight thousand three hundred sixty dollars ($3,978,360) appropriated in this section in the Social Services Block Grant for each year of the 2013-2015 fiscal biennium to the Department of Health and Human Services, Divisions of Social Services and Aging and Adult Services, shall be used for guardianship services pursuant to Chapter 35A of the General Statutes. The Department may expend funds appropriated in this section to support (i) existing corporate guardianship contracts during the 2013-2014 and 2014-2015 fiscal years and (ii) guardianship contracts transferred to the State from local

management entities or managed care organizations during the 2013-2014 and 2014-2015 fiscal years.

"LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT

"SECTION 12J.1.(s) 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 12J.1.(t) The sum of fifty million eight hundred seventy-six thousand four hundred forty dollars ($50,876,440) appropriated in this section in the Low-Income Home Energy Assistance Block Grant for each year of the 2013-2015 fiscal biennium 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 through the Division of Aging and Adult Services.

County departments of social services shall submit to the Division of Social Services an outreach plan for targeting households with 60-year-old household members no later than August 1 of each year. The outreach plan shall comply with the following:

(1) Ensure that eligible households are made aware of the available assistance with particular attention paid to the elderly population age 60 and above and disabled persons receiving services through the Division of Aging and Adult Services.

(2) Include efforts by the county department of social services to contact other State and local governmental entities and community-based organizations to (i) offer the opportunity to provide outreach and (ii) receive applications for energy assistance.

(3) Be approved by the local board of social services or human services board prior to submission.

"CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT

"SECTION 12J.1.(u) 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 12J.1.(v) 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 12J.1.(v1) 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 2014-2015 fiscal year shall be allocated to the Department of Administration, Division of Veterans Affairs, to establish a call-in center to assist veterans in locating service benefits and crisis services. The call-in center shall be staffed by certified veteran peers within the Division of Veterans Affairs and trained by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

"MATERNAL AND CHILD HEALTH BLOCK GRANT

"**SECTION 12J.1.(w)** 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 2013-2014 fiscal year or the 2014-2015 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 12J.1.(x)** The Department of Health and Human Services shall ensure that there will be follow-up testing in the Newborn Screening Program."

Follows $

House Version

REVISE DHHS BLOCK GRANTS

SECTION 12J.1. Section 12J.1 of S.L. 2013-360 reads as rewritten:

"**DHHS BLOCK GRANTS**

"**SECTION 12J.1.(a)** Except as otherwise provided, appropriations from federal block grant funds are made for each year of the fiscal biennium ending June 30, 2015, according to the following schedule:

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) FUNDS	**FY2013-2014**	**FY2014-2015**
Local Program Expenditures		
Division of Social Services		
01. Work First Family Assistance	$ 60,285,413	$ 60,285,413
02. Work First County Block Grants	82,485,495	82,485,495
03. Work First Electing Counties	2,352,521	2,352,521
04. Adoption Services – Special Children Adoption Fund	2,026,877	2,026,877
05. Child Protective Services – Child Welfare Workers for Local DSS	9,412,391	9,412,391
06. Child Welfare Collaborative	632,416	632,416
06A. Foster Care Services		1,385,152
Division of Child Development and Early Education		
07. Subsidized Child Care Program	57,172,097~~55,409,695~~	54,054,806
08. Swap Child Care Subsidy	6,352,644	6,352,644
08A. Pre-K Swap Out		7,195,807
Division of Public Health		
09. Teen Pregnancy Initiatives	2,500,000	2,500,000
DHHS Administration		
10. Division of Social Services	2,482,260	2,482,260
11. Office of the Secretary	34,042	34,042
Transfers to Other Block Grants		

Division of Child Development and Early Education			
12. Transfer to the Child Care and Development Fund	71,773,001	71,773,001	
13. Transfer to Social Services Block Grant for Child Protective Services – Child Welfare Training in Counties	1,300,000	1,300,000	
14. Transfer to Social Services Block Grant for Child Protective Services	5,040,000	5,040,000	
15. Transfer to Social Services Block Grant for County Departments of Social Services for Children's Services	4,148,001	4,148,001	
TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) FUNDS	**$307,997,158**	~~$306,234,756~~$313,460,826	
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS			
Local Program Expenditures			
Division of Social Services			
01. Work First County Block Grants	$ 5,580,925	$ 5,580,925	
02. Work First Electing Counties	25,692	25,692	
Division of Child Development and Early Education			
03. Subsidized Child Care	6,549,469	~~6,549,469~~11,679,394	
04. Pre-K Slots		4,000,000	
05. Pre-K Swap Out		8,646,527	
TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS	**$12,156,086**	~~$ 12,156,086~~$ 29,932,538	
SOCIAL SERVICES BLOCK GRANT			
Local Program Expenditures			
Divisions of Social Services and Aging and Adult Services			
01. County Departments of Social Services (Transfer from TANF $4,148,001)	$ 29,422,137	~~$ 29,422,137~~$ 27,427,015	

02.	Child Protective Services (Transfer from TANF)	5,040,000	5,040,000
03.	State In-Home Services Fund	1,943,950	1,943,950
04.	Adult Protective Services	1,245,363	1,245,363
05.	State Adult Day Care Fund	1,994,084	1,994,084
06.	Child Protective Services/CPS Investigative Services – Child Medical Evaluation Program	563,868	563,868
07.	Special Children Adoption Incentive Fund	462,600	462,600
08.	Child Protective Services – Child Welfare Training for Counties (Transfer from TANF)	1,300,000	1,300,000
09.	Home and Community Care Block Grant (HCCBG)	1,696,888	1,696,888
10.	Child Advocacy Centers	375,000	375,000
11.	Guardianship	3,978,360	3,978,360
12.	UNC Cares Contract	229,376	~~229,376~~57,344
~~13.~~	~~Foster Care Services~~	~~1,385,152~~	~~1,385,152~~
	Division of Central Management and Support		
14.	DHHS Competitive Block Grants for Nonprofits	3,852,500	3,852,500
	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services		
15.	Mental Health Services – Adult and Child/Developmental Disabilities Program/ Substance Abuse Services – Adult	4,030,730	4,030,730
	DHHS Program Expenditures		
	Division of Services for the Blind		
16.	Independent Living Program	3,361,323	3,361,323
	Division of Health Service Regulation		
17.	Adult Care Licensure Program	381,087	381,087

18.	Mental Health Licensure and Certification Program	190,284	190,284
DHHS Administration			
19.	Division of Aging and Adult Services	577,745	577,745
20.	Division of Social Services	559,109	559,109
21.	Office of the Secretary/Controller's Office	127,731	127,731
22.	Division of Child Development	13,878	13,878
23.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	27,446	27,446
24.	Division of Health Service Regulation	118,946	118,946
TOTAL SOCIAL SERVICES BLOCK GRANT		**$ 62,877,557**	~~**$ 62,877,557**~~**$ 59,325,251**
LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT			
Local Program Expenditures			
Division of Social Services			
01.	Low-Income Energy Assistance Program (LIEAP)	$ 50,876,440	$ 50,876,440
02.	Crisis Intervention Program (CIP)	33,866,195	33,866,195
Local Administration			
Division of Social Services			
03.	County DSS Administration	6,757,731	6,757,731
DHHS Administration			
04.	Office of the Secretary/DIRM	412,488	412,488
05.	Office of the Secretary/Controller's Office	18,378	18,378
Transfers to Other State Agencies			
Department of Environment and Natural Resources (DENR)			
06.	Weatherization Program	14,947,789~~14,947,789~~12,473,090	

07.	Heating Air Repair and Replacement Program (HARRP)	7,193,873	~~7,193,873~~6,636,633
08.	Local Residential Energy Efficiency Service Providers – Weatherization	37,257	~~37,257~~692,950
09.	Local Residential Energy Efficiency Service Providers – HARRP	338,352	~~338,352~~312,227
10.	DENR Administration – Weatherization	37,257	~~37,257~~692,950
11.	DENR Administration – HARRP	338,352	~~338,352~~312,226
	Department of Administration		
12.	N.C. Commission on Indian Affairs	87,736	87,736
TOTAL LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT		**$ 114,911,848**	**~~$114,911,848~~$113,139,044**

CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT

Local Program Expenditures

Division of Child Development and Early Education

01.	Child Care Services (Smart Start $7,000,000)	$ 156,566,345	~~$158,328,747~~$168,536,136
02.	Electronic Tracking System	3,000,000	3,000,000
03.	Transfer from TANF Block Grant for Child Care Subsidies	71,773,001	71,773,001
04.	Quality and Availability Initiatives (TEACH Program $3,800,000)	24,262,402	~~22,500,000~~24,168,551

DHHS Administration

Division of Child Development and Early Education

05.	DCDEE Administrative Expenses	6,000,000	~~6,000,000~~7,677,977

Division of Social Services

06.	Local Subsidized Child Care Services Support	13,274,413	13,274,413

Division of Central Administration

07. DHHS Central Administration – DIRM

		Technical Services	775,000	775,000
	08.	Central Regional Maintenance		202,000
TOTAL CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT			**$ 275,651,161**	~~$275,651,161~~**$289,407,078**
MENTAL HEALTH SERVICES BLOCK GRANT				
Local Program Expenditures				
	01.	Mental Health Services – Adult	$ 10,717,607	~~$ 10,717,607~~
	02.	Mental Health Services – Child	5,121,991	~~5,121,991~~
	03.	Administration	200,000	200,000
	04.	Mental Health Services – Adult/Child		12,398,643
	04A.	Crisis Solutions Initiative – Walk-In Crisis Centers		2,253,833
	05.	Crisis Solutions Initiative – Critical Time Intervention		750,000
	06.	Crisis Solutions Initiative – Peer Support Respite Centers Pilot		700,000
	07.	Crisis Solutions Initiative – Community Paramedic Mobile Crisis Management		60,000
	08.	Crisis Solutions Initiative – Mental Health First Aid		500,000
	09.	Crisis Solutions Initiative – Group Homes Skills Training		65,000
	10.	Crisis Solutions Initiative – Innovative Technologies		41,000
TOTAL MENTAL HEALTH SERVICES BLOCK GRANT			**$ 16,039,598**	~~$ 16,039,598~~**$ 16,968,476**
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~~	~~$ 14,960,371~~	~~$ 14,960,371~~

~~02.~~	~~Substance Abuse Treatment Alternative for Women~~	~~6,050,300~~	~~6,050,300~~
03.	Substance Abuse – HIV and IV Drug	3,919,723	3,919,723
~~04.~~	~~Substance Abuse Prevention – Child~~	~~7,186,857~~	~~7,186,857~~
04A.	Substance Abuse Prevention		8,669,284
~~05.~~	~~Substance Abuse Services – Child~~	~~4,190,500~~	~~4,190,500~~
05A.	Substance Abuse Services – Treatment for Children/Adults		29,519,883
05B.	Crisis Solutions Initiatives – Walk-In Crisis Centers		420,000
05C.	Crisis Solutions Initiatives – Collegiate Wellness/Addiction Recovery		1,085,000
05D.	Crisis Solutions Initiatives – Community Paramedic Mobile Crisis Management		60,000
05E.	Crisis Solutions Initiatives – Innovative Technologies		41,000
05F.	Crisis Solutions Initiatives – Veterans Crisis		250,000
06.	Administration	454,000	454,000
	Division of Public Health		
~~07.~~	~~Risk Reduction Projects~~	~~575,654~~	~~575,654~~
~~08.~~	~~Aid to Counties~~	~~190,295~~	~~190,295~~
08A.	HIV Testing for Individuals in Substance Abuse Treatment		765,949
TOTAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT		**$ 37,527,700**	**~~$ 37,527,700~~$ 45,184,839**
MATERNAL AND CHILD HEALTH BLOCK GRANT			
Local Program Expenditures			
Division of Public Health			
01.	Children's Health Services (Safe Sleep Campaign ~~$45,000~~ $45,000; Prevent Blindness $560,837)	$ 8,042,531	~~$ 8,042,531~~$ 7,574,703

02.	Women's Health (March of Dimes $350,000; Teen Pregnancy Prevention Initiatives $650,000; Perinatal Quality Collaborative $350,000; 17P Project $52,000; Carolina Pregnancy Care Fellowship ~~$250,000;~~$300,000; Nurse-Family Partnership $509,018)	8,532,935	~~8,532,935~~8,095,148	
03.	Oral Health	44,901	44,901	
DHHS Program Expenditures				
	Division of Public Health			
04.	Children's Health Services	1,301,504	~~1,301,504~~1,300,578	
05.	Women's Health – Maternal Health	105,419	~~105,419~~105,361	
06.	State Center for Health Statistics	164,487	~~164,487~~156,230	
07.	Health Promotion – Injury and Violence Prevention	89,374	~~89,374~~84,919	
DHHS Administration				
	Division of Public Health			
08.	Division of Public Health Administration	573,108	~~573,108~~552,571	
TOTAL MATERNAL AND CHILD HEALTH BLOCK GRANT		**$ 18,854,259**	**~~$ 18,854,259~~$ 17,914,411**	
PREVENTIVE HEALTH SERVICES BLOCK GRANT				
Local Program Expenditures				
01.	Physical Activity and Prevention	$ 1,186,142	~~$ 1,186,142~~$ 2,079,945	
02.	Injury and Violence Prevention (Services to Rape Victims – Set-Aside)	169,730	~~169,730~~173,476	
DHHS Program Expenditures				
	Division of Public Health			
03.	HIV/STD Prevention and Community Planning	145,819	145,819	
04.	Oral Health Preventive Services	46,302	46,302	

05.	Laboratory Services – Testing, Training, and Consultation	10,980	~~10,980~~21,012
06.	Injury and Violence Prevention (Services to Rape Victims – Set-Aside)	199,634	199,634
06A.	State Laboratory Services – Testing, Training, and Consultation		199,634
07.	Heart Disease and Stroke Prevention	162,249	~~162,249~~187,693
08.	Performance Improvement and Accountability	213,971	~~213,971~~738,784
09.	Physical Activity and Nutrition	38,000	~~38,000~~68,073
10.	State Center for Health Statistics	61,406	61,406
TOTAL PREVENTIVE HEALTH SERVICES BLOCK GRANT		**$ 2,234,233**	~~$ 2,234,233~~**$ 3,921,778**
COMMUNITY SERVICES BLOCK GRANT			
Local Program Expenditures			
Office of Economic Opportunity			
01.	Community Action Agencies	$ 22,402,724	~~$ 22,402,724~~$ 24,168,417
02.	Limited Purpose Agencies	1,244,596	~~1,244,596~~1,342,690
DHHS Administration			
03.	Office of Economic Opportunity	1,244,596	~~1,244,596~~1,342,690
TOTAL COMMUNITY SERVICES BLOCK GRANT		**$ 24,891,916**	~~$ 24,891,916~~**$ 26,853,797**

"GENERAL PROVISIONS

"SECTION 12J.1.(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 12J.1.(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 develop a plan to adjust the block grants based on reduced federal funding.

Notwithstanding the provisions of this subsection, for fiscal years 2013-2014 and 2014-2015, increases in the federal fund availability for the Temporary Assistance to Needy Families (TANF) Block Grant shall be used only for the North Carolina Child Care Subsidy program to pay for child care in four- or five-star rated facilities for four-year-old ~~children.~~children and shall not be used to supplant State funds.

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 Oversight Committee on Health and Human Services, the Joint Legislative Commission on Governmental Operations, and the Fiscal Research Division.

"**SECTION 12J.1.(d)** Except as otherwise provided, appropriations from federal Block Grant funds are made for each year of the fiscal biennium ending June 30, 2015, according to the schedule enacted for State fiscal years 2013-2014 and 2014-2015 or until a new schedule is enacted by the General Assembly.

"**SECTION 12J.1.(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 Joint Legislative Oversight 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.

"**SECTION 12J.1.(e1)** Except as otherwise provided, the Department of Health and Human Services shall have flexibility to transfer funding between the Temporary Assistance to Needy Families (TANF) Block Grant and the TANF Emergency Contingency Funds Block Grant so long as the total allocation for the line items within those block grants remains the same.

"TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) FUNDS

"**SECTION 12J.1.(f)** The sum of eighty-two million four hundred eighty-five thousand four hundred ninety-five dollars ($82,485,495) appropriated in this section in TANF funds to the Department of Health and Human Services, Division of Social Services, for each year of the 2013-2015 fiscal biennium shall be used for Work First County Block Grants. The Division shall certify these funds in the appropriate State-level services based on prior year actual expenditures. The Division has the authority to realign the authorized budget for these funds among the State-level services based on current year actual expenditures.

"**SECTION 12J.1.(g)** The sum of two million four hundred eighty-two thousand two hundred sixty dollars ($2,482,260) appropriated in this section in TANF funds to the Department of Health and Human Services, Division of Social Services, for each year of the 2013-2015 fiscal biennium shall be used to support administration of TANF-funded programs.

"**SECTION 12J.1.(h)** The sum of nine million four hundred twelve thousand three hundred ninety-one dollars ($9,412,391) appropriated in this section to the Department of Health and Human Services, Division of Social Services, in TANF funds for each year of the 2013-2015 fiscal biennium 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 post-adoption services for eligible families.

Counties shall maintain their level of expenditures in local funds for Child Protective Services workers. Of the Block Grant funds appropriated for Child Protective Services workers, the total expenditures from State and local funds for fiscal years 2013-2014 and 2014-2015 shall not be less than the total expended from State and local funds for the 2012-2013 fiscal year.

"**SECTION 12J.1.(i)** The sum of two million twenty-six thousand eight hundred seventy-seven dollars ($2,026,877) appropriated in this section in TANF funds to the Department of Health and Human Services, Special Children Adoption Fund, for each year of the 2013-2015 fiscal biennium shall be used in accordance with G.S. 108A-50.2. 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 12J.1.(j)** The sum of six hundred thirty-two thousand four hundred sixteen dollars ($632,416) appropriated in this section to the Department of Health and Human Services in TANF funds for each year of the 2013-2015 fiscal biennium shall be used to continue support for the Child Welfare Collaborative.

"**SOCIAL SERVICES BLOCK GRANT**

"**SECTION 12J.1.(k)** The sum of twenty-nine million four hundred twenty-two thousand one hundred thirty-seven dollars ($29,422,137) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, for ~~each year of the 2013-2015 fiscal biennium~~the 2013-2014 fiscal year and the sum of twenty-seven million four hundred twenty-seven thousand fifteen dollars ($27,427,015) appropriated in this section in the Social Services Block Grant for the 2014-2015 fiscal year shall be used for county block grants. The Division shall certify these funds in the appropriate State-level services based on prior year actual expenditures. The Division has the authority to realign the authorized budget for these funds among the State-level services based on current year actual expenditures.

"**SECTION 12J.1.(l)** 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 each year of the 2013-2015 fiscal biennium 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 12J.1.(m)** 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 12J.1.(n)** Social Services Block Grant funds appropriated for the Special Childrens Adoption Incentive Fund will require a fifty percent (50%) local match.

"**SECTION 12J.1.(o)** The sum of five million forty thousand dollars ($5,040,000) appropriated in this section in the Social Services Block Grant for each year of the 2013-2015 fiscal biennium 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 Social Services Block Grant 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 12J.1.(p)** The sum of three million eight hundred fifty-two thousand five hundred dollars ($3,852,500) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Central Management and Support, shall be used for DHHS competitive block grants pursuant to Section 12A.2 of this act for each year of the 2013-2015 fiscal biennium. These funds are exempt from the provisions of 10A NCAC 71R .0201(3).

"**SECTION 12J.1.(q)** The sum of three hundred seventy-five thousand dollars ($375,000) appropriated in this section in the Social Services Block Grant for each year of the 2013-2015 fiscal biennium to the Department of Health and Human Services, Division of Social Services, shall be used to continue support for the Child Advocacy Centers and are exempt from the provisions of 10A NCAC 71R .0201(3).

"**SECTION 12J.1.(r)** The sum of three million nine hundred seventy-eight thousand three hundred sixty dollars ($3,978,360) appropriated in this section in the Social Services Block Grant for each year of the 2013-2015 fiscal biennium to the Department of Health and Human Services, Divisions of Social Services and Aging and Adult Services, shall be used for guardianship services pursuant to Chapter 35A of the General Statutes. The Department may expend funds appropriated in this section to support (i) existing corporate guardianship contracts during the 2013-2014 and 2014-2015 fiscal years and (ii) guardianship contracts transferred to the State from local management entities or managed care organizations during the 2013-2014 and 2014-2015 fiscal years.

"**LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT**

"**SECTION 12J.1.(s)** 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 12J.1.(t)** The sum of fifty million eight hundred seventy-six thousand four hundred forty dollars ($50,876,440) appropriated in this section in the Low-Income Home Energy Assistance Block Grant for each year of the 2013-2015 fiscal biennium 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 through the Division of Aging and Adult Services.

County departments of social services shall submit to the Division of Social Services an outreach plan for targeting households with 60-year-old household members no later than August 1 of each year. The outreach plan shall comply with the following:

(1) Ensure that eligible households are made aware of the available assistance with particular attention paid to the elderly population age 60 and above and disabled persons receiving services through the Division of Aging and Adult Services.

(2) Include efforts by the county department of social services to contact other State and local governmental entities and community-based organizations to (i) offer the opportunity to provide outreach and (ii) receive applications for energy assistance.

(3) Be approved by the local board of social services or human services board prior to submission.

"CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT

"SECTION 12J.1.(u) 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 12J.1.(v) 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 12J.1.(v1) 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 2014-2015 fiscal year shall be allocated to the Department of Administration, Division of Veterans Affairs, to establish a call-in center to assist veterans in locating service benefits and crisis services. The call-in center shall be staffed by certified veteran peers within the Division of Veterans Affairs and trained by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

"MATERNAL AND CHILD HEALTH BLOCK GRANT

"SECTION 12J.1.(w) 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 2013-2014 fiscal year or the 2014-2015 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 12J.1.(x) The Department of Health and Human Services shall ensure that there will be follow-up testing in the Newborn Screening Program."

SENATE SERGEANT-AT-ARMS

COMMITTEE: Senate Appropriations on Health and Human Services

DATE: 06-17-2014 ROOM: 643

1. STEVE WILSON
2. DONNA BLAKE
3. ANDERSON MEADOWS
4. _____
5. _____
6. _____

THE FOLLOWING IMAGE(S)

IS NOT A DOUBLE FEED

BUT AN ADDITIONAL

DOCUMENT PASTED/

TAPED OVER THE

ORIGINAL DOCUMENT

PAGES ATTENDING

Date: 6-17 **8:30 am**

Committee: Approps - Health & Human Serv. **Room:** 643 LOB

PLEASE PRINT LEGIBILY!!!!!

Page Name	Hometown	Sponsoring Senator
6. Quinton Beale	Raleigh	Blue
7. Rachel Figard	Davidson	Tarte
8. Jackson Carr	Dunn	B. Jackson
9. Justin Perkins	Apex	Barringer
10. Trey Jones	Tabor City	Walters

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Pages: Please present this form to either the Committee Clerk at the meeting or a Sgt. at Arms.

8:30 a.m.

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
David Haven	NC Center for Nonprofits
NICHOLE KARIM	NAMI NC
Kay Castillo	NASW NC
Matt Gray	NCPC
Michelle Brooks	East Carolina University
Donna Beard	citizen
Paul Fleck	National MS Society
JOE LANIER	NELSON MULLINS
Allison Waller	Nelson Mullins
Ken Melton	KMA
Chris Kelly	Nelson Mullins
Ron Shelton	DHHS
Kerr Baltz	WTM
Sam Clark	NCHCA
Julia Adams	Aca NC, MARC, NCAFF, ASAC

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Mary Beth Poplin, RN, MHA	Caromont Regional Medical Center
Sharon Summer, RN, MSN	Caromont Regional Medical Center
Allen Marsh	" "
Peggy Blackburn, RN, MSN	Caromont Regional Medical Center
Doug Luckett	CaroMont Health - Gastonia, NC
Madeline Reeter	CaroMont Health - Gastonia
Laura Gaither, RN MSN	Cape Fear Valley Health System
Georgianna Jardine	Cape Fear Valley Health
Tricia Urquhart-Jones	Cape Fear Valley Health System
Michael Smith	Carolina East Health System
Mitchell Fisher	Cape Fear Valley Medical Center
David Boone	Catawba Valley Med. Center
Michael Dickson	Caromont Regional Medical
Char Bianorte, Dir Psych	Caromont Regional Med. CTR
Alex Mullinaux	Caromont Regional
Sandy Porter	Catawba Valley Medical Ctr.
Eric McDonough	Cape Fear Valley Health

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
John L. Dickerhoff	Cape Fear Valley Health System
Jim Bailey	CAROMONT GASTONIA, NC
Richard BRVENIK	Carteret General Hospital Morehead City
VERNON Small	Carteret General Morehead city
John W. Davis	Carteret General Hospital Morehead City
PAIGE WORSHAM	NC Center for Public Policy Research
Diane McNeill	Cape Fear Valley Health System
Scott THOMAS	Granville Health System

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Joe White	OSBM
Elizabeth Hudgins	CFTF
Chris McClure	[illegible]
Rebecca Troutman	NCACC
Canaan Huie	MVA
Padraig Gibbons	Capitol
Bill Rustin	AKP
J Peters	CSS
[illegible]	Lilly / PhRMA
John DelGiorno	Brubaker + Assoc.
[illegible]	R. [illegible]
Mary Jane Beeson	United Healthcare
Joanne Stevens	NC Nurses Assoc. (NCNA)
[illegible]	MF [illegible]
Mac Boxley	NCFLA Society
Hayes Griggs	CCNC
[illegible]	[illegible]

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Joanna Spruill	NCAFP
[illegible]	[illegible]
[illegible]	NCMS
Amanda Honaker	TSS
[illegible]	NP
Jennifer Gasperini	NCMS
Connor Randolph	NCMS
Madeline Rieker	Smith Anderson
Kara Weishaar	Smith Anderson
Alan Briggs	NC Food Banks
Tommy Suter	Novartis
Mike McBriety	Biogen Idec
Chuck Stone	SEANC
Tom Vitaglione	NC CHILD
Colleen Kocharek	KCG
Jim Johnson	BSA
Mike James	ACP

09-21-201

VISITOR REGISTRATION SHEET

Senate Committee on Appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Mike Quinn	NC Sch BRCO
[illegible]	[illegible]
Maeve Gordon	GSK
[illegible]	Forum Comm
Ken Wood	Sentara Albemarle
[illegible]	Sentara Albemarle
Andrew Stephenson	Sentara Albemarle
Christine Craig	WakeMed
Angli Curtis	WakeMed
Katie McKittrick	Duke Med
Julie Harris	NC Hospital Assoc
[illegible]	Jacksonville - Onslow Memorial Hospital
Mary Trombley	Cape Fear Valley Hosp. Fayetteville
BILL PAUGH	WAYNE MEM HOSPITAL GOLDSBORO
Shirley Harkey	Wayne Mem Hospital Goldsboro NC
Tom Bradshaw	Wayne Memorial Hosp., Goldsboro
Daniel VanLiere	Vidant Health

09-21-201

Greg Williams	Vidant Health (Vidant Bertie Hosp)
Barbara Venters	Vidant Health (Vidant Chowan Hosp)
Megan Booth-Mills	Vidant Health (Vidant Bertie Hosp & Vidant Chowan Hosp)
Kelly Wise	CAPE FEAR VALLEY HEALTH
[illegible]	Carolinas Medical Center - University
[illegible]	Carolinas Medical Ctr - MERCY
[illegible]	Cardinal medical center
Janet Conway	Cape Fear Valley Health System
Michael Magowski	Cape Fear Valley Health System
Breeden Blackwell	[illegible]
Bryn Tamary	Wake Forest Baptist Health - Lexington
Thomasine Kennedy	Vidant Health & Vid. Duplin
[illegible]	VIDANT HEALTH
Jay Briley	VIDANT DUPLIN HOSPITAL
Jody Thomas	Novant Health Franklin Medical Ctr.
Joseph LaBella	Novant Health FMC
Sean Sanz	NOVANT HEALTH, FMC, WINSTON-SALEM

1:30 pm

VISITOR REGISTRATION SHEET

Senate Committee on appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCRMA
Susanna Davis	UNC
[illegible]	CSS
Julia Adams	Arc NC, MARC, NCARF, ASNC
John Mettyz	[illegible]
Christian McDonald	Intern Stevens Lobby
Joanne Stevens	N.C.N.A
Marjorie Donaldson	DHHS
[illegible]	DHHS
Jim Slate	DHHS
Christine Weason	ACS CAN
Skye David	NCCADV
Alan Miller	KLG
Heather Barnett	W&S
[illegible]	ACP
[illegible]	✓
[illegible]	MVA

6-17-14

VISITOR REGISTRATION SHEET

Senate Committee on appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Jon Carr	Jordan Price
Hayes Griggs	CCNC
DEL MAYNARD	APM Gibbon
Joanna Spruill	NCAFP
Jim Dohnson	BSA
Kathryn Robinson	NCPeMA
Amanda Horaker	TSS
TJ Bugbee	NP
Allison Waller	Nelson Mullins
Katie McAuliffe	Duke Med
BJ Miller	Cone Health
Christine Cray	WakeMed
Madeline Ricker	Smith Anderson
Kara Weishaar	SA

6-17-14

VISITOR REGISTRATION SHEET

Senate Committee on appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Annaliese Dolph	Dolph Law
Evelyn Hawthorne	EHER
PAIGE WORSHAM	NC Center for Public Policy Research
John Metcalf	Policy Group
Chris McClure	Brooks Pierce
Jon Wiles	NCPATCH
Becki Gray	gzf
Rowena Pimm	Mission Health
J PETERS	CSS
Sarah Wolfe	MWC
Sarah Preston	ACLU-NC
David Kroll	NC Health News
Aaron Mullis	NC DHHS
Paul Fleck	National MS Society
William Stirling	Brooker and Associates
David Heinen	NC Center for Nonprofits
Alan Briggs	NC Food Banks

6-17-14

VISITOR REGISTRATION SHEET

Senate Committee on appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Joyce Peters	CSS
Mardy Peal	DHHS
RS Brooks	NCPTA
ALBERT EBY	NCPTA
Carol Hunt Lynch	NCPTA
Matt Gray	NCVC

6-17-14

VISITOR REGISTRATION SHEET

Senate Committee on appropriations on Health and Human Services

June 17, 2014

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Andy Chase	KMA
Doug Misken	PSG
Sam Clark	NCHCFA
Catheryn Rossberg	Amerigroup
Padraig Gibbons	Capitol
Shawn Shutt	EYS

6-17-14

2013

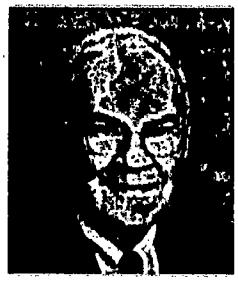
SENATE APPROPRIATIONS – HEALTH & HUMAN SERVICES (JOINT)

MINUTES

NORTH CAROLINA GENERAL ASSEMBLY

Appropriations on Health and Human Services
2013 – 2014 SESSION

Senator Ralph Hise
Co-Chair



Senator Louis Pate
Co-Chair

Senator Austin Allran

Senator Tamara Barringer

Senator Floyd McKissick

Senator Martin Nesbitt

Senator Gladys Robinson

JOINT APPROPRIATIONS SUBCOMMITTEE HEALTH AND HUMAN SERVICES

AGENDA

February 12, 2013
Legislative Office Building - Room 643
8:30 a.m.

Senator Louis Pate, Presiding Chair	
Welcome and Introductions by Chairs	
Members' Comments	
Team Assignment Areas	Denise Thomas, Committee Staff Fiscal Research Division
Appropriations Process	Donnie Charleston, Committee Staff Fiscal Research Division
Appropriations Calendar Subcommittee Guidance	Susan Jacobs, Committee Staff Fiscal Research Division
Department of Health and Human Services Overview	
Adjourn	
Next Meeting:	Wednesday, February13th, 8:30 a.m.

Senate Committee on Appropriations on Health and Human Services
Tuesday, February 12, 1912 at 8:30 a.m.
Room 643

MINUTES

The Senate Committee on Appropriations on Health and Human Services met at 8:30 a.m. on February 12, 2012 in Room 643. Representatives Marilyn Avila, Bill Brisson, Mark Hollo, Donny Lambeth, Susan Martin, Tom Murray, Beverly Earle, Jean Farmer-Butterfield, Carl Ford and Jim Fulghum, members, along with 5 Senators were present.

Senator Louis Pate presided.

Senator Pate recognized the following House Sergeants-at-Arms: Fred Hines and Charles Godwin; for the Senate were Leslie Wright and Steve Wilson. He then recognized Pages for the House: Alec Johnson – Haywood County, Erin Kehoe – Cumberland County, Riaz Lane – Chowan County and Claire Ledford – Yancy County. Jessica White from Mocksville was the Page assisting the Senate.

Senator Pate welcomed everyone and introduced all members and asked if they had comments to make regarding the committee. He then introduced the Research Staff and turned the meeting over to them for a general overview of Health and Human Services. Copies of their comments and overview are attached.

The meeting adjourned at 9:30 a.m.

Louis M Pate Jr

Senator Louis M. Pate, Jr.
Presiding

Edna L Pearce

Edna Pearce, Committee Clerk

Edna Pearce (Sen. Louis Pate)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 07, 2013 10:35 AM
To: Edna Pearce (Sen. Louis Pate)
Cc: Susan Lewis (Rep. Marilyn Avila)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Tuesday, February 12, 2013 at 8:30 AM

Principal Clerk
Reading Clerk

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Tuesday	February 12, 2013	8:30 AM	643 LOB

HHS Overview and Appropriations Process

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

HEALTH AND HUMAN SERVICES TEAM ASSIGNMENTS

Fiscal Research Division – 733-4910
Legislative Drafting – 733-6660
Research – 733-2578

Fiscal Research Division:
Susan Jacobs
Donnie Charleston
Denise Thomas
Sharita Thomas, Research Assistant

Legislative Drafting Division:
Joyce Jones
Ryan Blackledge
Lisa Wilks

Research Division:
Jennifer Hillman

Division of Central Management & Support	Susan Jacobs Donnie Charleston Joyce Jones – Legislative Drafting Lisa Wilks – Legislative Drafting
Division of Medical Assistance Medicaid for Aged and Adults Federal Medicare and Medicaid Issues Disproportionate Share Hospital Payments Community Care of North Carolina Health Choice DMA Administration and Staffing Forecasting for Medicaid and Health Choice	Susan Jacobs Denise Thomas Ryan Blackledge – Legislative Drafting Jennifer Hillman – Research
Division of Mental Health, Developmental Disabilities and Substance Abuse Medicaid 1915(b) (c) Behavioral Health Waiver Mental Health Services Block Grant Substance Abuse Prevention and Treatment Block Grant Local Management Entities Community Service Funds	Denise Thomas Susan Jacobs Joyce Jones – Legislative Drafting Ryan Blackledge – Legislative Drafting Jennifer Hillman - Research
Division of State Operated Facilities State Psychiatric Hospitals Development Centers Neuromedical Centers	Denise Thomas Donnie Charleston Joyce Jones – Legislative Drafting
Division of Health Service Regulation	Donnie Charleston Denise Thomas

Joyce Jones – Legislative Drafting

HEALTH AND HUMAN SERVICES (Continued)

Division of Public Health Chronic Disease & Injury Environmental Health Epidemiology Chief Medical Examiner State Health Lab Women's & Children's Health Preventive Health Services Block Grant Maternal and Child Health Block Grant	Susan Jacobs Denise Thomas Joyce Jones – Legislative Drafting
Division of Social Services State and County Administration Child Welfare and Administration Income Maintenance Programs Temporary Assistance to Needy Families Block Grant Social Services Block Grant Low-Income Energy Block Grant	Donnie Charleston Susan Jacobs Lisa Wilks – Legislative Drafting
Division of Aging and Adult Services	Denise Thomas Susan Jacobs Joyce Jones – Legislative Drafting
Division of Vocational Rehabilitation	Denise Thomas Donnie Charleston Lisa Wilks – Legislative Drafting
Division of Services for the Blind and Deaf and Hard of Hearing	Denise Thomas Donnie Charleston Lisa Wilks – Legislative Drafting
Division of Child Development and Early Education Child Care Subsidy Child Care Licensure Child Care Commission Smart Start Child Care Development Fund Block Grant	Donnie Charleston Susan Jacobs Lisa Wilks - Legislative Drafting

Appropriations Subcommittee Process and Role of Central Staff

Continuation and Expansion Budget

- **Continuation Budget** is the recommended funding to carry on the operations of programs at the level of support previously approved by the General Assembly. *Allowable increases* from previous funding levels include:
  - Inflation for certain operating costs (e.g. food, gas, medical)
  - Annualizing costs of programs funded part year in the previous fiscal year (e.g. programs started January 1 will need full funding in FY 2013-14).
  - Operating funds for newly completed facilities (e.g. operating funds for prison facilities that will open during FY 2013-15).

  Funding for new programs or to expand current programs must be requested in the expansion budget

- **Expansion Budget** includes new programs; expansion of existing programs; or permanently funding programs originally funded as pilots or with one-time funding. Expansion budget review was limited in 2011 and 2012 due to budget deficits.

  Expansion items include members' bills or suggestions; Governor's recommendations; and, expansion requests from agencies. Expansion requests by the Judicial Branch and Council of State agencies are submitted to the Governor and the Governor may recommend changes in their Recommended Budget.

Governor's Budget Documents

- **Governor's Recommended Continuation Budget for Agencies 2013-15.** This document is the agency recommended base operating budget, as completed in December 2012 by most Departments. This budget includes both reductions and increases in the **Continuation Budget**.

- **Governors Recommended Budget Adjustments for 2013-15**. This document summarizes reductions to the Continuation Budget as well as any **Expansion Budget** items.

Budget Review Schedule

Review in Joint Subcommittee normally takes approximately six weeks before the House and Senate split to develop their respective budgets. In 2013, the Senate will develop their budget first. The Joint committee schedule will be partly based on the Senate's projected date for sending a budget to the House.

Budget Targets

Typically, the House and Senate Subcommittees are each given a budget target by their respective Full Appropriations Chairs. The target is usually a total Subcommittee budget amount, not a target for each agency.

Subcommittee Goal

Prepare the Subcommittee Budget as represented through the Subcommittee Report and Special Provisions for presentation to full Appropriations.

Role of Fiscal Staff

- **Budget and Policy Analysis** - Fiscal Staff will review continuation and expansion budgets for each department with State Budget staff and departmental staff prior to Subcommittee review. Analysts will then highlight for Subcommittee discussion the following in each Department: Consider a list of: (1) cost components (staffing, contracts, etc.) of major programs (2) recent reductions or expansion of these programs; (3) major budget changes proposed by the Governor for 2013-15; and, (4) other budgetary or policy options. During this process, analysts will conduct further analysis of budget and policy issues identified by members.

- **Requests** - Fiscal Staff will work with State agencies to handle Subcommittee member requests for information. Staff will also maintain a list of any programs or areas that are "flagged" by member for possible increase or decrease since votes on budget reductions or increases are generally not taken until later in the subcommittee process.

- **Special Provisions** - As budget issues are discussed and decisions are considered, members may suggest special language that directs certain policy actions and/or specifies how budgeted monies are to be used. Bill Drafting staff, in consultation with members and fiscal staff, draft these special provisions.

- **Coordination** - Fiscal staff coordinate daily meetings and agenda with subcommittee chairs; develop and track subcommittee schedules for chairs; and, prepare the Subcommittee budget reports.

- **Fiscal Notes** - Fiscal staff prepare fiscal notes to estimate the effects of a bill on DHHS expenditures or revenues.

Role of Other Staff in the Appropriations Process

- **General Assembly Bill Drafting Staff** – In addition to drafting bills, Staff Attorneys in the Bill Drafting Division assist members with research on legal issues affecting Subcommittee deliberations and assist members in writing special provisions. Joyce Jones, Lisa Wilks, and Ryan Blackledge are the bill drafting attorneys assigned to the HHS subcommittees.

- **General Assembly Research Division Staff** – In general, staff of the Research Division provide assistance with the budget process as needed. Jennifer Hillman is the Research Division attorney assigned to HHS committees and subcommittees to provide research and information on legal issues impacting Medicaid, including Medicaid aspects of mental health.

- **Departmental Staff** – Department staff will answer members' questions during committee meetings and work with General Assembly staff to obtain additional information if needed.

Departments may also make presentations on budget issues and on studies required by the General Assembly.

- **Office of State Budget and Management (OSBM)** - OSBM analysts assist General Assembly members and staff with information on departmental budgets and programs.

3A

February 2013

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2
3	4	5 Fiscal Briefings 643	6 Fiscal Briefings 643	7	8	9
10	11 **Joint Subcommittees Begin Meeting**	12 **Organizational Meeting**	13 **Secretary Wos and DHHS Staff**	14 **State Auditor Presentation**	15	16
17	18 **Joint Subcommittee Meetings**	19 **Non-Profit Reports** House study bills to Bill Drafting deadline	20 **Non-Profit Reports**	21 **Non-Profit Reports**	22	23
24	25 **Joint Subcommittee Meetings**	26	27 House study bills filing deadline	28		

March 2013

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2
3	4 **Joint Subcommittee Meetings/ Potential Joint Meeting with IT**	5 Senate local bills to Bill Drafting deadline	6	7	8	9
10	11 **Joint Subcommittee Meetings**	12 House agency bills to Bill Drafting deadline	13 Senate local bills filing deadline	14	15 Senate public bills to Bill Drafting deadline	16
17 **Governor's Budget?**	18 **Joint Subcommittee Meetings**	19	20 House agency bills filing deadline; House local bills to Bill Drafting deadline	21	22	23
24	25 **Joint Subcommittee Meetings**	26	27	28 Senate public bills filing deadline; House public bills to Bill Drafting	29 **HOLIDAY**	30
31 EASTER						

April 2013

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1 **Joint Subcommittee Meetings** →	2	3 House local bills filing deadline	4 House approps & finance bills to Bill Drafting deadline	5	6
7	8 **Joint Subcommittee Meetings** →	9	10 House public bills filing deadline	11	12	13
14	15 **Senate Budget Process** →	16	17 House approps & finance bills filing deadline	18	19	20
21	22 **Senate Budget Process** →	23	24	25	26	27
28	29 **Senate Budget Process** →	30				

May 2013

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
			1	2	3	4
5	6 **Senate Budget Process**	7 **Senate Approps. Meeting; First Reading**	8 **Senate Second Reading** House approps and finance filing deadline	9 **Senate Third Reading**	10	11
12	13 **House Budget Process**	14	15	16 **CROSSOVER**	17	18
19	20 **House Budget Process**	21	22	23	24	25
26	27 MEMORIAL DAY **House Budget Process**	28 **House Approps Meeting; First Reading**	29 **House Second Reading**	30 **House Third Reading**	31	

June 2013

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
						1
2	3 **Conference Process**	4	5	6	7	8
9	10 **Conference Process**	11	12	13 **Pass Conference Report**	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29/30

2013 House Request/Filing Deadlines

Drafts	To Bill Drafting By 4:00 PM	Filed in House By 3:00 PM
Bills recommended by Study commissions	Tuesday, February 19	Wednesday, February 27
Bills recommended by State Agencies	Tuesday, March 12	Wednesday, March 20
Local Bills	Wednesday, March 20	Wednesday, April 3
Public Bills & Resolutions (**Not** Appropriations or Finance)	Thursday, March 28	Wednesday, April 10
Public Bills (Appropriations and Finance)	Thursday, April 4	Wednesday, April 17

2013 Senate Request/Filing Deadlines

Drafts	To Bill Drafting By 4:00 PM	Filed in Senate By 3:00 PM
Local Bills & Resolutions	Tuesday, March 5	Wednesday, March 13
Public Bills & Resolutions	Friday, March 15	Thursday, March 28

Crossover Deadline: Thursday, May 16

Eligible to file in 2013 but no deadlines:

(1) Redistricting bills for House, Senate, Congress or local entities (H).
(2) Ratification of amendments to the Constitution of the United States (H).
(3) Bills introduced on the report of the House Committees on Appropriations, Finance, or Rules, Calendar, and Operations of the House. (H)
(4) Adjournment resolution (H & S).

02/06/2013

3B

House and Senate Appropriations Chairs' Guidance for Subcommittee Chairs
February 7, 2013

Joint Budget Strategy

- Focus on core functions of government and whether they are adequately funded
- Continue to look for efficiencies across State government, including looking at duplicative programs
- Evaluate appropriate funding level for non-core services, including non-profits and other non-essential services
- Consider ways to strengthen the General Fund; evaluate special funds

Subcommittee Work

- Conduct joint meetings with House and Senate
- Rotate presiding over meetings
- Maintain transparency (open meetings & web pages)
- Start with joint educational meetings
    - Fiscal Research staff will provide relevant budget background
    - Review past legislative budget and policy actions
    - Review interim committee reports
    - Review federal changes impacting states
    - Hear Governor's Budget (when appropriate)
- Refer certain items to the Full Chairs
    - Salary-related items, debt service, or other Statewide issues
    - Fee increases/decreases
    - Unresolved items
- Consult other subcommittees as necessary

Guidance Forthcoming

- Spending targets
- Subcommittee deliberations and voting
- Special provisions

§ 143B-138.1. Department of Health and Human Services – functions and organization.

(a) All functions, powers, duties, and obligations previously vested in the following commissions, boards, councils, committees, or subunits of the Department of Human Resources are transferred to and vested in the Department of Health and Human Services by a Type I transfer, as defined in G.S. 143A-6:

(1) Division of Aging.
(2) Division of Services for the Blind.
(3) Division of Medical Assistance.
(4) Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
(5) Division of Social Services.
(6) Division of Health Service Regulation.
(7) Division of Vocational Rehabilitation.
(8) Repealed by Session Laws 1998-202, s. 4(v), effective January 1, 1999.
(9) Division of Services for the Deaf and the Blind.
(10) Repealed by Session Laws 2011-326, s. 19, effective June 27, 2011.
(11) Division of Child Development.
(12) Office of Rural Health.

(b) All functions, powers, duties, and obligations previously vested in the following commissions, boards, councils, committees, or subunits of the Department of Human Resources are transferred to and vested in the Department of Health and Human Services by a Type II transfer, as defined in G.S. 143A-6:

(1) Respite Care Program.
(2) Governor's Advisory Council on Aging.
(3) Commission for the Blind.
(4) Professional Advisory Committee.
(5) Consumer and Advocacy Advisory Committee for the Blind.
(6) Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services.
(7) Social Services Commission.
(8) Child Day Care Commission.
(9) Medical Care Commission.
(10) Emergency Medical Services Advisory Council.
(11) Board of Directors of the Governor Morehead School.
(12) Board of Directors for the North Carolina Schools for the Deaf.
(13) North Carolina Council for the Hearing Impaired.
(14) Repealed by Session Laws 2002, ch. 126, s. 10.10D(c), effective October 1, 2002.
(15) Council on Developmental Disabilities.

(c) The functions, powers, duties, and obligations previously vested in the following commissions, boards, councils, committees, or subunits of the Department of Environment, Health, and Natural Resources are transferred to and vested in the Department of Health and Human Services by a Type I transfer, as defined in G.S. 143A-6:

(1) Division of Dental Health.
(2) State Center for Health Statistics.
(3) Division of Epidemiology.
(4) Division of Health Promotion.
(5) Division of Maternal and Child Health.
(6) Office of Minority Health.

(7) Office of Public Health Nursing.
(8) Division of Laboratory Services.
(9) Office of Local Health Services.
(10) Division of Postmortem Medicolegal Examinations.
(11) Office of Women's Health.

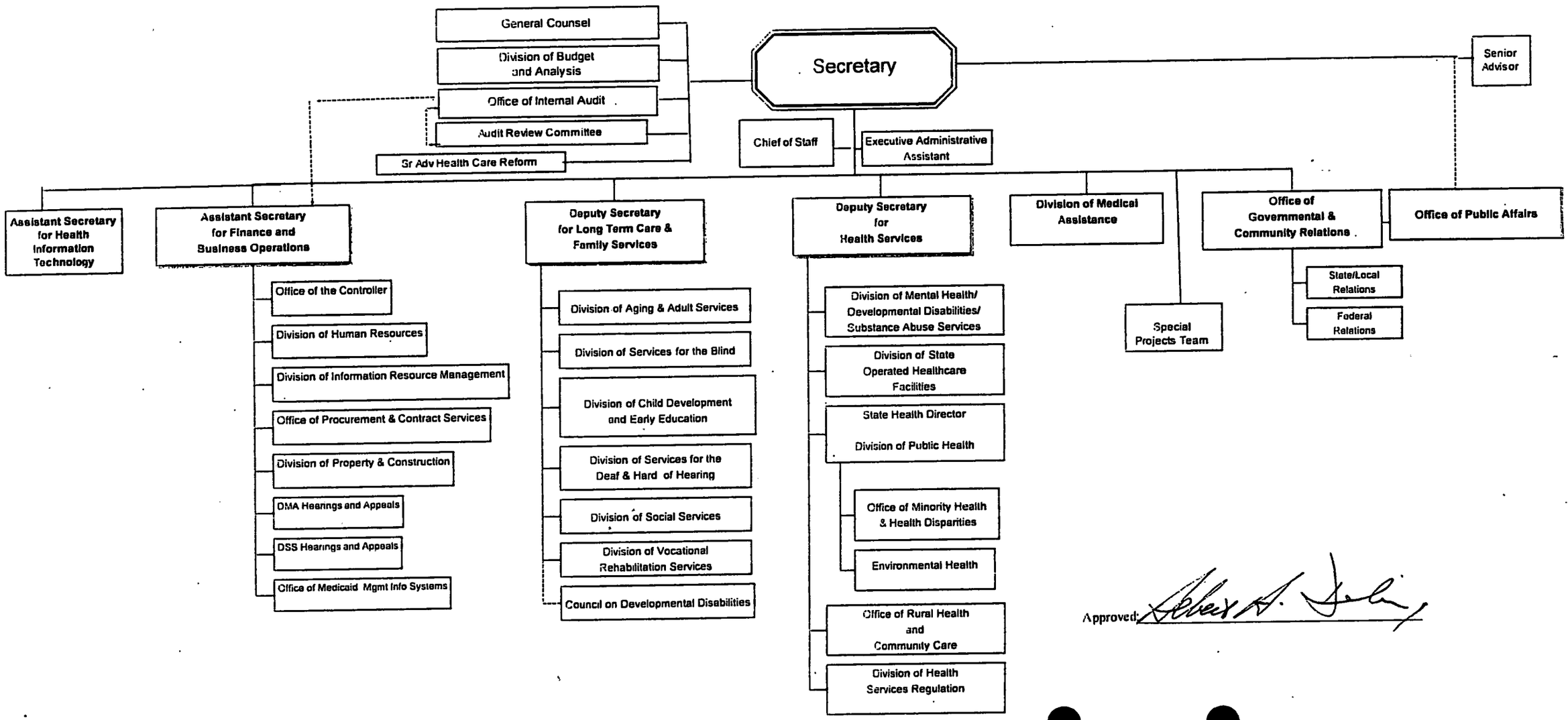
(d) All functions, powers, duties, and obligations previously vested in the following commissions, boards, councils, committees, or subunits of the Department of Environment, Health, and Natural Resources are transferred to and vested in the Department of Health and Human Services by a Type II transfer, as defined in G.S. 143A-6:

(1) Commission for Public Health.
(2) Council on Sickle Cell Syndrome.
(3) Repealed by Session Laws 2011-266, s. 1.30(b), effective July 1, 2011.
(4) Commission of Anatomy.
(5) Minority Health Advisory Council.
(6) Advisory Committee on Cancer Coordination and Control.

(e) The Department of Health and Human Services is vested with all other functions, powers, duties, and obligations as are conferred by the Constitution and laws of this State. (1997-443, s. 11A.3; 1998-202, s. 4(v); 2002-126, s. 10.10D(c); 2007-182, ss. 1, 2; 2011-266, s. 1.30(b); 2011-326, s. 19.)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

July, 2012

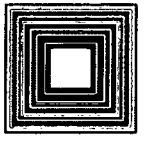


Approved:

Department of Health and Human Services Overview

Susan Jacobs
Fiscal Research Division

February 12, 2013



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Department of Health and Human Services
Authority

G.S. 143B-137.1. Department of Health and Human Services – duties.

It shall be the duty of the Department to:

- provide the necessary management, development of policy, and establishment and enforcement of standards for the provisions of services in the fields of public and mental health and rehabilitation
- with the intent to assist all citizens – as individuals, families, and communities – to achieve and maintain an adequate level of health, social and economic well being, and dignity.
- Whenever possible, the Department shall emphasize preventive measures to avoid or to reduce the need for costly emergency treatments that often result from lack of forethought.
- The Department shall establish priorities to eliminate those excessive expenses incurred by the State for lack of adequate funding or careful planning of preventive measures. (1997 443, s. 11A.3.)

Department of Health and Human Services

Organization G.S. 143B-138.1

See Handout

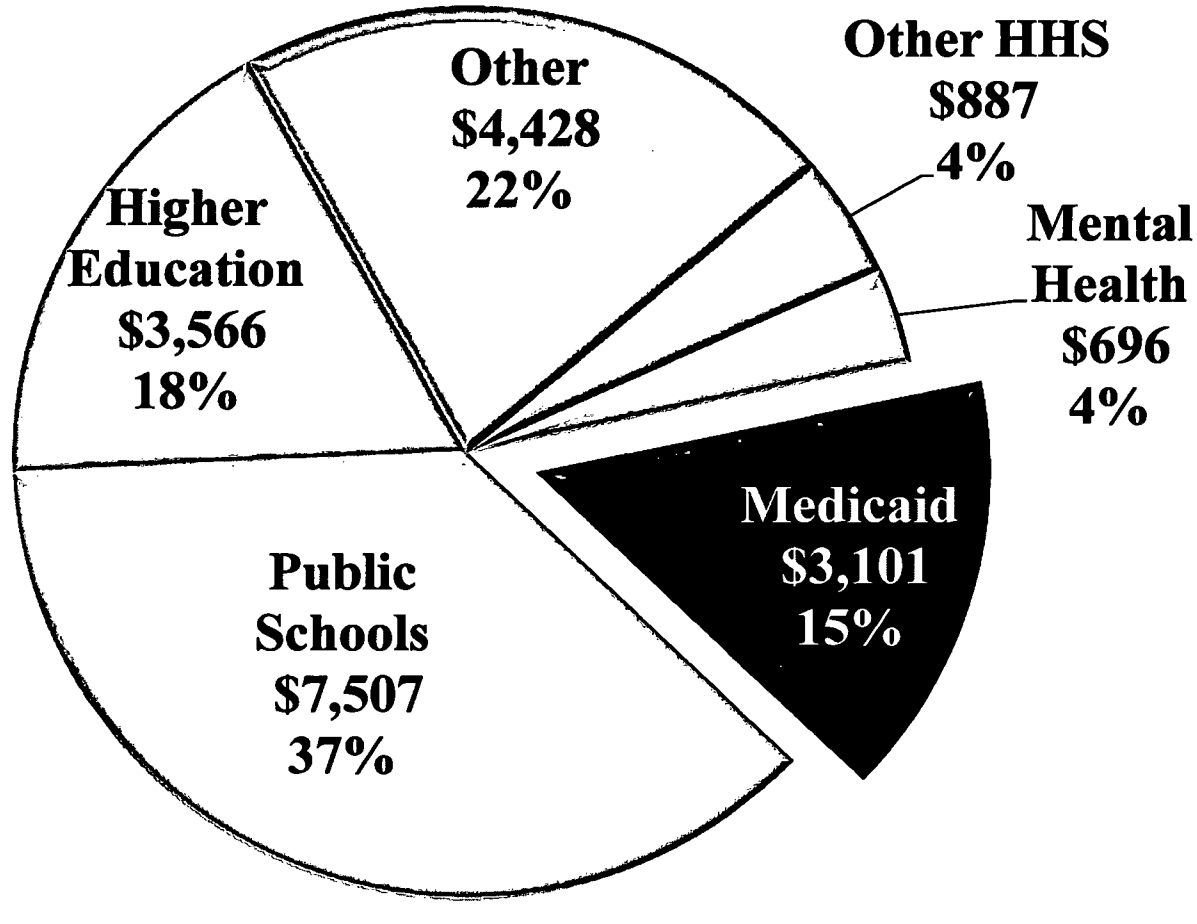
Department of Health and Human Services
2012-13 General Fund Budget

Subcommittee/Area	General Fund Appropriation	% of Total
Education	11,072,499,236	54.86%
Health & Human Services	**4,683,868,314**	**23.21%**
Justice & Public Safety	2,282,236,908	11.31%
Natural & Economic Resources	373,772,147	1.85%
General Government	396,266,560	1.96%
Capital & Debt Service	708,696,719	3.51%
Statewide Reserves and Capital	666,895,930	3.30%
TOTAL	**$20,184,235,814**	**100.00%**

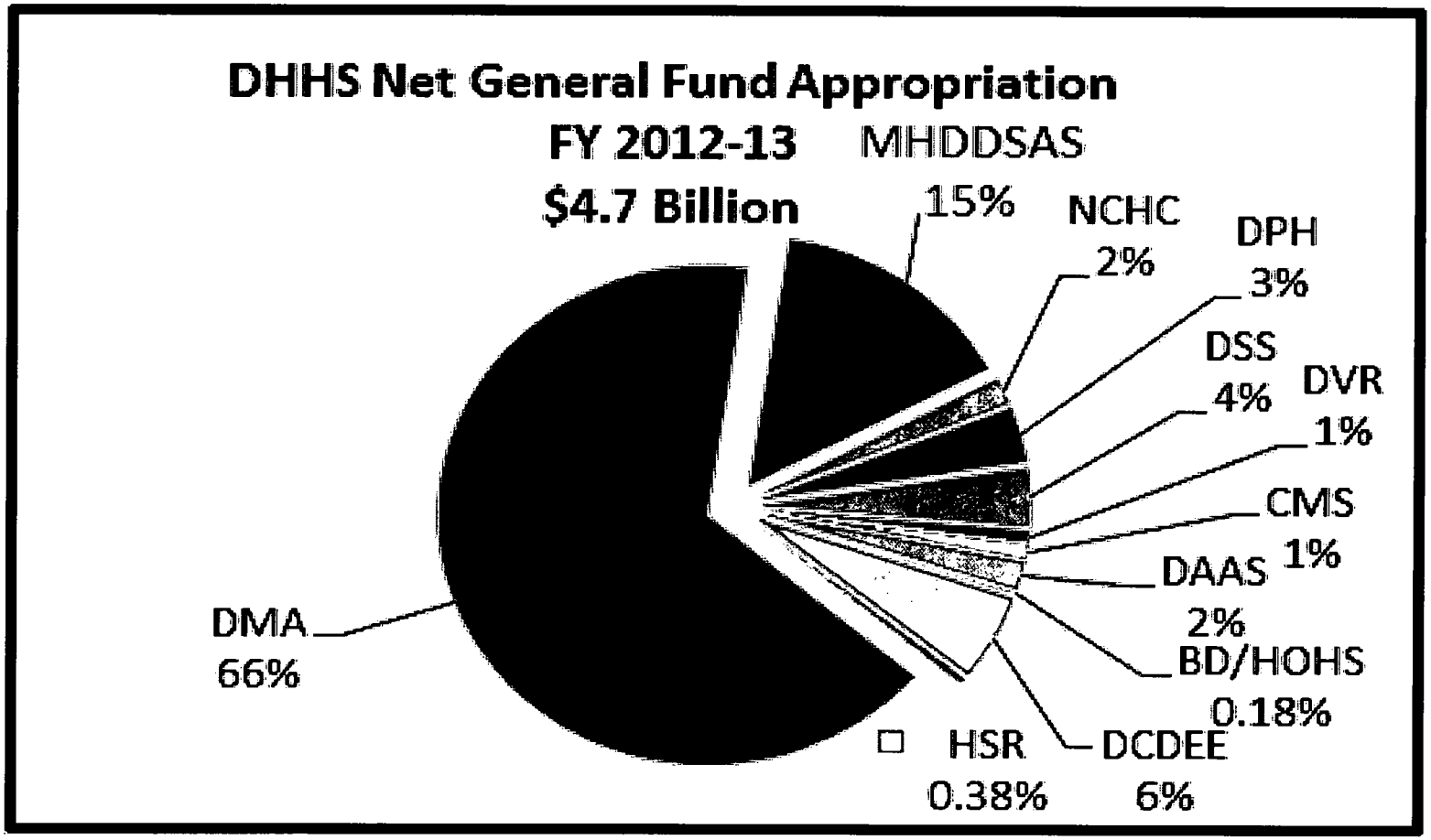
Department of Health and Human Services
2012-13 General Fund Budget

General Fund Appropriations FY 2012-13

Total: $20,184.2 million



Department of Health and Human Services
2012-13 General Fund Budget



Department of Health and Human Services
2012-13 General Fund Budget

DHHS Agency	2012-13	% of Total
Blind and Deaf / Hard of Hearing Services	8,204,550	0.18%
Health Service Regulation	17,925,590	0.38%
Vocational Rehabilitation	37,528,128	0.80%
Central Management and Support	45,885,628	0.98%
NC Health Choice	81,710,435	1.74%
Aging and Adult Services	87,019,667	1.86%
Public Health	168,923,612	3.61%
Social Services	177,103,952	3.78%
Child Development	262,602,933	5.61%
Mental Health, Dev. Disabilities and Sub. Abuse	695,515,251	14.85%
Medical Assistance	3,101,448,568	66.22%
Total Health and Human Services	**$ 4,683,868,314**	**100.00%**

Department of Health and Human Services
2011-12 Legislative Adjustments

	Governor's Continuation Budget	Legislative Net Changes	Revised Appropriation 2011-12	% Change
Central Management and Support	70,229,335	(20,051,958)	50,177,377	-28.55%
Aging and Adult Services	37,419,667	(400,000)	37,019,667	-1.07%
Blind and Deaf / Hard of Hearing Services	8,389,110	0	8,389,110	0.00%
Child Development*	261,759,600	4,343,333	266,102,933	1.66%
Health Service Regulation	17,925,590	(1,792,559)	16,133,031	-10.00%
Medical Assistance**	3,314,539,538	(356,151,354)	2,958,388,184	-10.75%
Mental Health, Dev. Disabilities and Sub. Abuse	723,675,112	(57,962,880)	665,712,232	-8.01%
NC Health Choice	88,373,806	(8,921,489)	79,452,317	-10.10%
Public Health***	161,930,589	28,512,656	190,443,245	17.61%
Social Services	202,245,063	(16,061,995)	186,183,068	-7.94%
Vocational Rehabilitation	41,252,238	(4,126,450)	37,125,788	-10.00%
Total Health and Human Services	**4,927,739,648**	**(432,612,696)**	**4,495,126,952**	**-8.78%**

*Pre-Kindergarten funds ($65,011,651) were transferred from the Department of Pubic Instruction to the Division of Child Development.

** In Fiscal Year 10-11, a Federal Medical Assistance Percentage (FMAP) shortfall of approximately $222 million was managed based on legislative authority provided to the Budget Director. Session Law 2011-23 prohibited the use of provider rate reductions in covering the FMAP shortfall (estimated at $26,618,875 in the 2010 Budget Technical Corrections FMAP contingency plan). Session Law 2011-145 earmarked $125,000,000 of the year-end unreserved fund balance to repay an early-draw down of federal funds. These earmarked funds are not reflected in the appropriation for the Division of Medical Assistance.

***Funds from the Health and Wellness Trust Fund were transferred to the Division of Public Health ($32,904,411) for one year.

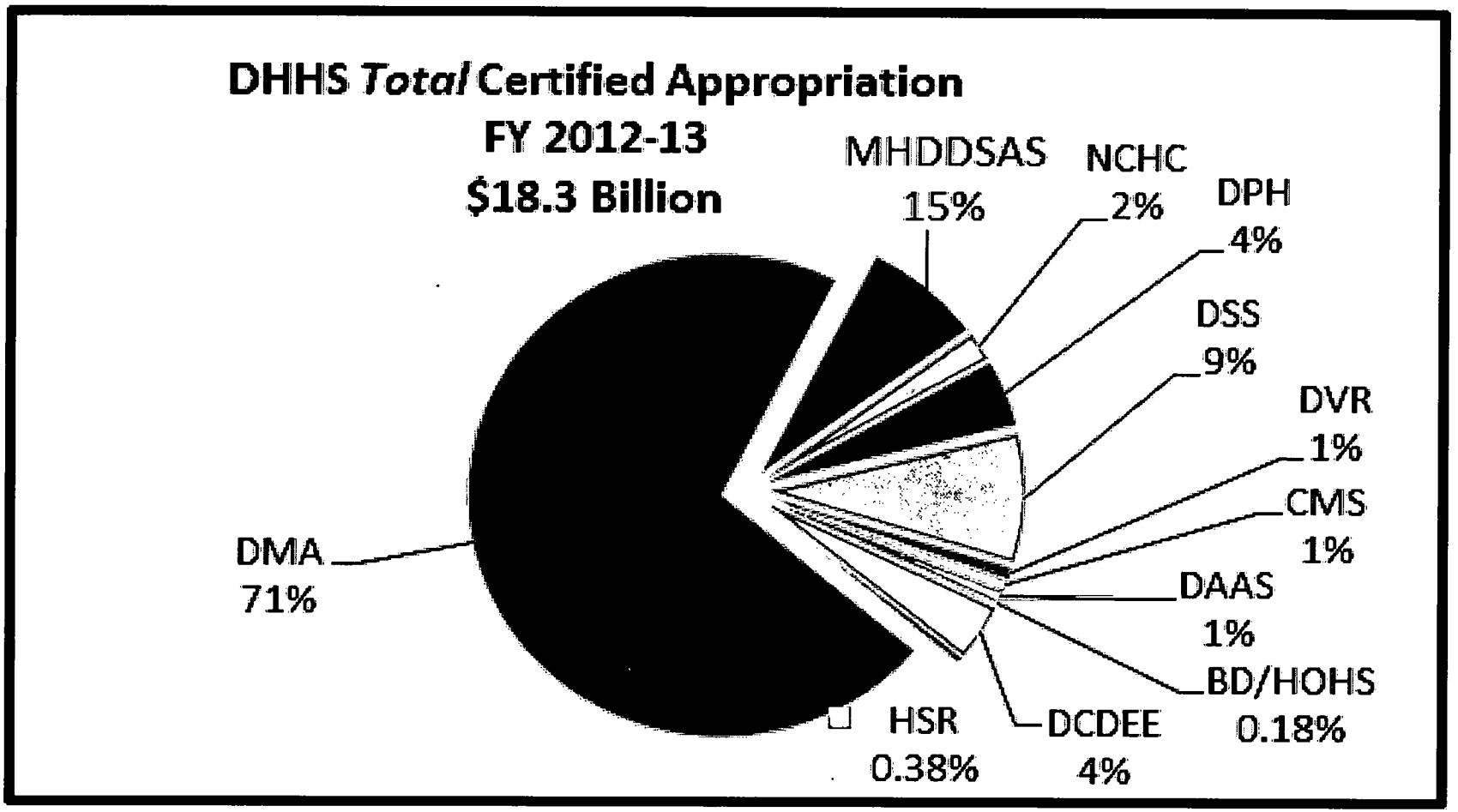
Department of Health and Human Services
2012-13 Legislative Adjustments

	Governor's Continuation Budget	Legislative Net Changes	Revised Appropriation 2012-13	% Change
Central Management and Support	70,229,335	(24,343,707)	45,885,628	-34.66%
Aging and Adult Services	37,419,667	49,600,000	87,019,667	132.55%
Blind and Deaf / Hard of Hearing Services	8,372,886	(168,336)	8,204,550	-2.01%
Child Development	261,759,600	843,333	262,602,933	0.32%
Health Service Regulation	17,925,590	0	17,925,590	0.00%
Medical Assistance*	3,314,539,538	(213,090,970)	3,101,448,568	-6.43%
Mental Health, Dev. Disabilities and Sub. Abuse	723,675,112	(28,159,861)	695,515,251	-3.89%
NC Health Choice	88,373,806	(6,663,371)	81,710,435	-7.54%
Public Health**	161,930,589	6,993,023	168,923,612	4.32%
Social Services	202,245,063	(25,141,111)	177,103,952	-12.43%
Vocational Rehabilitation	41,654,578	(4,126,450)	37,528,128	-9.91%
Total Health and Human Services	**4,928,125,764**	**(244,257,450)**	**4,683,868,314**	**-4.96%**

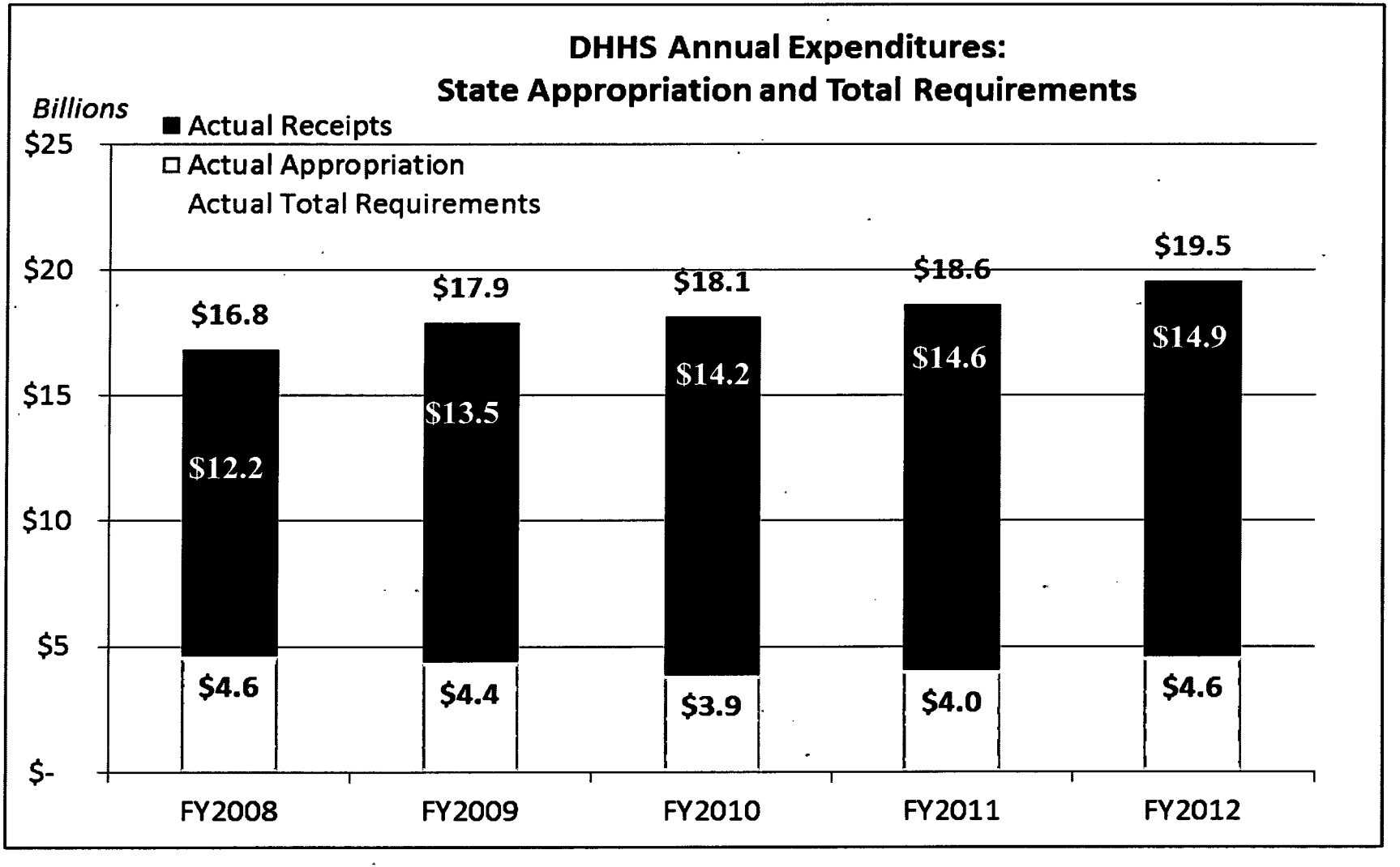
*In order to manage a Medicaid shortfall in FY 11/12 the legislature had to take several actions: Session Law 2012-2 transferred funds to the Division of Medical Assistance($205,000,000); Session Law 2012-57 allowed for an additional amount to be transferred ($94,000,000) from the Repairs and Renovations Reserve (R&R) Account. The actual amount of R &R funds used was ($27,850,559); Transfers and other receipts used to cover the shortfall totaled $142,064,399. The total gap managed by the Budget Director and the legislature for FY 11/12 was $375,369,399.

*Technical adjustment - Transfer of Environmental Health from DENR to Public Health.

Department of Health and Human Services
2012-13 Total Budget

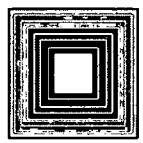


Department of Health and Human Services
Historical Expenditures by Fund Source



Attachment

DHHS Agencies



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Division of Central Management and Support (Office of the Secretary)

PURPOSE

- Provides agency-wide administrative support to the divisions and offices within DHHS. Sections include:

- Budget and Analysis
- Internal Auditor
- Information Resource Management
- Citizen Services
- Medicaid Management Information System
- Office of the Secretary
- Human Resources
- Controller
- Property & Construction
- Government & Community Relations
- Office of Rural Health

Division of Child Development (DCD)

PURPOSE

- Supports early childhood services, including:
  - Regulation and Licensure of child care centers and homes
  - Administration of Child Care Subsidies
  - Early childhood initiatives
  - Other

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and State Operated Facilities (DMH/DD/SAS)

PURPOSE

- Provides prevention, intervention, treatment and services to people who have or at risk of having:
  - Mental illness
  - Developmental disabilities
  - Substance abuse problems

- Includes
  - Community-based services
  - State-operated residential treatment facilities
    - Psychiatric hospitals and developmental centers
    - Alcohol and drug abuse treatment centers (ADATCs)
    - Neuro-medical centers (psychiatric and developmental disability)
    - Residential programs for children

Division of Medical Assistance (DMA)

PURPOSE

- Title XIX of the Social Security Act – Medicaid is an entitlement program designed to pay for medical care for low-income families and individuals. Costs for the program are shared by states and the federal government.

- Health insurance for
  - Low-income families
  - Long-term care for elderly
  - Services for people with disabilities

- Eligibility is determined by income, assets, age, and disability

Health Choice (CHIP)

PURPOSE

- Provide health insurance to uninsured children
  - Up to age 18
  - From families with income up to 200 percent FPL
- Benefits that mirror the State Health Plan, plus
  - Dental, Vision, Hearing
- Not an entitlement program
- Administered by Division of Medical Assistance

Division of Aging and Adult Services (DAAS)

PURPOSE

- Provides services for the elderly and services for disabled adults through
  - 17 Area Agencies on Aging
  - 100 county departments of social services

- Programs include :
  - Home and community based services
    - Adult day care
    - Nutrition services
    - Transportation
    - Senior Centers
  - Adult protective services and guardianship
  - State/County Special Assistance for adult care homes
  - At-risk and adult care home case management

Division of Health Service Regulation (DHR)

PURPOSE

- Establish and enforce the regulation of facilities

- Major functions:
  - Medical facilities planning
  - Licensure and regulation of the construction and operation of facilities
  - Operation of the health care personnel registry
  - Development of statewide emergency medical services (EMS)

Division of Public Health (DPH)

PURPOSE

- Supports the Local Health Departments
- Epidemiology
  - State Laboratory
  - Communicable Disease
  - Public Health Preparedness
  - Epidemiology
- Women's and Children's Health
  - Maternal and Infant Health
  - Early Intervention
  - Child Health
- State Center for Health Statistics
- Chronic Disease
  - Diabetes, Heart Disease, Stroke, Tobacco-use, & Obesity

Division of Social Services (DSS)

PURPOSE

- Provides services ,through the 100 county social services departments, to children and families, including:
  - Work First Family Assistance
  - Food and Nutrition Services (aka Food Stamps)
  - Child Welfare
    - Child Support Enforcement
    - Child Protective Services
    - Adoption and Foster Care
  - Other
    - Low-income Home Energy Assistance (LIHEAP) Refugee Assistance

Division of Vocational Rehabilitation (DVR)

PURPOSE

- Serve persons with physical, intellectual, and psychiatric disabilities
  - Employment training and readiness services.
  - Independent living services.
  - Assistive Technology services.
- Processes applications and determines eligibility for federal Social Security Disability, Supplemental Security (SSI), and Medicaid benefits

Divisions of Blind, Deaf and Hard-of-Hearing

PURPOSE

- Provide comprehensive range of services including information, referrals, advocacy, training, outreach, interpreters, assistive technology
- Services to Blind: blind or visually impaired individuals
- Services for Deaf and Hard-of-Hearing: deaf, hard-of-hearing, or speech impaired individuals, affected families, agencies, and businesses

Questions?

North Carolina General Assembly
Fiscal Research Division
Room 619
Legislative Office Building
Raleigh, NC 27603-5925
(919)-733-4910

http://www.ncleg.net/FiscalResearch/

Committee Sergeants at Arms

NAME OF COMMITTEE JOINT APPRORIATIONS ON HEALTH AND HUMAN SERVICES

DATE: FEB. 12, 2013 Room: 643

House Sgt-At Arms:

1. Name: FRED HINES
2. Name: CHARLES GODWIN
3. Name: _____
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: Leslie Wright
2. Name: Steve Wilson
3. Name: _____
4. Name: _____
5. Name: _____

Senate Page

PAGES ATTENDING

COMMITTEE: Approps. on Health & Human Services ROOM: 643 & 643

DATE: 2-12-13 TIME: 8:30

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!

	Page Name	Hometown	Sponsoring Senator
1	Jessica White	[redacted] Mocksville	Brock
2			
3			
4			
5			
6			
7			
8			
9			
10			

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

House Pages

Wednesday, February 12
APPROPRIATIONS
HEALTH & HUMAN
SERVICES

Room
643

Time
8:30 am

Date Feb. 12, 2013

Name	County	Sponsor
Alec Johnson	Hagwood	Queen
Erin Kehoe	Cumberland	Glazier
Riaz Lane	Chowan	Steinburg, Sr.
Claire Ledford	Yancey	Presnell

VISITOR REGISTRATION SHEET Tuesday

Appropriations Subcommittee on HHS — 2.12.2013

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Townes Maxwell	Public Sector Group
Michelle Frazier	MFS
Kerra Bolton	LCS
Annaliese Dolph	DRNC
Mary Bethune	AARP
Sarah Preston	ACLU-NC
Elizabeth Hudgins	CFTF
Louise Fisher	Advocate for Mentally Ill
Whitney Christianson	NCRLA
Bill Scott	DHHS
Chuck Stone	SEARC
Kara McDonald	# Benchmarks
Paula Cox Fishman	Volunteer Advocate for IDD

VISITOR REGISTRATION SHEET Tuesday

Appropriations Subcommittee on HHS — 2/12/2013

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Caroline Webb	The Policy Group
Johanna Reese	NCACC
Jennifer Mahan	ASNC
Andrew Blackburn	SSG
Andy Chase	KMA
Magdalena Fernández	NCCHCA
Rebecca Whitaker	NCCHCA
Matt Gross	NCPC
Sarah Rothecker	Brubaker Associates
Daniel Ambrose	NCRMA
Steven Webb	NCHBA

VISITOR REGISTRATION SHEET Tuesday

Appropriations Subcommittee on HHS — 2.12.2013

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carissa Hilliard	NCHA - Cary, NC
Kay Pallay	NASW-NC
Reston Jones	Governor's Office
George Smith	Nexsen Pruet
Mattie McEneely	Carolinas HealthCare
Henry Hutaff	N.C.B.D.
Deborah Landry	OSBM
Wanda Mitchell	OSBM
Heather Densmore	Merck
Yolanda Smith	Capitol Access, Inc.
Alan Briggs	NC Food Banks
Colleen Kochanek	NCCEP
Cory Dunn	JRNC
Carolyn Hamilton	FLCD

Name	Organization
Andrew Meehan	Capstrat
Cody Hand	NCHA
Joel Mahaffey	GPM & Assoc.
Dan E. Way	Carolina Journal
Abby Emanuelson	NMSS
[illegible]	MWC
DAVID BARNES	Echelon's work for Jeff Barnhardt
Mark Fleming	
John Moyale	Policy Group

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS
Name of Committee

Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bill Rustin	AARP
Kara Weisharr	Smith Anderson
Wendy Kelly	Poyner Spruill
Joe Kamer	Nelson Mullins
Chris [illegible]	[illegible]
JAY PETERS	CSS
Jorge Peters	CSS
Joe Donovan	SC NC
Steve Shore	NC Pods Society
Bob Hoyt	NCAFP
[illegible]	NCSNA
Marci Waldman	Novant

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

AGENDA

February 13, 2013
Legislative Office Building - Room 643
8:30 a.m.

Representative Marilyn Avila, Presiding Chair

Aldona Wos, M.D., Secretary
Department of Health and Human Services

Priorities for the Department of Health and Human Services

Adjourn

Next Meeting:

February14, 2013- 8:30 a.m.

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

CHAIR'S AGENDA

February 13, 2013
Legislative Office Building - Room 643
8:30 a.m.

Representative Marilyn Avila, Presiding Chair

Aldona Wos, M.D., Secretary
Department of Health and Human Services

Priorities for the
Department of Health and
Human Services

Line Up of Speakers:

- Secretary Aldona Wos
- Deputy Secretary Sherry Bradsher
- Secretary Aldona Wos
- HHS CIO Joe Cooper
- Medicaid Director Carol Steckel

Adjourn

Next Meeting:

February14, 2013- 8:30 a.m.

Senate Committee on Appropriations on Health and Human Services
Wednesday, February 13, 2013 at 8:30 a.m.
Room 643

MINUTES

The Senate Committee on Appropriations on Health and Human Services met at 8:30 a.m. on February 13, 2013, in Room 643. Representatives Avila, William Brisson, Mark Hollo, Donny Lambeth, Susan Martin, Carl Ford, and Jim Fulghum were present, along with 5 Senate members.

Representative Marilyn Avila presided.

Representative Avila opened the meeting by welcoming everyone. She then introduced the House Sergeants-at-Arms,Young Bae and Martha Gadison along with Senate Sergeants-at-Arms, Leslie Wright and Steve Wilson. She also recognized the House Pages for the day which were Makayla Wiseman – Yancy County, Elizabeth Underwood – Iredell County, Eric Zelina – Mecklenburg, Max Wolfe – Forsyth County. The Senate Page was Jessica White of Davie County.

Secretary Aldona Wos was then recognized to speak regarding the priorities of the Department of Health and Human Services in the coming year. She explained the situation within the Department which she inherited when she was appointed as the Secretary, the difficulty of meeting deadlines and being sure the people being served were getting what they needed. She introduced members of her staff, Deputy Secretary Sherry Bradsher, HHS CIO Joe Cooper, and Medicaid Director Carol Steckel, who will be assisting her in getting the Department back on track. Each of them spoke about their specific job and how they hope to be able to make a difference within the Department.

Secretary Wos opened the meeting for members to have a brief "question and answer session" in which she called on members of her staff to respond.

The meeting adjourned at 9:50 a.m.

Marilyn W. Avila
Representative Marilyn Avila
Presiding

Edna Pearce
Edna Pearce, Committee Clerk

Susan Fanning (Sen. Ralph Hise)

From: Edna Pearce (Sen. Louis Pate)
Sent: Thursday, February 07, 2013 10:55 AM
To: Edna Pearce (Sen. Louis Pate)
Subject: <NCGA> Senate Appropriations on Health and Human Services Committee Meeting Notice for Wednesday, February 13, 2013 at 8:30 AM

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The **Senate Committee on Appropriations on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	February 13, 2013	8:30 AM	643 LOB

Secretary Wos to present priorities for biennium

Senator Ralph Hise, Co-Chair
Senator Louis Pate, Co-Chair

Department of Health and Human Services

Unfunded Liabilities as of January 5, 2013

Jim Slate, Director, Budget & Analysis, DHHS
Jim.Slate@dhhs.nc.gov; 919-855-4850

- **Total Unfunded Liabilities** **$49,927,369**

  - Permanent Reduction to Non-profit Contracts $5,000,000
    Per HB 950, Section 10.18
    - This reduction was required by legislation in 2011, but was addressed with one-time funding.
    - This reduction was re-emphasized in the 2012 session, but was not addressed prior to January, 2013.
    - To comply with the legislative mandate, contract reductions have been identified and will be implemented with an effective date of March 1.

  - Division of Mental Health Unpaid Bills $35,629,079
    - Beginning in SFY 08-09, Broughton and Cherry both temporarily lost their ability to bring in patient receipts from Medicare and Medicaid to support hospital operations.
    - More recently the closure of the Dorothea Dix hospital and the opening of the new Central Regional Hospital also had a negative impact on revenue collection.
    - The Division Mental Health carried forward $35M in unpaid invoices into the current state fiscal year.

  - Recurring Mental Health Facility Revenue Shortfall $4,998,290
    - Steps have been taken to reduce the ongoing revenue shortfall through administrative efficiencies and revenue enhancement initiatives.
    - However, even with these efforts, the SFY 12-13 shortfall amount is expected to be $5M.

  - Intellectual\Developmental Disabilities Community Services Funding $4,300,000
    - Due to an error in communication between the Department and the legislature in developing the Social Services Block Grant, funding for ongoing services were not included in budget.

Department of Health and Human Services

1915 b/c Waiver Expansion (Behavioral Health Managed Care)

Kelly Crosbie, Assistant Director of Behavioral Health Services
Division of Medical Assistance, DHHS
Kelly.Crosbie@dhhs.nc.gov; 919-855-4293

SL 2011, HB 916 required DHHS to roll-out Medicaid managed care using Local Management Entities (LMEs) as Medicaid vendors. LMEs were required to prove 'readiness' as evaluated by Mercer Human Services Consulting, to operate managed care operations according to the Medicaid contract. Nine of 11 LMEs have passed readiness reviews to begin by February 1, 2013. Final expansion must be completed by July 1, 2013.

- Managed Care Organizations (MCOs) currently operating under the waiver**
  - Cardinal Innovations (formerly PBH)--2005
  - Western Highlands Network (WHN)--January 2012
  - East Carolina Behavioral Health (ECBH)--April 2012
  - Smoky Mountain Center (SMC)--July 2012
  - Sandhills Center--December 2012
    - Will add Guilford county in April 2013
  - Eastpointe--January 2013
  - Partners Behavioral Health Management--February 2013
  - Alliance Behavioral Healthcare--February 2013
  - CenterPoint Human Services--February 2013
  - ****These MCOs have annual external monitoring (Mercer)**

- LMEs with final readiness reviews pending
  - **MeckLINK**--February 13
  - **CoastalCare**—February 12
    - Final decisions on readiness by February 15
  - **Goal is March 2013 start-date**

- DHHS Contingency Planning
  - Mercer is performing capacity studies at each MCO to determine their ability to absorb other MCO catchment areas. Those completed include:
    - **Cardinal Innovations**—December 19, 2012
    - **East Carolina Behavioral Health (ECBH)**—January 17, 2013
    - **Smoky Mountain Center (SMC)**—February 7, 2013

Department of Health and Human Services

U.S. Department of Justice Agreement Implementation

Jessica Bradley Keith, Special Advisor on ADA, DHHS
Jessica.Bradley@dhhs.nc.gov; 919-855-4809

Implementation Plan Deliverable	DOJ Settlement Requirement July 1, 2013	January 2013 DOJ Rate	February 2013 Target DOJ Rate	March 2013 Target DOJ Rate	April 2013 Target DOJ Rate	May 2013 Target DOJ Rate	June 2013 Target DOJ Rate
Supported Employment	100	0	0	15	30	60	100
Assertive Community Treatment	32 teams, 3225 individuals	0	0	0	15 teams	25 teams	35 teams
Supportive Housing	100	0	0	15	40	75	120
In Reach and Transition Activity	In Reach Begins February 18, 2013	0	50/0	100/20	200/40	300/80	400/160

US DOJ Settlement Budget (100% State Appropriations Required)

SFY 12-13	SFY 13-14	SFY 14-15	SFY 15-16
$7,098,027.00	$14,134,275.20	$19,694,658.26	$27,774,663.37
SFY 16-17	SFY 17-18	SFY 18-19	SFY 19-20
$35,946,653.94	$44,182,278.63	$52,328,426.08	$58,807,374.16

Settlement Milestones

- In reach training materials developed
  - 3 trainings with MCOs and State Hospitals
  - PASRR trainings- Every Friday in February

- Diversion
  - PASRR Screening and Diversion process began January 1, 2013
  - Hearing on Temp Rule: Rule Passed 2/6/13 in effect March 1st for independent screening process

- Communications
  - Website http://www.ncdhhs.gov/mhddsas/providers/dojsettlement/milestones.htm
  - If staff receive questions: refer to Jessica.Bradley@DHHS.NC.gov or to website

Next Steps to Meet Requirements

In Reach and Transitions

- In-Reach in Adult Care Homes begins February 2013- Settlement requires in reach to begin by February 18th.
  - Letter sent out Monday to ACH Providers about In reach

Housing

- Housing Subsidy Administrator contracts completed monthly cost to administer subsidy program and provide tenancy supports $132,314 plus cost of subsidies. Housing slots for transitions will be available March 1st
  - Each MCO was assigned 15 housing slots for FY 12/13
  - Coastal Care- 4 individuals were approved for housing slots and are currently residing in New Hanover in apartments
  - Completed RFQ sent out of DSSH 2/7/13 for apartment locator with IT enhancements

The Reviewer was in town on the February 11 and 12, 2013. Met with staff responsible for Diversion and Housing Services. Also met with the new Medicaid director and visited Cherry Hospital.

First conference call between Department of Justice and DHHS since signing the agreement will be held February 15, 2013.

Edna Pearce (Sen. Louis Pate)

From: Davis, Katherine M <katherine.m.davis@dhhs.nc.gov>
Sent: Thursday, February 14, 2013 02:59 PM
Rep. Marilyn Avila; Rep. William Brisson; Rep. Mark Hollo; Rep. Donny Lambeth; Rep. Susan Martin; Rep. Tom Murry; Rep. Beverly Earle; Rep. Jean Farmer-Butterfield; Rep. Carl Ford; Rep. Jim Fulghum; Rep. Verla Insko; Sen. Louis Pate; Sen. Ralph Hise; Sen. Austin Allran; Sen. Tamara Barringer; Sen. Floyd McKissick; Sen. Gladys Robinson
Cc: Sholar, Adam
Subject: Message sent of behalf of Adam Sholar, DHHS Dir. Intergovernmental Relations
Attachments: Responses to Questions from 2-13 meeting (3).doc

Importance: High

Members of the Appropriations Subcommittee on Health and Human Services,

Please find attached responses to questions asked during the meeting the morning of Wednesday, February 13, 2013. If I can provide any additional information, please do not hesitate to contact me.

Sincerely,

Adam Sholar

Adam Sholar, J.D.
Director of Intergovernmental Relations
Department of Health and Human Services
adam.sholar@dhhs.nc.gov
919 855.4830

Katherine M. Davis
NC DHHS
Office of Governmental and Community Relations
101 Blair Drive
Raleigh, NC 27603

Phone: 919/855-4832 (direct)
Fax: 919/715-4645

Joint Appropriations Subcommittee on Health and Human Services
Additional information from DHHS
February 13, 2013 Meeting

Question 1:

In response to the question regarding HHS's CAP funding:

	SFY 2012	YTD 2013 at 1/13
CAP Disabled	$237,809,885	$127,891,008
CAP MR	$485,143,172	$216,588,971

These are total dollars (federal and state)

Question 2:

In response to the question regarding the number of substantiated child abuse claims:

In SFY 2011-12, county departments of social services across NC received 76,253 reports of child abuse and/or neglect impacting 147,337* children. Of those, 72,575 children were found to be in need of services.

*Children may have more than one finding or be included on multiple reports.

Question 3:

In response to the question regarding NC FAST costs to the state per year, HHS's Budget team is still in the process of compiling information and will provide an update as quickly as possible.

Question 4:

In response to the question for updated information regarding HHS's organization and hiring, HHS will provide periodic updates as that information changes.

House Committee Pages / Sergeants at Arms

NAME OF COMMITTEE Joint App. HSS.

DATE: 2/13/13 **Room:** 643

*Name: MA Kayla Wiseman
County: Yancey
Sponsor: Rep Michele Presnell

*Name: Elizabeth Underwood
County: Iredell
Sponsor: Rep Robert Brawley

*Name: Eric Zelina
County: Mecklenburg
Sponsor: Rep Larry Pittman

*Name: Max White
County: Forsyth
Sponsor: Rep Justin Burr

*Name: Jessica White
County: Davie
Sponsor: Sen Andrew Brock

House

~~House~~ Sgt-At Arms: Senate

1. Name: Young Bae
2. Name: Martha Gadison
3. Name:
4. Name: Steve Wilson
5. Name: Leslie Wright
6. Name:

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — **Name of Committee**

2-13-2013 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sandra Farmer	Brain Injury Association of N.C.
CAROL ORNITZ	NC BRAIN INJURY ADVISORY COUNCIL
Chris Kiricoples	NC Developmental Disabilities Consort
Julia Adams	The Arc of NC / NCARF
Yvonne Copeland	NC Council of Comm Progs
Tom [illegible]	LEADING AGG NC
Alex Mullinax	CCBHC Mental Health
[illegible]	[illegible]
[illegible]	NCATCP
Michael Maybee	MH Commission
Greg Griggs	NCAFP

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — 2-13-2013

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kelly Nicholson	UNC Health Care
RICHARD TOPPING	CARDINAL INNOVATIONS
JEFF BARNHART	MWC
Robin Huffman	NC Psychiatric Association
Steve Mitchell	Astellas
Will Woodell	Value Options
Jon Carr	Jordan Price
Lou Wilson	NCOAPCF
Michelle Frazier	MFS
Johanna Reese	NCACC
Ally Neuhoff	NAMI NC

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — **Name of Committee**

2-13-2013 — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chris Danford	NCAFP
Judy Jenkins	OAPI
	SDC
	NCCHCR
Rebecca Whitaker	NCCHCR
Daniel VanLiere	Vidant Health
Kevin Kelley	NC DHHS DSS
DAVID STONE	The Carolinas Center for Hospice and EOL Care
Karen Lemmons	NCNA - Nurse for the Day
	NCNA NCSNA

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — 2-13-2013

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Harrell	Home Assoc
	DCDSR
Chris Payne	NCMS
	NCDC
Maeve Hanlon	GSD
John McMillan	MFOS
David Crawford	AIA NC
Tony Dunn	DRNC
Angel Sams	NSS
Erica Nelson	NCHA
Chip Killian	Nelson Mullins

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — 2-13-2013

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Delon Fletcher	DHHS/
[illegible]	R. Clark & Assoc.
Bill Rustad	NCP
Mike Stone	DCP
[illegible]	[illegible]
Dana Simpson	NCSA
Hugh Tilson	NLHA
John Monroe	Privity Group
BD Health	McGuireWoods
Brian Francis	Mack Cary
Daniel Baum	Troutman Sanders

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on HHS — 2-13-2013

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kevin FitzGerald	UNC GA
Wendy Kelly	Policy Group
Doug Miskiew	PSG
Amy McConkey	NC Beverage

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

2-13-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Whitney Christensen	NCRLA
TRACY GOLVARD	AHHE
ALAN BRIGGS	NC FOOD BANKS
Jimmy Broughton	Womble Carlyle
Rob Thompson	Covenant / NC's Children
Jill Cox	United Way of NC
DWAYNE MCKINLEY	STATE AUDITOR
Maria Whitehead	Senator Berger
Madisson Mackenzie	DOJ
Karen Moriarty	Carillon Assisted Living
Chris McClure	Brooks Pierce
KAREN GILLESPIE	BMS
JESSICA HOFFMANN	GOVERNOR'S INSTITUTE
Sarah Rothacker	Brubaker & Associates
Jonathan Brubaker	Brubaker & Associates
Ben O'Connell	March of Dimes
Elizabeth Hedgepeth	CFTF

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

2-12-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
George Smith	Nexsen Pruet
Louise Fisher	Advocate for Mentally Ill
Melissa Reed	PPHS
Morgan Beam	Gov. Office
[illegible]	DHHS
Matt Gross	NCIL
Stephanie Fanjul	NCPC
Kerra Bolton	LCA
Annaliese Dolph	DRNC
BRAD ALLEN	NCSC
Pam Shipman	Cardinal Innovations
Evelyn Hall Rome	UNC
Dean Plunkett	PS
Mary Bethune	AARP
Jessica Faddy	Governors Institute
[illegible]	[illegible]
Lauren Abraham	NASW-NC

09-21-201

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
(Committee Name)

2-13-13
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Johanna Field	NASW-NC
Mike Freeman	NCHE
[signature]	SEANC
[signature]	MWC
[signature]	HP
Michael Mutter	MoHH

09-21-201